

CHILDBIRTH EXPERIENCES OF WOMEN FROM ONE
MI'KMAQ COMMUNITY IN NOVA SCOTIA

by

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Dedication

This thesis is dedicated to the Mi'kmaq women who so kindly shared their childbirth experiences to make this research work possible. Their voices are important to making change. I also dedicate this thesis to my dear husband Bill, who supported and inspired me and who tirelessly gave of his time in many ways to help me to accomplish this study. Also this thesis is dedicated to my sons Arthur and Matthew, step-children Tanya, Yvette, and grandchildren Victoria and Jason who were encouraging, patient, and understanding during this academic endeavor. To my mother and my sister Elizabeth who were always there to listen and give praise and encouragement, I am eternally grateful. I am thankful to my siblings and their families, who were so supportive and genuinely interested in this work.

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ABSTRACT

The fundamental life change that occurs during childbirth is influenced by culture. Current literature provides little information on the childbirth experiences of Mi'kmaq women, particularly giving birth in settings outside their own culture. This qualitative study provided new knowledge and a greater understanding about Mi'kmaq women's childbirth experiences. Feminist methodology formed the guiding principle. An Indigenous framework used helped to understand Mi'kmaq women and to recognize Indigenous Knowledge. Eleven first time Mi'kmaq mothers living in a First Nations Community in Nova Scotia participated. Data was collected by means of interviews and thematic analysis was used for interpretation. The findings revealed four major themes, which were (a) Unpreparedness For Childbirth, (b) Professional Relations as Sites For Invalidation, (c) Access to Health Care and (d) Support During Birthing. Continued collaboration and commitment from key stakeholders are necessary to address and improve health inequalities for Mi'kmaq women and families.

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Chapter I

INTRODUCTION

Background

Childbirth, the time when a woman gives birth to her child, is a life event for a mother and her family. Callister, Semenic, and Foster (1999) describe childbirth as “a deeply physiologic, cognitive, cultural, social and spiritual event” (p. 280). Labour and birth is generally a time of excitement and anticipation, in addition to uncertainty and fear for women and families (Health Canada, 2003a). Having a baby is a major transition in women’s lives (Health Canada, 2000) as they learn to become first time mothers. Memories and experiences of the birth remain in their minds forever (Health Canada, 2003a). Therefore, the care and support women receive during the intrapartum period is critical for maintaining health and preventing/minimizing complications. Supportive care during labour provides women with emotional support, comfort measures, information, advocacy, and support to the husband/partner all help women to relax and cope with labour (Hodnett, 1996). In doing so, women experience shorter labours, require less analgesia/anesthesia and operative deliveries, and other medical interventions, contributing to better birth outcomes (Hodnett).

The primary purpose of this research study is to generate knowledge about childbirth experiences of Mi’kmaq women living in a First Nations Community in Nova Scotia. In this chapter, I will discuss the purpose and significance of the study, the childbirth process, and culture. This research study will specifically focus on the intrapartum period of the birth. The intrapartum period is defined as the “time from the onset of true labour until the birth of the infant and placenta” (Ladewig, London,

Moberly, & Olds, 2002, p.173). Feminist research methodology guided the study. An Indigenous framework was also used to help understand Mi'kmaq women, and to make connections and recognize Indigenous knowledge and pedagogy.

Although most women require minimal interventions during labour and delivery, childbirth is associated with perinatal risks and challenges for women, babies, families, and health care providers (Kendrick & Simpson, 2001). Aboriginal¹ women experience significant health problems such as hypertension and diabetes, which affect childbirth outcomes despite overall improvement in perinatal morbidity and mortality rates in Canada (Health Canada, 1999). In fact, some Aboriginal women have more serious health problems than the general population, which place them at higher risk for maternal and infant complications (Smylie et al., 2001).

Pregnancy, labour, and delivery are normal life processes and most women have good outcomes with support and minimal medical interventions (Kendrick & Simpson, 2001). However, current birth practices are rigid because of strong beliefs about medical protocols in birthing units. These birth practices and protocols include continuous fetal monitoring, high epidural rates, frequent use of episiotomies, and induction of labour (Lothian, 2001). Savage (2002) states that “such practices are absolutes in obstetrical culture so that the medical establishment communicates that any deviations from the medical norm place mother and infant in jeopardy” (p. 8). The biomedical model defines what most people think of birth. This model represents technology used during the birth process, which limits birth choices (Michaelson, 1988). As pointed out by (Savage), the birth practices and protocols mentioned above are standard protocol for perinatal care.

Savage also claims that prior to the medicalization of childbirth, women passed stories to

¹Aboriginal – an inclusive term which refers to First Nations, Inuit, and Metis people (Smylie, 2000).

younger women saying that giving birth is powerful and not a difficult and painful experience. The influence of modern medicine and technology has now essentially replaced women's ways of knowing about childbirth with fear (Savage).

In contrast to the medically managed hospital birth experiences, present day home births offer women more choice about the care they receive. While labouring in their home, women tend to feel more active and positive because the person performing the delivery (most likely a midwife) is considered a guest in the mother's home (Spindel & Suarez, 1995). Spindel and Suarez note that "the choice of home birth can certainly be framed, in most cases, as a rejection of the more passive medical model of hospital birth" (p. 543).

Childbirth is a major transition and special celebration for all cultures (Callister, 2001). Callister states that "healthcare beliefs and health seeking behaviors surrounding pregnancy, childbirth and parenting are deeply rooted in cultural context" (p. 68). The extent to which women follow cultural practices and customs depends upon acculturation within the dominant culture, social support and generation ties.

Individual values, beliefs, and traditions all affect cultural identity (Narayanasamy, 2002). Since culture is one of the determinants of health (Health Canada, 2001), recognizing the impact it can have on health is critical. In order for nurses and other health care providers to identify the limitations of care given to Aboriginal women and their families, it is necessary to be aware of the lack of knowledge around what constitutes culturally competent care. Meleis (1996) defines culturally competent care as "care that takes into account issues related to diversity, marginalization, and vulnerability due to culture, race, gender and sexual orientation" (p.2).

In Canada, cultural minority groups such as the Mi'kmaq, often find themselves receiving health care from people who have very different beliefs, values and attitudes than their own (Baker & Daigle, 2000). Therefore, culturally competent care for Mi'kmaq women during childbirth needs to be explored. The fact that Aboriginal women have a higher incidence of health problems, as compared to mainstream society (Health Canada, 1999) indicates a need for closer medical observation and technological interventions for this population. This situation identifies the contradiction that the medical management of birth might be in an Aboriginal woman's physical best interests – while at the same time, not be in her cultural or emotional best interests (Michaelson, 1988). The Mi'kmaq women's physical and psychological best interests must be considered during the childbirth process.

Purpose of the Study

The purpose of this qualitative research study was to provide new knowledge about Mi'kmaq women's childbirth experiences, which occurred in a large tertiary care center outside their rural Nova Scotian community. The study provided greater understanding of Mi'kmaq women's sociocultural childbirth experiences. This qualitative study explored Mi'kmaq women's perceptions of the provision of care during childbirth to determine if that care was culturally appropriate. In doing so, issues around access to care, support, health care encounters, and childbirth education were identified and discussed.

The following research questions were addressed: (1) What is the experience of Mi'kmaq women giving birth outside their cultural community? (2) What do Mi'kmaq women perceive to be an optimal birth experience from their own cultural perspective?

Significance of the Study

Like many First Nations women, these Mi'kmaq women living in a First Nations Community in Nova Scotia receive the majority of their prenatal care and postnatal follow-up care at the Health Center in the community, primarily by First Nations care providers. However, their actual childbirth experiences are primarily managed by non-Aboriginal health care professionals and occur in a tertiary care center approximately forty-five minutes from their community, by road. All Mi'kmaq women deliver their babies in the tertiary care center because there is no hospital located in this First Nations Community. In instances where the mother or baby is high risk, requiring more intensive health care that can be provided at the local hospital, transfer to the main tertiary Health Center in the region is carried out. Prior to the establishment of an Aboriginal Health Center in the First Nations Community four years ago, women received health services at neighboring facilities. The First Nations Health Center does not provide intrapartum and immediate postpartum care, thus, women continue to receive these services away from their community. This scenario is similar to other Aboriginal and non-Aboriginal communities in Canada, who often find themselves, being cared for at a distance from their home communities and often by non-Aboriginal healthcare professionals (Baker & Daigle, 2000).

As Mi'kmaq women deliver their babies in a culture different from their own, that exposure, with dissimilar values, beliefs and attitudes, may result in enhanced vulnerability in their transition to motherhood (Meleis et al., 2000). Moffitt and Wuest (2002) have noted that Aboriginal people² living in the Northwest Territories believe that

² Aboriginal people- refers to more than one Aboriginal person rather than the group of First Nations People (National Aboriginal Health Organization, 2003).

individual and community values are directly related to individual health and recovery from illness, and if not acknowledged, recovery may be hampered. Moffitt and Wuest recommend that cultural caregivers include customary healing traditions, and the use of interpreters to be active participants in the care process. Although Mi'kmaq women may be different from Aboriginal women in the North West Territories, these views are similar to the ideas that Mi'kmaq women share.

In a society dominated by non-Aboriginal culture, women from a minority group such as Mi'kmaq, may experience childbirth in an arena that is not culturally sensitive to their needs. Rice (1999) asserts that different cultures in the world communicate the meaning of childbirth through their traditions, values and practices. Being culturally sensitive to the needs of people, means that health care providers are more aware of not saying anything that may be offensive to clients (Purnell, 2005). Enang (1999) maintains that the link between culture and health is apparent with marginalized groups, in reference to racially visible individuals experiencing social and economic hardships as a result of unemployment. According to Willis (1999), "models of care that are patient-driven and that respect cultural preferences and motivations are most likely to promote the desired health behaviors and positive health status" (p. 58). For example, culturally competent care that respects cultural strengths is a key factor in helping families feel empowered and therefore, enable them to maintain their cultural beliefs, values, and health practices throughout health care experiences. Since there is very little literature available about the experiences of Mi'kmaq women during childbirth, it is hoped that the knowledge and insights generated from this study will assist health care professionals to provide more culturally appropriate care. Receiving culturally competent care can

potentially enable Mi'kmaq women to have healthier outcomes for both themselves and their babies. The findings in this study are significant because they reveal the importance of developing culturally inclusive policies and guidelines for providing culturally competent care. The findings from the study also affirm issues concerning gender, sexism, racism and class that affect the lives of Mi'kmaq women and families. Results from this study may be used to inform policy development for Aboriginal health in Canada.

Chapter II

LITERATURE REVIEW

Introduction

Although there is a significant amount of literature on the concepts of culture and transcultural nursing, there is limited research that specifically explores childbirth experiences of Mi'kmaq women. This chapter will focus on Mi'kmaq culture and on Aboriginal health in an effort to provide an understanding of what is known about the health of Aboriginal women and their families.

The literature review begins with a brief overview of appropriate names to use when addressing the Aboriginal population and the impact of colonization on the health and well being of Aboriginal peoples. Historical background, Aboriginal women's health, Aboriginal Health Model, historical evolution of childbirth, alternate birthing arenas, culture and childbirth, and personal communication with a Mi'kmaq Educator will be addressed. Socioeconomic issues, discrimination and other societal factors affecting health, in particular as it relates to childbirth, will also be included in the discussion.

Smylie et al. (2000) states that, in Canada "Aboriginal peoples refer to themselves by their specific tribal affiliation (such as the Mi'kmaq, Cree, Innu, Ojibwa) or First Nations, Inuit, or Métis" (p. 1071). In contrast, in United States, the term "Native Americans" and other names according to region, "Native Hawaiian and Alaska Native" all refer to Aboriginal peoples. Davis (1997) reports that the name 'Micmac' is derived from the word 'nikmaq' meaning "my kin-friends" (p. 23). However, the spelling has changed now to the more modern form called 'Mi'kmaq'. Throughout this study, reference is made to the terms Aboriginal, First Nations, Native and Mi'kmaq, all which

apply to the Indigenous population in general. First Nations³ peoples may also be referred to as ‘Native’ or ‘Indian’ people (Smylie et al., 2000).

Historical Background

Colonialism is defined as “the process by which some nations enrich themselves through political and economic control” (Macionis & Geber, 2002, p. 630). According to O’Neil (1986), colonialism began from the first encounter Native people had with Europeans who were looking to find inexpensive natural resources. There was no consideration given for the Native people’s commodities, creating huge changes in economic relationships. With the development of new settlements, the Aboriginal people went from being hunter gatherers to becoming dependent on the colonial system. As the ecosystem changed, so did epidemiology and Aboriginal people developed new diseases. As a result of the economic and ecological changes, they became reliant on the colonial system to survive (O’Neil).

Colonization attempted to destroy the Aboriginal worldview but fortunately it failed (Bear, 2000). This left Aboriginal people with unclear views about their people. They do not embrace Eurocentric views, but instead are trying to regain their heritage (Bear). Colonization has had a disruptive effect on the health and well being of Aboriginal peoples (Smylie et al., 2000). Health care providers need to have some background history for the following reasons: (a) colonization has impacted the physical, mental, emotional, and spiritual dimensions of Aboriginal health; (b) today’s relationship between Aboriginal people and health care professionals and the health care system are affected by the colonial system; and (c) policies and attitudes from the colonial system

³ First Nations – generally refers to status and non-status Indians (National Aboriginal Health Organization, 2003).

continue to thrive (Smylie et al.). Smylie et al. state that “prior to colonization, Aboriginal communities in the Americas were diverse and thriving” (p. 1074). Social and political issues impact many levels in health care. In Canada, the mainstream health care system has been shaped by years of internal colonial politics that have managed to marginalize Aboriginal peoples from the dominant group (O’Neil, 1986). Colonialism has resulted in Aboriginal women having to endure institutional discrimination and feeling disadvantaged based on their race, gender and class (Dion Stout, 1996).

Aboriginal Women’s Health

In 1996, the female Aboriginal population made up approximately 51 % of the total Aboriginal population in Canada (Health Canada, 1999a). While the majority of the Canadian population is aging, 42% of females in the Aboriginal population are under 19 years of age. This is attributed to the birth rate for Aboriginal women being twice that of the Canadian female population (Health Canada). According to Health Canada, “Aboriginal mothers are younger-about 55% are under 25 years of age (vs 28% for the non-Aboriginal population) and 9% are under 18 years of age (vs 1% for the non-Aboriginal population)” (p.1).

According to Phillips (1995), “women’s health involves women’s emotional, social, cultural, spiritual and physical well-being, and is determined by the social, cultural, political and economic context of women’s lives as well as by biology” (p. 507). The health of Aboriginal women has improved over the last thirty years, even though health inequities exist in relation to the general population in Canada (Health Canada, 1999a). For example, a health initiative has been underway to increase the number of community-based projects under the Canadian Prenatal Nutrition Program (CPNP) to

serve First Nations and Inuit women (Health Canada, 1999a). The focus of the CPNP is to support activities that will improve the health of pregnant women and their babies for six to twelve months of age (Health Canada, 1999 a). Aboriginal people have begun to accept the many sufferings they have had to endure (Health Canada, 2003b). They have now placed emphasis on healing as a way by which individual and collective development can occur in harmony with the environment (Health Canada, 2003b). With the control of health care services being given back to First Nations communities, and acceptance of increasing traditional forms of medicine, there is some optimism about the future direction of Aboriginal women's health in Canada.

Beliefs about illness and wellness are deeply rooted in every culture. Mi'kmaq views on health are holistic and unite "the ideology of balance and the interconnectedness of the natural world" (Baker, 1998, p. 323). These beliefs are powerfully linked to spirituality; healing occurs when there is harmony and connectedness. The medicine wheel represents a model of health in which emotions, thought, spirituality, and the physical being all play vital roles in maintaining balance in the person. Battiste (2000) asserts that the medicine wheel depicts "symbolically that all things are interconnected and related, spiritual, complex, and powerful" (p. xxii). Battiste illustrates the use of the medicine wheel using the four directions of the Sacred Wheel (winds of the West, North, East, South). The Western Door represents the direction of autumn showing "the ideas that have shaped the last era of domination underpinning modern society" (Battiste, p. xxiii). The Northern Door means that Indigenous peoples are challenged by the winter, however, it is when they learn endurance and wisdom. The Eastern Door represents the spring. It is associated with the place of beginnings and enlightenment and where new

knowledge is created or received to bring about harmony. The fourth direction is known as the Southern Door, which is the direction of the summer and a time of growth. Here the Indigenous people honour their teachings, elders, and ancestors in ceremonies and gatherings.

The history of the medicine wheel originated from the white men “(discovering it at the end of the 19th century) who named it "Medicine Wheel," terminology they applied to anything Indian’s observed or told them they didn't understand” (Giese, 1997, p.1). As tourism in the Bighorn National Forest began to grow, the white men of the Sheridan Chamber of Commerce made the medicine wheel a mystery disregarding the fact there are “at least 40 other wheels on the high plains (mostly in Canada), as well as some sites far removed, both spatially and culturally” (Giese, p.1). The fact that the medicine wheel was a generalized term for many wheels would explain its inconsistent use by Aboriginal peoples who may use other terms for this concept.

People’s perception of their health and their ability to have control has an effect on overall health (Potter & Perry, Ross-Kerr, & Wood, 2001). Since Aboriginal women’s cultural beliefs, and traditions are interconnected with childbirth, then recognizing and adhering to their cultural beliefs and practices can provide a more culturally appropriate environment for the birth experience. A culturally sensitive environment can help to empower women who ultimately can improve their health and that of their families.

During childbirth, Aboriginal women, single parents, women with disabilities, women of colour, and others, do face significant health issues (Health Canada, 2003b). Aboriginal women have a higher incidence of certain health problems than non-

Aboriginal women (Health Canada, 1999a), which place them at high risk for perinatal complications. Aboriginal women have a higher risk of health problems such as diabetes, cardiovascular disease, respiratory diseases, and cancer of the cervix. There is increased incidence of diabetes, cardiovascular disease and respiratory diseases as the person ages (Smylie et al., 2001). They also have a lower life expectancy and experience overall poorer health than the general population. When a woman begins pregnancy with a chronic health problem such as those mentioned, both the mother and the baby are at risk for perinatal complications (Pillitteri, 2003). A high-risk pregnancy is defined by Pillitteri as “one in which a current disorder, pregnancy-related complication, or external factor jeopardizes the health of the mother, the fetus or both” (p. 329). Normal pregnancy can bring on medical complications that are exacerbated by an existing chronic condition, leaving the mother with less reserve to function, and perhaps affecting future pregnancies (Pillitteri).

In 1999, the Mi’kmaq Health Research Group assisted The Unions of Nova Scotia Indians with the First Nations and Inuit Longitudinal Regional Health Survey, which studied the health of the Mi’kmaq population living on reserves in Nova Scotia. The participants (N=723) included children, youth and adults, ranging in age from infancy to 55 years and older. Areas of concern relevant to maternal/child included Mi’kmaq women’s smoking rate while pregnant at 52% compared to 24% among the general population of Canadian mothers. Breastfeeding rates revealed that 28% of Mi’kmaq mothers breastfed their babies in comparison to 72% of Canadian mothers. Both the high smoking and low breastfeeding rates can have a negative impact on an Aboriginal mother’s health and the health of her baby (Mi’kmaq Health Research Group, 1999).

Smoking also increases the incidence of premature labour and low birth weight babies (Freda, 2001). Walker and Creehan (2001) reported that breast milk meets the needs of the infant to build an immune system needed for healthy brain development among other benefits such as decreasing respiratory diseases, otitis media, and gastrointestinal illness. Although there is some research on childbirth issues, among Aboriginal women, it is very limited.

Infant mortality is considered one of the main indicators of health of a population, and generally lessens with an increase in women's health (Adelson, 2005). The infant mortality rate for First Nations is 8 deaths per 1000 live births, which is 1.5 times higher than the mainstream population (Adelson). High birth weight (>4000 grams) is 18% in First Nations babies compared to 12.2% for Canadian babies, while low birth weight babies <2500gms, a group who are generally considered more at risk is actually slightly less than the general Canadian population (Smylie et al., 2001).

Good maternal, sexual, and reproductive health is needed to assist children to develop positive self-esteem and establish long lasting healthy relationships throughout life. Healthy outcomes occur when a strong foundation is established. High rates of sexual and reproductive problems such as teen pregnancy, sexually transmitted diseases, and sexual and family violence are found in the Aboriginal population; thus health care strategies need to reflect these health concerns (Health Canada, 2001). Reducing social and economic disparity, primarily poverty and discrimination, which affect sexual and reproductive health, are essential.

Aboriginal women's needs and concerns have been under represented in previous research studies. Including Aboriginal women in research studies to establish key

priorities and strategies is an effective way of promoting Aboriginal health (Dion Stout, Kipling, & Stout, 2001). The Royal Commission on Aboriginal Peoples (1996) recommended that governments and organizations give Aboriginal women fair opportunity to participate in areas that effect the health and healing of their population. According to Health Canada (2003), a significant challenge for health care providers is to acknowledge the strengths of minority people and to work with the minority populations they serve.

Aboriginal Health Model

There is minimal research on the childbirth experiences of Mi'kmaq women and this necessitated a personal communication with Murdena Marshall, a Mi'kmaq educator/elder and mother living in a First Nations Community in Cape Breton. Marshall discussed the beliefs about the Mi'kmaq people's views on health and a brief excerpt on labour and childbirth was cited from her unpublished manuscript.

The health model in Aboriginal communities usually incorporates physical, mental, emotional and spiritual health (Mi'kmaq Health Research Group, 1999). According to Murdena Marshall, (personal communication, April 22, 2004) the above health model includes the same four components of a person that are "required to work together in harmony and balance for good health to happen". The physical represents the "body-birth" and the spiritual refers to the "soul and death", a "duality" which signifies opposites in meaning. Marshall states "you have to overcome the negative for healing to begin" with four components integral to the healing process. For example she says, "you will feel better even though you have cancer". Just 'thank God' for what you have (personal communication). Many Aboriginal people believe that traditional customs that

reflect this balance of essential parts are necessary to help improve and maintain the health of Aboriginal societies (Mi'kmaq Health Research Group). Understanding the beliefs of a well-respected Mi'kmaq educator provides insight into Mi'kmaq beliefs (ie., balance and health). This suggests that providing culturally relevant childbirth care for Aboriginal women may have a direct positive impact on the physical and psychosocial outcome of the process.

An unpublished manuscript titled “Parenting and Traditional Beliefs Are Essential” by Murdena Marshall (1992), provides her views on childbirth and parenting. In this manuscript, Marshall described the experience of birth in the following manner:

During labour and childbirth the mother is instructed not to make too much noise or use abusive language during delivery. The old ladies will ask that you maintain yourself so that when the baby is born, he or she will be in a world that is calm and peaceful. It's bad enough that the baby leaves the dark, warm cradle to be exposed to cold, light and abusive language. They say at least eliminate the noise, it still will be cold and bright but it could be welcoming. (p. 4).

Historical Evolution of Childbirth

Prior to the 17th century, birthing in most countries was considered within the realm of women and it occurred primarily outside a hospital setting (Johanson, Newman, & MacFarlane, 2002). Hospital births were essentially unheard of prior to the 20th century (Savage, 2002). According to Lothian (2001), “the social structure surrounding birth [has] changed dramatically” since a century ago when the labour and delivery of childbirth was considered an everyday event (p. 13). During that time, women learned about childbirth from their mothers, sisters, other relatives, and friends; birth stories were passed down from generation to generation. Women delivered at home, often with midwives, and surrounded by their loving and supportive families. In North America, by

the 1950s, a shift to delivering babies in hospitals had gradually occurred (Savage, 2002). With this change, came the idea that birth is a medical event (Jordan, 1983).

Medicalization continues to be the principal ideology underlying current health policies and practices in the Aboriginal population (The Royal Commission on Aboriginal Peoples, 1996). Consistent with Western biomedical beliefs about health and illness, there has been a tendency to “medicalize social problems as arising from individual lifestyles, cultural differences or biological predisposition - rather than from impoverished social and economic circumstances, marginalization and oppressive internal colonial politics”(Browne & Smye, 2002, p. 29). Although biomedicine has helped to lower morbidity and mortality rates, their focus on disease often ignores gender issues and the social, historical and cultural aspects of health and illness (Meleis & Im, 2002). Biomedical models, which promote the medicalization of women and women’s bodies, create feelings of helplessness, thus promoting loss of control regarding managing the whole wellness-illness continuum (Meleis & Im).

Women are vulnerable during childbirth and often have limited control over their childbirth experiences including decisions surrounding the medical care they receive from health care professionals (Esposito, 1999; Lazarus, 1997). Lazarus studied three groups of women: a lay middle class group, a health professional group, and a group of poor women (those with limited resources). She found those women with limited resources had fewer choices and less control over their care than did the rest of the population. The disadvantaged group of women reported being burdened with social and economic problems that left them feeling overwhelmed. Women in the poor group were primarily focused on “continuity of care rather than on issues of control” (Lazarus, p.

133). Because many of these economically disadvantaged women had given birth at a very young age, they were also unemployed and had limited education. Having choice and control over their childbirth experience was given low priority because of the urgent nature of their socioeconomic situation. Lazarus concluded that women with more education seemed to enjoy greater control over their childbirth experience.

Davis-Floyd (1992) reported similar findings when she interviewed 100 pregnant women in both the hospital and at home. She described how most women in American hospitals were given hospital gowns, connected to fetal heart monitors, and given intravenous therapy. Some women were given a synthetic hormone called pitocin to speed up 'ineffective' labour contractions (changes in cervical dilatation is less than 1 cm per hour); and during the delivery of the baby, many received an episiotomy, which was done to widen the birth outlet. Because most obstetricians used these obstetrical procedures, they were considered the norm in most urban settings or towns. Davis-Floyd described how childbirth action groups tried to change the hospital technical environment to a more natural childbirth approach to eliminate technical rituals incorporated into the obstetrical interventions that women were subjected to as part of their childbirth experiences. Davis-Floyd acknowledged the importance of respecting women's birth choices stressing the need for a holistic approach instead of a technical model for childbirth.

Prior to the medicalization of childbirth, women in general listened to stories about the strength and power of giving birth and less about the pain they were about to endure (Savage, 2002). Farley and Widmann (2001) describe storytelling as "a culturally universal interaction", by which events in people's lives are shaped, thus enabling

understanding of the meaning of a particular situation so they can move forward (p. 22). In a medicalized birth environment, sharing birthing stories is not visibly supported or enabled (Savage). Savage describes how the “cultural constructs of the twenty-first century overwhelmingly support the technocratic model” (p. 10). Increasing knowledge about historical childbirth practices that women have passed on for many generations is disregarded as a mechanical view emerges in birthing units. Strong influences from medicine and technology “have replaced women’s ways of knowing” about birthing practices resulting in fear of experiencing pain, fear of failure, and fear that if one does not follow medical recommendation, there is a risk of birth complications and a “less than perfect birth and baby” (Savage, p.9). In most birthing units today, medical equipment such as fetal heart monitors, intravenous therapy, epidural anesthesia, oxygen therapy, and pain medications are often used to assess and provide care to mothers in labour (Health Canada, 2003a). However, Hiebert (2003) claims “childbearing practices, heavily influenced by Western medicine are in opposition to an Aboriginal worldview that embraces childbirth as an influenced natural event” (p. 47).

Alternate Birthing Arenas

Removing births from Aboriginal communities has created profound spiritual and cultural consequences (National Aboriginal Health Organization [NAHO], 2004). As a result, the loss of traditional birth practices has created a loss of cultural identity (NAHO). British Columbia Reproductive Care Program (BCRCP) (2002) acknowledges that providing family-centered care is challenging when a woman /and or her baby have to be transported to an unexpected environment. Although the woman and family understand when the facility can not provide the optimum resources, she has to be

transported to a center that can provide high levels of maternal childcare (Klein, Johnson, Christilaw & Carty, 2002). However, the situation can create anxiety because the mother is separated from her family and in unfamiliar surroundings.

The birth experiences of Aboriginal women in the North West Territories provide insights into the possible caregivers of women giving birth outside their communities. Childbirth for Native women in the Northwest Territories has changed over the last decades. Paulette (1990), a member of the Native Women's Association of the North West Territories and current member Canadian Association of Midwives of the N.W.T., undertook a "modest research project", known as the "Family Centered Maternity Care Project", in 1978. The purpose of the project was to examine the current trends and issues in maternal/infant health (p. 45). All women are transported from their communities to larger centers to deliver their babies; thus, they are essentially removed from the family (Paulette). In the days when families gave birth together, the family bond was much stronger than it is today (Paulette). Men seemed to have had a different kind of admiration for their wives and a closer connection with their children (Paulette).

In recent years, despite the belief of health care providers that the best place to give birth is the hospital, there has been no sound evidence to support that the hospital setting is safer for women to deliver with uncomplicated pregnancies (Lothian, 2001). Although seven of the Mi'kmaq women in this study did not fit in the category of uncomplicated pregnancies, because of medical problems associated with pregnancy placing them at high-risk, four of these women had no complications during pregnancy or childbirth. Therefore, the Mi'kmaq women with no medical problems during pregnancy would be the same as other women advocating for a home birth in Canada. Women with

uncomplicated pregnancies have begun advocating for the establishment of birthing centers and home births. Although this change is gradual in North America, women in general are beginning to make some significant strides toward natural childbirth. For example, the Reproductive Care Program in Nova Scotia (2003) reports that, although most women in Canada deliver in hospitals, there are some free-standing birth centers and a small but increasing number of Canadian women giving birth at home. According to Bourgeault, Benoit, and Davis-Floyd (2004), there has been a growing movement toward home births since the late 1960s and 1970s, with “lessening of trust in professional authority, an unprecedented decline in respect for medicine and a growing recognition of emotional, social, and spiritual components of life and healing in particular” (p. 7). Bourgeault et al. report that, it is anticipated, that most areas in Canada will soon legalize midwifery and integrate it into the current health care system. Currently in Canada, midwifery has been adopted in Ontario, British Columbia, Alberta, Saskatchewan, and Manitoba (Potter et al, 2001). Thus, unique forms of midwifery practice will emerge giving women an option of choosing home birth.

The introduction of the family-centered care concept into hospitals, where the birth experience belongs to the mother and her family, has made a significant change to maternal-child practices (Kendrick & Simpson, 2001). Birth is increasingly being seen as a family event where women select their support persons during the childbirth experience. According to the Reproductive Care Program of Nova Scotia (RCP) (2003), “In a truly family-centered care environment, women are active participants in every aspect of their care” (p. 1). Therefore, families are visible and part of the decision-making process. Respect is given to women for their knowledge of their own health and that of

their families (RCP). Aboriginal families are allowed to take their women to the hospital and remain with them during the childbirth experience. However, in some remote areas such as in the Northwest Territories, Aboriginal women are transported out of their community to deliver in larger hospitals leaving their husband and children at home (Paulette, 1990).

The delivery of safe and competent care that meets women's and their families' needs is a major priority. Evidence is growing to support the benefits of having a normal and natural birth experience (Lothian, 2001). Although there are some freestanding birth centers in Canada, some women choose to give birth at home. By choosing a home birth, women and their families share responsibility for care and the outcome with the labour attendants (Vedam & Kolodji, 1995). Although tremendous effort goes into assessing the mother to determine if she is a candidate for home birth, the benefits of being able to deliver her baby in the home environment may make the entire process satisfying for mothers and families. Since Aboriginal people value the importance of sharing the birth experience with members of family and community, being able to deliver in their own community in a birth center or home birth could help to build strong bonds and caring relationships between community members (Paulette, 1990).

Marion (2004) conducted a study to learn about women's experiences of choosing midwifery care in Nova Scotia from 1975 to 1998. Although midwifery is still an unregulated practice in Nova Scotia, some women have chosen home birth by a midwife over a hospital birth. Responses from the women indicated that the home birth was an incredible and enriching experience, which brought a woman and her family closer together. It was also an empowering experience, and some women believed that their

birthing experiences would help to empower the children in the future (Marion, 2004). The benefits of moving away from the medicalization concept and back to recognizing that birthing is women's work, and supported by women is evident here.

Stapleton (1998) argues that the health care system and hospitals are founded on a medical model, which follows a hierarchical process. In contrast, a collaborative approach is directly the opposite. In the latter instance, no one person is solely responsible for the client and there is essentially more flexibility. Power is based on knowledge and control changes, depending on the situation, anyone of which could belong to the client, midwife, physician or other health care professionals (Stapleton). This philosophy values freedom of expression, equality and autonomy - attributes which are important to developing a therapeutic relation with clients in nursing practice. Also, this type of collaboration enables clients to be empowered and bring meaning to their lives. Using a collaborative approach with Aboriginal people would be effective because it would provide them an opportunity to discuss their care including their beliefs and traditions and decide what is culturally appropriate for their childbirth experience.

Culture and Childbirth

Childbirth for women and families is generally a happy and exciting event characterized by anticipation and uncertainty about giving birth (Health Canada, 2003a). This birth experience represents a major life transition for mothers and families (Chick & Meleis, 1986, Health Canada; Nelson, 2003). According to VandeVusse (1999), the memories and experiences of giving birth remain with women for decades. As such, childbirth has deep and lifelong effects for women. The overall aim of childbirth is for

women to have a positive birth experience, while maintaining health and preventing and/or minimizing complications to babies and women.

Salimbene (1999) defines culture “as a shared system of values, beliefs, traditions, behaviors, verbal, and nonverbal patterns of communication that hold a group of people together and distinguish them from other groups” (p. 26). Individuals perceive the world around them through a cultural lens that is created and accepted by their own members. When a message is communicated to someone from another culture, this message is viewed through a cultural lens that determines how the message will be interpreted. In situations where individuals are not “trained in intercultural communication” (Salimbene, p. 27), the message may be interpreted through an individual’s own cultural lens and may be quite different than what was intended.

Communication barriers between cultures must also be considered (Callister, 2001). A common problem occurring in acute care facilities is the practice of hiring nonprofessional employees to provide the main interpretation who have little understanding of English medical terminology (Callister). As a result, translation may be difficult for them and/or they may be reluctant to converse in a dominant culture.

Callister (2001) asserts that one’s healthcare beliefs and behaviors about the childbirth experience are deeply entrenched in cultural context. She contends that culture represents women’s identity. Women’s cultural practices, beliefs and traditions are complex and depend on factors such as support and acculturation into a dominant culture within society (Callister). It is important to remember that, even though individuals share a common birthplace, their cultural traditions may be different. Sokoloski’s (1995) qualitative study of First Nations women reported similar findings - the First Nations

women viewed pregnancy as a very natural and normal event, requiring neither medical interventions nor attending to prenatal care.

In Canada, cultural minority groups often find themselves receiving health care from people who have beliefs, values and attitudes different than their own (Baker & Daigle, 2000; Sokoloski, 1995). Clarke (1997) emphasizing that research approaches, in addition to being culturally appropriate, need to be culturally suitable to the population being studied in order “to generate valid knowledge about culture, to develop theory, and to translate this into culturally suitable nursing and health care” (p. 12). Since feminism has historically focused on valuing women and challenging injustices based on gender (Du Gas, Esson, & Ronaldson, 1999), a feminist perspective for this study would explore the importance of gender in relation to Mi’kmaq women’s childbirth experiences.

Individual values, beliefs, and traditions all affect cultural identity because individuals receiving care may differ from those who are providing care (Narayanasamy, 2002). Baker and Daigle (2000) state “few studies have examined Mi’kmaq people’s perceptions of being cared for in a non-Aboriginal health care setting, but the limited data available suggest this can be a problematic experience for them” (p. 8). In order to promote healing among cultural minority groups, health care providers need to understand the meaning of childbirth for women who deliver their babies in an unfamiliar culture.

First Nations women hold traditional healing knowledge in high regard because this knowledge is passed down from female elders (Browne & Fiske, 2001). Such recognition of knowledge helps to validate their cultural identity and improve relations with health care providers. Brown and Fiske describe First Nations women’s health care

experiences from a reserve in northwestern Canada. Some informants described situations where their health concerns were not taken seriously. For example, some participants reported that when they arrived at the clinic, nurses told the women there was nothing wrong with them, and sent them home. As a result, they became more ill. The participants described some of the clinic nurses as being intimidating. Yet, a memorable experience occurred when a nurse who, rather than leaving at the end of her shift, remained with a mother and held her hand while she gave birth to a premature baby. When health care providers provided emotional support and medical care, they felt they received outstanding care.

The value placed on respect and cultural identity is evident in a qualitative study conducted by Browne (1995) with Cree-Ojibway people in northern Manitoba. The participants described instances in which they perceived the nurse as not being sincere during clinic visits for health care. The informants quickly sensed whether the nurse was in a hurry or did not want to answer their questions. The health care providers' verbal and nonverbal behaviors in the initial contact with the patients were interpreted as a sign of respect. Being sensitive to the importance of respect during interactions with First Nations people was considered highly important. Trust develops when First Nations people believed that health care providers genuinely care.

According to Davidhizar and Giger (1998), "cultural behavior or how one acts in certain situations is socially acquired, not genetically inherited" (p. 41). Individuals learn cultural behavior through enculturation (also called socialization) where knowledge is acquired and processed (Davidhizar & Giger). Culture is learned through family interaction and the more formal social processes in which individual beliefs, roles, and

behaviors are shaped into the expected norms in society (Dennis & Small, 2003). Cultural behavior is important to nursing because it provides reasons for behaviors in relation to important life events/situations such as birth, death, childbearing, and childrearing (Davidhizar & Giger, 1998).

People from diverse cultures have varying opinions about cultural preferences. For example, cultural differences have been identified related to women's perception of pain during labour and birth (Callister, 2001). Some women view labour as a natural event, and conceptualize pain as an opportunity for personal growth (Callister). According to Callister, "American Indian women are often more stoic, using meditation, self control, and traditional herbs to manage pain" (p. 73). Others view the childbirth pain as inhumane and see the need for pharmacological interventions to ease the pain and suffering.

Maternal positioning during labour and birth is another cultural consideration. The Western cultural tradition uses recumbency, which began as an obstetrician preference. However, cultural preferences regarding position during labour and delivery need to be considered. Generally, women in the Northwest Territories give birth in a "squatting or kneeling position, never laying on their backs" (Paulette, 1990, p. 45). According to the elders, living a healthy lifestyle minimizes childbirth complications.

Cultural rituals affect various aspects of the childbirth experience. For example, the disposal of the placenta varies across cultures. Some preferences may be to burn, dry, or bury the placenta (Callister, 2001). Family preferences should be considered as much as possible because the degree of acculturation varies from family to family even in a cultural group.

As the Mi'kmaq people have lived in close proximity with close family members for centuries, if a member is hospitalized during childbirth, it is customary for some family members to stay with the mother, enabling her to feel connected to her community (Baker, 1998). According to Baker, "the cultural emphasis on the interconnectedness of people to their environment, to their family and to the community can make hospitalization a particularly difficult experience for the Mi'kmaq people" (p. 318). Having family members present during hospitalization respects cultural traditions. The family plays a prominent role during childbirth and should be involved in decision-making.

Birth is an active, not passive experience and women's role as active participants is of primary importance in childbirth (Lothian, 2001). Support to the mother during childbirth is essential. Nurses must be competent to assess the women's needs based on her cultural expectations and preference; and support women in having a positive childbirth experience (RCP, 2003).

The Reproductive Care Program of Nova Scotia (2003) contends that woman-centered care needs to be shared by all healthcare providers who provide care to women during childbirth. This philosophy, an individualized approach to care, is consistent with a woman's preferences and is upheld by everyone involved in her care.

In the absence of childbirth options, women and families often feel a sense of powerlessness, which may interfere with the role of becoming a parent, a developmental transition important in the life cycle. In recent years, however, the concept of family-centered care has provided women with the option of defining the 'family', and include taking photos of the delivery (Kendrick & Simpson, 2001). A family-centered care

approach has brought about positive change and given women and families an opportunity to experience birth in a more natural way.

Since research on cross-cultural issues is limited and with growing numbers of ethnic and minority groups in Canada, research is required in cultural groups to further understand effective cross-cultural caregiving (Baker & Daigle, 2000). Studies are limited on cultural encounters within the health care settings; available literature demonstrates serious concerns about the lack of cultural sensitivity and respect by the non-Aboriginal population (Baker & Daigle, 2000; Browne, 1995). Enang (1999) in a local study on another minority group had similar findings.

Conclusion

The literature review demonstrates that culture has impact on the childbirth process. It also identifies that minimal research has been undertaken in the area of Aboriginal woman's health including the childbirth experience of Mi'kmaq women.

Aboriginal people value their traditional health practices and customs and many prefer to follow them during their childbirth experience. Traditional knowledge is also important to Aboriginal women and their families and therefore, there is a strong desire to adhere to their own beliefs and traditions about childbirth. Aboriginal women view health as inseparable from their families and communities (Dion Stout et al., 2001). Their major role consists of being caregivers, leaders and nurturers to people in their community (Dion Stout et al.). However, because these women have a high incidence of medical conditions such as diabetes and hypertension during pregnancy, they often become high-risk and require more intensive medical interventions. As a result, they are often cared for in a tertiary health care setting by health care providers who may have

very different beliefs and values regarding their health and childbirth. This study calls for health care professionals to strive to balance the need to provide culturally competent care and to effectively manage high-risk situations in tertiary settings. This study provides new insights into Mi'kmaq women's childbirth experiences.

Chapter III

METHOD AND METHODOLOGY

Introduction

Women's health needs include many dimensions of their lives, such as pursuing a career, being a caregiver for others, and dealing with chronic health problems. Stern (1996) suggests women's beliefs about their social status, and meanings relevant to health and to society, leave endless variables to investigate. Qualitative research helps to provide answers to questions that may not be quantifiable and to reveal similarities and differences among individuals, as well as the meaning of particular experiences for them. Researchers must consider the uniqueness of each person during the investigation because no two people have the same experiences or the same response to similar experiences (Streubert-Speziale & Carpenter, 2003). Qualitative research is recognized as a meaningful and important methodological approach to developing a concrete body of nursing knowledge (Streubert-Speziale & Carpenter). The childbirth experiences of Mi'kmaq women were explored using qualitative inquiry process. Specifically feminist research method guided the study.

The chapter begins with a description of qualitative research, followed by feminist research methodology, an Indigenous framework and locating myself in the research. Further discussion includes data collection, which encompasses the setting, participants and interviews. Ethical considerations are specified, thematic analysis, trustworthiness of the data, dissemination of findings, and a conclusion completes this chapter.

Qualitative Research

Denzin and Lincoln (1994) define qualitative research as “multimethod in focus, involving an interpretive, naturalistic approach to its subject matter” (p. 2). Researchers using this method are able to study people in natural settings, trying to understand and/or interpret phenomena according to what it means to those participants being studied (Denzin & Lincoln, 1994; Mays & Pope, 1996). Qualitative research has been used in the social sciences for a long time and health care is one of a number of areas where participants can be viewed in interactions with health care providers (Mays & Pope). Qualitative research strives to understand human behavior within the context of the individuals being studied (Potter et al., 2001), and is, therefore, a most suitable method for researching childbirth experiences.

Qualitative research designs take place in real life settings and the researcher does not influence the phenomenon being studied (Patton, 2002). There is a natural unfolding process, where the researcher observes and interviews participants in familiar surroundings that are comfortable to them. For example, in this study of childbirth experiences of Mi’kmaq women, the participants were interviewed in their own community. In this way the researcher interviewed the Mi’kmaq women in an environment where they could feel relaxed and at ease.

Since nurse-scientists are accountable for generating new knowledge, they must clearly define the issue and then decide on which type of framework to use, either quantitative or qualitative (Streubert-Speziale & Carpenter, 2003). Therefore, based on the type of question being asked, the nurse uses inductive or deductive reasoning. Inductive reasoning begins with the details of the experience and shifts to the overall

picture used in qualitative research methods, whereas, deductive reasoning moves from the broad to the particular. In this research, inductive reasoning was appropriate because the researcher studied the experiences of Mi'kmaq women in childbirth to discover their experiences of labour and delivery. Although frameworks are important for knowledge development, ultimately, the question that needs answering will steer the research type and paradigm selected.

Qualitative data generally comes from fieldwork. The results of qualitative research are derived from three kinds of data: (a) in-depth, open-ended interviews; (b) directly observing the situation; and (c) written documents (Patton, 2002). The quality of data obtained depends on the methodological skill, sensitivity, and integrity of the researcher (Patton). In-depth open-ended interviews were used for this study because they allowed the participants an opportunity to describe the phenomenon in detail. There is more ease in sharing information if participants are interviewed in a comfortable setting (Streubert-Speziale & Carpenter, 2003). Reinhartz (1992) adds that an open-ended interview approach actually delves into individuals' views of their reality and allows the researcher to contribute to theory.

Feminist Research Methodology

Doering (1992) defines feminism as “a world view that values women and confronts systematic injustices based on gender” (p. 26). Feminist theory and research are focused on women with a major emphasis on class and race bias (Wuest, 1994). Feminist theories have progressed by placing gender first, by including women in the dialogue of social and political theory and by raising awareness of women's needs (Morse, 1995) and the oppression of women (MacPherson, 1983). They also offer the potential for new

visions of justice and freedom for women (MacPherson, 1983). The purpose of feminist research is to create a social system that represents equality, as well as question the status quo, challenge existing social systems, challenge old and create new personal choices related to health/life choices, and shift the balance of power (Wuest, 1994). In this study, feminist methodology was the most suitable choice because it addressed Mi'kmaq women's lives, thus valuing women and women's experiences. Enang (1999) asserts that feminist methodology provides the flexibility that is required to comprehend women's views and their experiences.

Reinhartz (1992) suggests that "feminist research methods are methods used in research projects by people who identify themselves as feminist or as part of the women's movement" (p. 6). Feminists presume that gender in human relations and societies is important, and thereby, target their research in this direction (Patton, 2002). Reinhart refers to the principles of feminist inquiry, which include: (a) a shared power between the researcher and the participants; (b) an acknowledgement and valuing of women's ways of knowing; (c) a participatory process characterized by reflexivity and conscious-raising; and (d) knowledge generation for social action.

Feminist research is particularly appropriate to this study of childbirth experiences of Mi'kmaq women. Since childbirth is about women having babies, and the family is one of society's most important institutions (Wong, Perry, & Hockenberry, 2002), then the manner in which women are cared for by health care professionals requires cultural sensitivity and competence. Since this study is about women, and traditionally women have been oppressed, then not only the participant but also the nursing profession who are predominately female, can benefit from using a feminist approach to doing research.

According to Du Gas et al. (1999), “feminism has historically focused on valuing women and confronting systemic injustices based on gender” (p. 315). From a feminist perspective, caring requires that nurses use a feminist critique, and to advocate for gender equality and promote equal rights (Du Gas et al., 1999). Enang (1999) asserts “As nurses become more involved with feminism, we must not ignore the feminist perspective that is relevant to the experiences of women of colour and other marginalized groups” (p. 47). Evans (1993) adds that feminist research can in fact act as a healer regarding issues related to equality and social justice for women.

Nurses have the knowledge and ability to find solutions to health related problems through nursing research. Sophier (1992) states “creative solutions can be uncovered through a process that acknowledges and embraces feminist logic and abandons the patriarchal structures of knowledge and power that have dominated Western health care and health care policy-making” (p. 62). Empowerment through the feminist process may be the key to creating change within the health care system. In this research, Mi’kmaq women give birth in a non-Aboriginal health care setting where policies and procedures are already in place, with no room for individual choice on style and type of care.

According to Wuest (1994), “A major goal of feminist research is seeing the world through the eyes of ‘the other’ for the purpose of emancipation” (p. 578). Streubert-Speziale and Carpenter (2003) add that feminist researchers strive to see the world from the women being studied and attempt to be analytical in examining the issues and advocate for improving the lives of those being studied. Using feminist theory moves the concept of emancipation closer and addresses specifically women’s lives (Streubert-Speziale & Carpenter). In this study, the findings generated by this researcher may

improve the birth experience of Mi'kmaq women if shared with health professionals and Aboriginal women.

Keddy (1992) asserts that schools of nursing and health care institutions are slowly embracing feminism as a means of hope for a discordant nursing profession. Researchers are beginning to re-examine their traditional methods for examining questions and are seeing the value of having a feminist perspective in the nursing theories they are using. By using a feminist approach, the hierarchical relationship is avoided and power differences between the researcher and the participants are reduced. In this way, feminist research gives an opportunity for the participants' voices to be heard. Hence, in this study it was found that using a feminist approach helped to diminish the power difference.

Feminist research is also characterized by a commitment to a non-hierarchical research process. MacPherson (1983) maintains that feminist research is not solely fixated on making women visible but is concerned also with theory and methods, issues concerning sexual boundaries, and approaches in which they may be used when published (MacPherson). Replacing a hierarchical organization with a horizontal structure brings about a means of sharing power and decision-making (MacPherson). When engaging in "research with relatively powerless groups", it is particularly important to provide clear information (MacPherson, p. 19). In this research, the participants determined the time and place for interviews and had the choice to invite a family member or friend. They contributed to data analysis by verifying themes in either a focus group meeting or by phone in a second interview as ways to minimize the power differential between the researcher and the participants themselves.

King (1994) concurs that “congruent with the non-hierarchical perspective, it is important for the researcher to identify her biases as well as her subjective interpretation of the object of the research” (p. 21). Therefore, my biases were identified within this research. The research questions and the researcher’s interpretation of data will affect the data analysis and therefore, the researcher’s view point or “reflexivity” should be admitted (Harding, 1991, p. 161). Patton (2002) states that reflexivity reminds those engaging in qualitative research to pay attention to cultural, political, social, and linguistic origins from one’s own perspective, as well as those individuals interviewed and to whom the data is reported.

Indigenous Framework

In addition to using a feminist approach in this study, an Indigenous Framework was used to help understand First Nations people, make connections and recognize Indigenous knowledge and pedagogy. Indigenous knowledge includes “a web of relationships within a specific ecological context; contains linguistic categories, rules, and relationships unique to each knowledge system; has localized content and meaning; has established customs with respect to acquiring and sharing knowledge...” (Battiste, 2002, p.14). Battiste (2000) asserts that Indigenous knowledge, including oral modes of transmission, is an essential and significant process for Indigenous educators and scholars. The Supreme Court of Canada recognizes it as a legal form for transmitting and understanding Indigenous knowledge. Battiste (2000) adds that, if the courts are required to uphold Indigenous knowledge, then others in society should value oral traditions and recognize them as an important source of knowledge and scholarship. Knowledge from a First Nations perspective, is a process that comes from creation and is considered sacred.

Learning is considered to be a life-long journey. Knowledge educates people about how to take responsibility for their lives, helps to develop relationships with others, and guides First Nations people to use respectful behavior. Traditions and ceremonies are considered part of everyday life. In keeping with the Indigenous framework, I interviewed a Mi'kmaq educator as part of my literature review about her beliefs, and the beliefs of Mi'kmaq people on health and childbirth. During this interview, dissemination of her findings was conveyed using the oral mode of transmission, which is consistent with the Mi'kmaq culture.

Locating Myself in Research

My interest in this research study evolved over time as a result of my professional practice and academic experiences. I was raised in a Euro-Canadian environment and trained in a nursing school (1972-1974) to care for mainly Euro-Canadian, Caucasian patients. Curriculum content involving multiculturalism was virtually absent in my nursing school program. Therefore, like many other nurses, I was not aware of differences among various cultures and lacked the knowledge to provide culturally competent care. At that time, being a young nurse starting in clinical practice, all of my efforts were directed toward improving clinical skills and developing a 'comfort zone' in communicating with patients, families and the health care providers. Little thought was given to different cultures and the need to provide culturally competent care as we know today. As I became more knowledgeable in maternal child nursing, my desire to understand culture, from the context of "others" everyday lives, began to grow.

Long before beginning the Master of Nursing Program, I had a yearning to learn about Mi'kmaq culture, traditions, and beliefs. While working in a number of capacities

as staff nurse, head nurse, and unit manager in the Neonatal Intensive Care Unit, Labour/Delivery and the Maternal/Baby Unit at a regional health care setting, I had frequent contact with many Mi'kmaq mothers and babies and this deepened my interest in their culture. I encountered clinical practice situations that made me question why Mi'kmaq mothers and families appeared hesitant and/ or avoided communicating with healthcare professionals. I questioned whether it was the hospital environment and/or the communication skills and competency of caregivers who provided care to Mi'kmaq people that made mothers appear reluctant to communicate with nursing staff and other health care providers. Perhaps it was due to the language barrier.

As a perinatal nurse, most of my career has been spent working with mothers, babies and families providing education and support so as to help to ensure healthy birth outcomes. Providing care to Mi'kmaq women is unique and sometimes challenging because I am not a Mi'kmaq woman and therefore, I am not as knowledgeable as I would like to be in what is culturally appropriate for them. As an advocate for client care, I do my utmost to learn and understand how different cultural values, beliefs, traditions, and language are affected by the nursing care that I and other nurses provide.

A further motivation for pursuing research with Mi'kmaq people evolved from being an invited member of a committee of graduate students studying Canada's Aboriginal peoples in various capacities related to health. The national conferences of that committee enabled me to see the broad issues and to appreciate the need for improving health outcomes for Aboriginal peoples.

Prior to beginning my graduate education, I was also involved in initiating a local Native Awareness Committee at a health care setting for the purpose of addressing

cultural issues surrounding prenatal, intrapartum, and postnatal health. While a member of the committee, I learned more about Mi'kmaq culture than I had learned in the previous twenty years working in maternal/child nursing. A video titled "Epit Aji Weje tut" (Mi'kmaq Childbirth Video, 2000) was produced for Mi'kmaq women to show them what to expect during the prenatal, intrapartum, and postnatal period. Although the video was thought to be helpful to Mi'kmaq women, as it focused on procedures, it also highlighted the hierarchical unidirectional mono-cultural approach to childbirth experiences, which offered a powerful message of unequal power relations. At this point in time, I realized that policies and procedures developed for Euro-Canadian women during the perinatal period were too generic in nature. Policies and procedures were applied to all cultures, with little or no attention given to the specific cultural beliefs of minority groups such as Mi'kmaq. I began to seriously reflect upon my current practice and also began to observe how other health care professionals provided care to Mi'kmaq women and families. What I saw was that women of all cultures received minimal health care choice. Mi'kmaq women, who are quiet by nature, exchanged only minimal conversation with health care providers. They therefore, accepted whatever medical and nursing care was given without question.

My current graduate education program has helped me to understand the socioeconomic, political and economic determinants of health and to add a gender and cultural analysis of how these factors impact the health of marginalized populations. I have a greater appreciation of the importance of family and community and the importance of knowing and respecting individual beliefs and community traditions.

Being a non-Aboriginal nurse presented some challenges in this study. Since I was not a Mi'kmaq woman, I was concerned initially about whether the participants would open-up to me about intimate details of their childbirth experiences. However, during the interview the majority of participants appeared relaxed and eager to describe their childbirth experience.

Communication was another potential challenge. I was concerned about the participants fully understanding the implications for engaging in the study. Also, I wanted to ensure that the participants understood the interview questions in order to respond appropriately. Although the language barrier was a concern, the participants stated that they understood the consent form and could answer the questions in English.

Using an indigenous framework presented an even greater challenge. I was unable to fully embrace the indigenous framework because it was not part of my lived experience. Although I researched this topic and attended national student conferences on Aboriginal health, not being a member of this culture prevented me from having an in-depth understanding of the traditional beliefs and values of Mi'kmaq women and families. For example, I did not explore some of their cultural traditions and beliefs such as the medicine wheel. In future research, I plan to explore this area more fully to gain a better understanding of its use.

To increase my personal growth during this research, I kept a reflective journal. The journal was used to describe my thoughts and responses to the interviews and focus group. Patton (2002) defines reflexivity as a way of stressing the need for self-awareness, being politically and culturally astute and accepting ownership of one's point of view.

Reflecting on my personal beliefs, observations and interview responses in my journal help me to identify my biases, which affect the collecting and analyzing of data.

I bring to this research project many years of experience in interacting with Mi'kmaq women and their families as a caregiver and manager of the nursing unit where they delivered their babies. More recently, I have been an educator working with some Mi'kmaq nursing students. Personal experience as a mother also has enhanced my understanding of giving birth. My introduction to the Mi'kmaq First Nations Community and to the community health nurses, as well as physicians and other health care professionals, over the past number of years has helped me recognize the importance of culturally appropriate care.

Data Collection

The Setting

This research was conducted in a First Nations Community in Cape Breton, Nova Scotia. Approximately 60 to 100 Mi'kmaq women from this community give birth each year. The health center is located in the community and one of the functions of this facility is to provide prenatal and postnatal care services to Mi'kmaq women.

The First Nations Community health nurse, a Mi'kmaq nurse employed at the health center works primarily with prenatal and postnatal Mi'kmaq women. She has also provided community health services to other people in the community for more than nine years. The community health nurse has several roles and responsibilities at the Health Center. During pregnancy, she assesses the mother for possible prenatal complications and makes referrals to the physician in the First Nations Community. If women experiences psychological problems during pregnancy, she may refer them to the

counseling center also located in the community. The community health nurse coordinates the Canadian Prenatal Nutrition Program previously discussed in chapter I. This program provides women with free nutritional supplements, prenatal educational material, and videos pertaining to prenatal care. Breastfeeding education is provided on a one-on-one basis during pregnancy and postpartum. The community health nurse immunizes babies and older age groups in the community. She collaborates with home care staff, the doctor's office, and other health care professionals in this community, and health care facilities outside the community, on health issues in order to provide the best possible care clients. The community health nurse is recognized as a knowledgeable and valuable health care professional in the community.

Since the community health nurse had this rapport with the women and being of the same culture, a Mi'kmaq woman, the participants may have been more willing to participate in the research. She had established a trusting, professional relationship with Mi'kmaq women during pregnancy, which made it easier for her to approach them for this study. The community health nurse approached some eligible Mi'kmaq women who were 19 years of age and older, as well as first time mothers, living in the First Nations Community, to inform them of the study and to initially ask whether they might consider being participants.

OCAP which stands for ownership, control, access, and possession is a body that has been established to ensure that Aboriginal people's input and perspectives play a central role in research conducted in their communities (Atlantic Aboriginal Health Research Program, 2004). This means that the community has influence on the various phases of the research process. According to the National Aboriginal Health Organization

(NAHO) (2005), “the OCAP principles apply the concepts of self-determination and self-governance to research, statistics and information involving First Nations communities ” (p. 2). In this research, a number of steps were taken to adhere to the principles of OCAP. First, ownership refers to protection as it relates to cultural knowledge. I preserved their cultural knowledge by staying true to their stories. Control refers to research processes involving various parts of Mi’kmaq people’s lives. Access to data was obtained through proper channels which meant that the research had to be approved by the Ethics committee at Dalhousie University and the Mi’kmaq Ethics Watch prior to commencing the study. Possession refers to community involvement and consultation through community leaders. Consultation with various health care professionals, which included the community health nurse and the director of the health center in the First Nations Community, was held prior to commencing this study. They were given a copy of the research proposal for feedback before being sent to the ethics committee for approval. Also, a Mi’kmaq Educator living in this First Nations Community was informed of the study and consulted about Mi’kmaq women’s childbirth experiences. I also informed the staff working at the Health Center in the community prior to beginning the study. Ethical approval was received from The Mi’kmaq Ethics Watch, comprised of Mi’kmaq leaders, elders, educators, and other professionals in Nova Scotia before the study was conducted. Participants were informed that they would receive a copy of this research report. Also the Health Center, the Chief, and Band Council in the community and the Mi’kmaq College Institute, Cape Breton University will receive a copy of the research.

The Participants

Participants were purposively selected (Patton, 2002) on the basis of the following criteria: Mi'kmaq women, 19 years or older living in a First Nations Community in Cape Breton, Nova Scotia, who are first time mothers, having given birth within the past two years at a hospital in a city geographically separated from this community. Data were collected from 11 women, when saturation was reached. Participants were informed prior to the interview that they had the option of having a Mi'kmaq interpreter present to assist with interpretation if necessary. However, Mi'kmaq interpreters were not required as all participants were fluent in English. In contrast to quantitative research, qualitative research often employs a purposeful sampling technique and relies on small sample sizes, in some cases as small as a single case. The benefit of this sample size is the generation of rich in-depth data about people's lives.

The community health nurse approached the women when they came to the health center for their postnatal care and/or contacted them by telephone. In either instance, she handed out or mailed potential participants a copy of a letter of introduction to the study. The community health nurse verbally clarified information in the letter in the introduction if necessary to ensure that potential participants understood the purpose of the study and the nature of participation. This letter described the research, its purpose, and the nature of Mi'kmaq women's participation (see Appendix A). It also asked potential participants to contact the researcher if they would like more information or wanted to participate in the study. The researcher's phone number was provided. However, the community health nurse was not aware of the women's intention to participate in the study. Additionally, a stamped envelope and a participation form were provided with the letter of introduction.

Participants were asked to complete the participation form indicating their wish to participate (see Appendix B). If the participants did not have a phone, they were asked to indicate on the participating form how they could be contacted. Those wishing to participate provided their name, address, and contact number on this form and returned it to the researcher in a self-addressed, stamped envelope provided. I contacted those who indicated willingness to participate. All participants provided a phone number where they could be contacted.

Once a participant expressed interest in participating in the study, a time and place convenient for her and the researcher were arranged to discuss the purpose of the study in more detail and to answer any questions or concerns. If the woman agreed to participate, a participation consent form (see Appendix C) was signed. A total of two interviews per participant were conducted. The participation consent form was signed at the time of the first interview. All participants were able to read the participant consent form and were asked to sign. A confidentiality form was available to be signed by a Mi'kmaq interpreter if needed (see Appendix D). However, this was not necessary as all participants could speak and read English.

The Interviews

The aim of the interview was to allow the participants an opportunity to express their feelings and beliefs. Therefore, establishing a permissive atmosphere for the participants helped to achieve this result (Oakley, 1981).

Participants were interviewed in a private area of their home or another area mutually agreed upon by participant and researcher, away from interruptions. If a participant expressed a desire to be accompanied by a friend or family member, he/she

also was asked to sign a confidentiality agreement (see Appendix E). Two participants requested to have a family member present, so both of these persons signed a confidentiality form.

Data was collected by means of one-on-one in-depth interviews and a follow-up discussion with each participant. The one-on-one in-depth interviews were a suitable method for discussing sensitive topics as it enabled me to obtain information from the participants in order to gain an understanding of their situation and attain details. Each interview lasted from one to one and one half-hours. In qualitative research, data collection continues until there are no vague areas, all information is clear, and no new information is revealed (Du Gas et al., 1999). When the researcher interviewed the 11th participant, I felt confident that I had not heard any new data and that saturation had been reached.

The interviews were scheduled when it was convenient for the women to meet with me, either following the baby's feeding or when the baby was sleeping. An informal conversation was used to begin the interview with the participant, in order to achieve a comfortable relaxed environment. An interview guide was developed to guide the conversation (see Appendix G). The guide included open-ended questions about the mother's childbirth experience. Rheinart (1992) supports the use of open-ended questions as it "maximizes discovery and description" (p. 18). She also adds that feminist researchers find that interviewing provides a means of acquiring individual's thoughts, and ideas in their own words, instead of coming from the researcher's words.

Nine of the 11 interviews were audiotape recorded and transcribed verbatim to ensure accuracy of the data. Two participants preferred not to be audiotaped, so I wrote

detailed notes during the interview. Confirmation of confidentiality was obtained from the transcriber prior to transcribing the data (see Appendix H). The researcher wrote field notes after the interview had been completed. Field notes helped provide a more accurate and comprehensive account of the interview (Streubert-Speziale & Carpenter, 2003). During the interview, Oakley (1981) stresses the importance of using “non-directive comments and probes to encourage a free association of ideas which reveals whatever truth the research has been set up to uncover” (p. 37).

The researcher invited the participants to participate in a focus group meeting with the researcher for validation of data interpretation. However, only one participant attended this event so preliminary findings were communicated to other participants through a follow-up telephone call from the researcher. This meeting with one participant lasted approximately two hours and was tape-recorded. The meeting was held at a time and location that was mutually agreed upon by the participant and the researcher. In this meeting, I presented my preliminary interpretation of the interview data and encouraged feedback as to whether the themes I identified fit with her experience. Although it was not possible to have the majority of participants at the planned focus group meeting, doing a second interview by telephone helped to provide valuable data for the themes. The data analysis was enriched by feedback from participants and this influenced the themes that emerged.

Ethical Considerations

Approval to engage in this study was obtained from the Human Ethics Review Committee, Dalhousie University. Also, additional approval was obtained from the Mi'kmaq Ethics Watch Committee, prior to commencing the study.

Participant consent forms were signed by all participants (Appendices C). A focus group consent form was signed by the participant who attended the planned focus group meeting. I informed the participants that they could withdraw from the study at any time without influencing the health care they receive. The participants were assured that confidentiality would be maintained throughout the research process and in the dissemination of information by the researcher. To guarantee anonymity, a pseudonym was used during transcription, publishing, and for presentation of research results. There are approximately 60 to 100 births per year in this community. The sample for this research was therefore drawn from a possible 100 women and about 30-40% were first time mothers, thereby meeting one of the criterion for this study. To protect the identities of participants, information about each participant was purposefully kept vague so as to avoid reader recognition.

I asked the participants for permission to audio-tape the interviews. I also received permission to audio-tape one participant who attended the planned focus group meeting. I informed the participants that they could refuse to answer any questions they did not feel they wished to answer and they could discontinue the interview or withdraw from a focus group at any time. All participants were informed that all information discussed in the second group meeting/interview would be kept confidential.

All data and materials were stored in a locked file cabinet, which is accessible only to the researcher. All potential identifiers were removed and participants were identified by pseudonyms. Audio-tapes used for the interviews will be destroyed once the study is completed. All material used in this research study including forms and

transcripts will be destroyed five years after the thesis is accepted, as per recommendations of the Human Ethics Review Committee, Dalhousie University.

Thematic Analysis

Data were examined using thematic analysis. Morse and Field (1995) describe thematic analysis as “the search for and identification of common threads that extend throughout an interview or set of interviews” (p. 139). The researcher was searching not only for commonalities but also for evidence of natural differences, all the while staying alert for emerging patterns (Polit, Beck, & Hungler, 2001). Aronson (1994) says thematic analysis aims at identifying themes and patterns of human behavior and or daily living. The process aims at clustering information in order to detect identifiable themes (Streubert- Speziale & Carpenter, 2003). The themes may be abstract and difficult to recognize until one reflects carefully on the situation. Researchers must ask themselves: “What is the message the participant is trying to convey?” (Polit et al.), and to whom do themes apply: to mothers, the group or subgroups, the community? Identification of themes in data requires a meticulous and detailed reading of the information (Desantis & Ugarriza, 2000; Morse & Field) and once the themes are identified, the researchers report them in a way that is meaningful to the audience (Streubert-Speziale & Carpenter).

Aronson (1994) proposes the following steps in performing thematic analysis. Initially, the data are collected via audio-tapes and from the transcriptions; patterns of experiences were evident either in direct quotations or in general discussions with the participants. After the data were collected, the researcher listened to the audio-tapes of nine participants and read the notes of the two participants who were not audio-taped. I made notes in my journal and then the researcher carefully examined the transcripts for

emerging patterns. Then the researcher labeled, and colour-coded these notes. The next step entailed taking the data that pertained to the specific patterns of experiences and categorized them according to similarities and related patterns as well as for differences. From these responses, the researcher saw some themes emerging such as being unprepared for the birth, so the researcher labeled this first theme, Unpreparedness for Childbirth, one of the four major themes identified in the study. The third step involved combining and cataloguing similar patterns into sub-themes. Responses that did not fit with any of the identified themes were discussed separately. Themes that arose from the participant's stories were pieced together to give a more comprehensive view of the collective experience. Leninger (1985) affirms that "coherence of ideas rests with the analyst who has rigorously studied how different ideas or components fit together in a meaningful way when linked together" (p. 60). For example, during the analysis, a key concept, lack of knowledge appeared in the narratives of six participants. Because of this frequency, the researcher labeled it a sub-theme. Lack of knowledge concerning prenatal health conditions such as gestational diabetes, and its effect on the baby, signs of preeclampsia, and high blood pressure were some primary concerns for women. Additionally, women lacked knowledge on what to expect during pregnancy, and labour including equipment and procedures. Also two participants raised concerns about teenage mothers requiring prenatal classes, because they were young having babies. Fear related to safety, another sub-theme, appeared in responses from eight participants. Participants expressed fear about developing diabetes, having an unhealthy baby, of labour pain and of dying. It became evident that these fears created anxiety and uncertainty for these women regarding healthy outcomes for their babies and themselves.

The final step involved building a valid case for selecting the themes. The researcher used extensive literature from various sources to support four themes identified in the study. An example of literature support the researcher used for the sub-theme lack of knowledge is included in the following statement. Kendrick (2001) asserts that women need appropriate information and support from nurses in order to allay their anxiety and empower them by giving resources needed to help them adjust to the diabetic protocol....By using the related literature, the researcher was able to make inferences from the data collected. The researcher created theme statements based on the literature and the information obtained from the participants. Aronson has found that when the literature is intermingled within the study findings, the researcher's story receives more credibility.

Trustworthiness of the Data

Qualitative research studies require evaluation for credibility and trustworthiness (Du Gas et al., 1999). Patton (2002) recommends that those choosing qualitative research should avoid using words such as objectivity and subjectivity; instead they should use words such as "trustworthiness and authenticity" (p. 51). Trustworthiness and authenticity can be used to assess the quality of qualitative research. Trustworthiness can be ensured through processes of participant validation and audibility (Peter, 2000). In this study, I evaluated data through participant validation followed by a meeting or a telephone call after the initial interviews and data analysis were completed, to ensure trustworthiness. Documentation, communication, and materials were safely maintained. Authenticity is attained when the participants recognize their own experiences from written accounts (Guba & Lincoln, 1994). Therefore, a sense of authenticity was ensured

when the participants were able to recognize their own childbirth experiences during the focus group meeting or second interview by telephone.

Four criteria have been recommended for evaluating qualitative research: credibility, dependability, confirmability and transferability (Guba & Lincoln, 1994). These four criteria are important to demonstrate the attention that qualitative researchers give to their research (Streubert Speziale & Carpenter (2003).

Credibility is achieved when the participants recognize the findings of the study to be accurately described (Lincoln & Guba, 1985). Through various ways I ensured the credibility and accuracy of this research data. Initially, I used many sources of data such as in-depth one-on-one interviews, field notes, and literature to determine the similarities of findings. Secondly, I conducted a follow up meeting with the participants which provided an opportunity for them to review my understanding of their childbirth stories, validate my analysis, and broaden the analysis even further.

Dependability refers to the quality, consistency, and acceptability of the research process (Lincoln & Guba, 1985). One way dependability can be achieved is through an “audit trail” which is the provision of raw data and detailed descriptions of activities over time (Lincoln & Guba). Dependability of this study was ensured through the provision of the raw data, such as direct quotations from the participants and detail accounts of the processes such as use of field notes, data generation and data analysis. This allows the readers to make judgment regarding the dependability of this study.

Confirmability refers “to the objectivity or neutrality of the data” (Polit et al., 2001, p.315), whereby the extent to which the data and interpretations of the research are rooted in the context of the people’s lives and not personally constructed by the

researcher (Lincoln & Guba, 1985). Similar to dependability, confirmability can also be confirmed through an “audit trail”. Systematic collection documentation, integration of raw data, and detailed description of the research processes are clear to facilitate that an independent auditor may reach conclusions about the data for this research. Also important to confirmability was the integration of reflexivity through the research process. Contextual influences need to be made clear to highlight any personal bias that may be present. During this study, although my professional knowledge increased, which helped me to identify categories that may potentially fit as emerging themes, field notes were kept to reflect my personal experiences as a maternal child nurse to maintain objectivity or neutrality. As I interviewed the participants, I increased my understanding of the similarities between my previous experiences working with mothers in maternal child nursing and the experiences of the mothers in the study, thus eliminating the necessity to rely on my past experiences.

Transferability, the fourth criteria, means that the findings from the study have similar meanings to others (Streubert Speziale & Carpenter, 2003). “Transferability is always relative and depends entirely on the degree to which salient conditions overlap or match” (Lincoln & Guba, 1985, p. 241). As the researcher, it was my responsibility to provide sufficient data in the research for others to evaluate the applicability of the data to other contexts. Therefore, the burden of proof lies with the researchers to present sufficient information to determine contextual similarity (Polit et al., 2001). Throughout the research, sufficient data regarding the processes and transactions were evident through detailed descriptions and integration of significant amounts of raw data to allow the person reading the study to decide regarding transferability.

Conclusion

Having been a former member of the Native Awareness Committee at Cape Breton Regional Hospital in Sydney and now having completed a qualitative study with Mi'kmaq women, regarding their childbirth experiences, I have a much broader perspective of the issues that effect women's lives. A qualitative research method helped me to understand human behavior within the context of Mi'kmaq women's lives. Feminist methodology and an Indigenous framework were helpful in viewing the world from the Mi'kmaq women's perspective during childbirth. This methodology was also useful in examining childbirth issues and advocating for ways to improve the lives of Mi'kmaq women and their families.

Criteria for participant participation were outlined in this study. Data was collected using semi-structured interviews, a meeting and/or a second interview via telephone and was examined using thematic analysis. Ethical considerations, trustworthiness of the data, and locating myself in the research dissemination of the findings were also discussed in this chapter.

While engaged in this research, I have made every effort to attend seminars and conferences (and to present at conferences) and student gatherings as a means of disseminating this information. After attending the cultural competence workshop, as previously mentioned, I am more confident that there is a vision and commitment by health care providers in Nova Scotia to remove barriers to health by implementing cultural competent guidelines. Being associated with the experts in Aboriginal health will enhance and strengthen my knowledge, build partnerships, and foster collaboration

among researchers and provide the information so that I will be able to disseminate to colleagues, students and others.

Chapter IV

THEME I: UNPREPAREDNESS FOR CHILDBIRTH

In collaboration with the Mi'kmaq women, four key themes were identified with the purpose of revealing a true picture of the women's childbirth experiences in a non-Aboriginal setting. Although their birth stories varied, as one would expect, there were frequent commonalities found among the women's experiences.

The four major themes that emerged from the interviews with the Mi'kmaq women include: Theme I-Unpreparedness for Childbirth; Theme II- Professional Relations as Sites of Invalidation; Theme III-Access to Health Care; and Theme IV-Support During Birthing. The focus of this chapter will be Unpreparedness for Childbirth while Theme II, III and IV will be presented in subsequent chapters.

Unpreparedness for childbirth refers to lack of knowledge and fear about what to expect when having a baby for the first time. Prenatal education is a fundamental component of prenatal care for women and their families (Health Canada, 2000). Prenatal health care provides a means to appropriately assess and diagnose prenatal complications that may occur during a woman's pregnancy (Wong et al., 2002). Women who do not receive adequate prenatal care may not be promptly diagnosed when prenatal complication(s) arise. As a result, the medical condition may advance to a point where women become critically ill.

Wong, Perry and Hockenberry (2002) affirm that childbirth education is aimed at assisting mothers and their families to make informed decisions about their pregnancy and birth. In order to achieve this goal, women need information about factors that will bring about a healthy pregnancy, labour and delivery process and ways to cope with

parenthood (Wong, et al.). The sub-themes associated with Unpreparedness for Childbirth include: lack of knowledge, fear related to safety, and feeling prepared for childbirth. These sub-themes will be discussed in this chapter.

Lack of Knowledge

Clarification of the following terms knowledge, information, education, and support, and how they are used in this research will be provided. Knowledge refers to acquiring facts and being able to remember them (Potter, Perry, Ross-Kerr & Wood, 2006). Knowledge is used to find meaning in what one is learning and understand the reasoning behind it (Delaune & Ladner, 2002). In this study, knowledge refers to women's ways of knowing about childbirth. These include intuitive knowledge, written and academic knowledge, and knowledge passed on through stories. Information is defined as "knowledge that is exchanged through communication, either verbal, written or data (O'Toole, p.930). In this study, information refers to the data obtained from doing an extensive literature review, conducting interviews with the participants, from the Mi'kmaq Educator. It also refers to data the participants obtained from different sources such as reading books, pamphlets, videos, birth stories passed down from family and friends. Education refers to the way in which knowledge and information are transmitted-passed on to a person. Patient education is a way of influencing behavior, bringing about changes in knowledge, way of thinking, and skills for the purpose of improving health (Rankin & Stallings, 2002). In this study, education refers to the way participants received information, which included teaching, instruction, and through cultural tradition. Support is a very important aspect to health care and the uptake, implementation and understanding of information and knowledge. Orem (2001) defines

support as a “means to sustain in an effort and thereby prevent the person from failing or from avoiding an unpleasant situation or decision” (p.57). Support was evident in various ways such as allowing time for discussion, listening to concerns, and offering information to help the mother gain autonomy. The Mi’kmaq women received support from family, friends, the community health nurse and other health care professionals.

As part of a lack of knowledge, the women described a lack of information on pre-existing and pregnancy-induced diseases, normal changes in pregnancy and the labour process and parenting and mothering. The women also described the impact of this lack of information as including stress, isolation, uncertainty and anxiety. The women also offered good examples of the benefit of getting timely information. Lack of knowledge relating to the participants’ prenatal health during pregnancy was also a common finding during this research study. Many participants discussed the need for more education about their pregnancy and resulting changes in their bodies.

It is important for women to be assessed as early as possible in order to receive information about pregnancy complications. A common prenatal complication found in this research and also known to be higher in the Aboriginal population than in the general population is gestational diabetes. Five of the eleven women interviewed had gestational diabetes. Gestational diabetes (GDM) is defined as “any degree of glucose intolerance that has its onset or is first diagnosed during pregnancy (Ladewig, London, Moberly & Olds, 2002. p. 267). Kendrick (2004) asserts that poor glucose control during pregnancy increases the chance of women having miscarriages and infants born with congenial malformations. In this research study, one of the Mi’kmaq women who was diagnosed with gestational diabetes had a history of miscarriages. Another mother had a baby with a

congenital malformation. Congenital malformations are serious and may affect several body organs. These malformations may involve the heart, the central nervous system and skeletal system (Ladewig et al., 2002). Other complications of diabetes include increased incidence of respiratory distress syndrome as hyperglycemia and hyperinsulinemia tend to delay lung maturity in infants. Macrosomia (meaning abnormally large in size) and intrauterine growth retardation are also complications that occur as a result of diabetes in pregnancy. Maternal risks are associated with conditions such as preeclampsia and eclampsia, ketoacidosis, infections and other complications.

Margaret recalled her lack of knowledge about gestational diabetes as:

I had lack of knowledge of diabetes. No one told me that the baby could die. You could be fine but your baby could die because your sugars are high. How the baby was going to be, and the new insulin that I was getting that day and the next day anyway. I was concerned because they won't tell me much.

She described how distressed she felt after being informed by her doctor that her baby could have died as a result of having high sugars. Her distress also stems from a lack of knowledge regarding her high blood pressure and blood sugar, in addition to having poor eating habits all which could have harmed her baby. Feelings of anger were evident in her remarks:

Does insulin affect the baby? No one had an answer for me, so I told them, what if my sugars are too high, what will happen? No one said anything so when my doctor came in ... said if your sugar is too high the baby could be fine that night on the fetal heart monitor, the next morning you wake up the baby could be dead. Oh my God, I cried for three hours, thinking that here I was goofing off, drinking pop, eating candy whatever I want, I totally had a misconception about diabetes because my dad has it, dad always goofs off, so it wouldn't be nothing like – it wouldn't be murder having a candy you know, so when he told me that, I quit drinking pop, the candy everything like that except for my bran muffins, and I told him you should have told me this in the beginning the first week you know I had to take insulin, you should have told me that, I mean maybe I wouldn't be in the hospital right now if you had...it was a total misconception for me – seven weeks that I had been taking insulin, goofing off, eating whatever I want, I even

told the doctor, I told the doctor (the specialist) that I said you should have told me that from the first moment you told me you're taking insulin, I should have been more informed.

The stress experienced by Margaret was compounded by her knowledge of a family member who lost a baby as a result of gestational diabetes. She was therefore worried about gestational diabetes and its effect on herself and her own baby.

I had a family member and the same thing, she got taken into the hospital like me, she got a day pass – weekend pass, she went to go back Sunday, the baby was fine on the fetal heart monitor, the next morning they would induce her, they went back for the fetal heart monitor and there was nothing on it. It was gestation diabetes that she had and she goofed off as well – she probably had a total misconception as well – I kept mentioning that to the doctors – I said that's happened before in my family I do not want it to happen to me I said, I was totally worried.... with the sugar it's like anall day thing....

Kendrick (2001) asserts that women need appropriate information and support from nurses in order to allay their anxiety and empower them by giving resources needed to help them adjust to the diabetic protocol and thereby decreasing the risks of prenatal complications. Although many of the participants in this study conveyed that the Health Center was a good educational resource, they did not feel they had sufficient understanding of their health condition. According to Kendrick, “women who have been diagnosed with GDM need immediate counseling and education” (p. 225). Receiving this diagnosis can bring about anxiety and uncertainty (Kendrick).

The benefits of receiving information about diabetes and glucose control were evident in the following remarks by Marie:

I needed more information, could have been told by the nurses. They told me right away about my sugars being up, they gave me a sugar test and it was up the first time, then it stayed normal.

Hypertension ranks as the second leading cause of maternal death in the United States (Peters & Flack, 2004). Three participants in this study had pregnancy-induced

hypertension. Optimal management requires prompt diagnosis and treatment (Peters & Flack, 2004). Nurses play an important role in performing frequent nursing assessments and interventions during pregnancy to determine the disease progression (Poole, 2001). Notifying the primary health care provider when signs or symptoms arise can prevent complications from becoming a crisis (Poole). Since the majority of prenatal care is given on an outpatient basis, education is fundamental (Pillitteri, 2003).

A participant with gestational diabetes taking insulin during pregnancy did not understand why her blood pressure fluctuated. Despite this lack of understanding Cathy was reluctant to seek more information from health care professionals. She stated:

I don't know I have to go to a diabetic test. I have to go to one because I was diabetic (during her pregnancy) ...I was taking insulin three times a day, and the pressure was always up – not always up it was weird... Yes like it would be sky high and then it would be normal... I was scared to ask. I was reading a lot. Well they all say that Mi'kmaq people are more prone to diabetes.

One participant, Angela was unaware of the signs of preeclampsia and was angry with the physician for failing to promptly diagnose her. She recalled:

When I was about five months I was at the beach at my grandparents and I was just walking around... and all of a sudden I noticed my feet were swollen and I couldn't even put my shoes on and I said oh my God and then I would go like this to my leg... And there was like a dent in there and I was oh my God.....they tested me for a diabetic pregnancy but my cousin... she said you don't have a diabetic constitution you have preeclampsia toxemia.... Like, eat right then she said, keep your feet up and so I had to stay in bed and my diabetic test results came back negative and I told the doctor and the community health nurse what if I have toxemia and they said no and they said you're just going to have a large baby and that scared me ...but when I was in the hospital they told me I had very bad toxemia...I was scared. I wasn't really aware of my condition.

Women with preeclampsia may require hospitalization for preeclampsia in which case, mothers will require bedrest, a quiet dark room and restriction on visitors among other standard protocol. Being informed helps to minimize stress, a key factor in lowering

blood pressure (Pillitteri, 2003). Receiving clear and concise information regarding what is happening and what is planned assists women to accept their health condition.

Cathy described how she was not prepared for the treatment protocol when she was admitted to the hospital with a diagnosis of preeclampsia. She remarked:

I really dreaded going into the hospital because I hadn't been in the hospital since I was little... my blood pressure was off, my sugar was off, my kidney's were goofing up the most awful thing I had to deal with at the hospital was getting up at three in the morning and getting my blood pressure taken, getting weighed because I had preeclampsia you know, getting weighed, go pee, and uh fetal heart monitor, the only good thing about it was the fetal heart monitor.

White and Ritchie (1984) found in their study on psychological stressors in antepartum hospitalization, antepartum women experience the most stress from being away from home, emotional concerns, changes in family situations, health problems, and their sense of self. Potential stressors included taking medications, diagnostic tests, fetal monitors and others (White & Ritchie). Stress may inhibit women's ability to carry out the pregnancy tasks such as ensuring safe passage during pregnancy and childbirth, acceptance by others, binding-in of the child and giving of oneself, identified by Rubin (1984) which can affect how they cope with pregnancy. Antenatal hospitalization created feelings of stress and depression for another participant with gestational diabetes, admitted three weeks before delivery. Margaret recalled:

One thing I didn't worry about was my blood pressure because I had never had it before, with the sugar it's like a ...all day thing, there's not a day... the whole day was all about your sugars...And I had so much depression when I was taking these things [glucose monitoring and administering insulin]. I had a little bit of it before, just a little like feeling down, once I took the insulin it was all day consuming my whole day...I'd stay in my room when the nurse comes sometimes I won't talk to her. I'll just wait – sick and tired of those same questions every blessed day.

When asked if she experienced depression in the past, Margaret replied:

I had it before I was pregnant, this feeling down sometime, but it didn't take the whole – it didn't consume my whole day, it made me like two hours feel down, and then I'd snap out of it, when I was in the hospital it was endless...

Prenatal education classes must be designed according to the needs of the clients they serve and be based on formation that is relevant to women (Keppler & Simpson, 2001). Classes should be available to a variety of mothers including teenagers, those who wish a private session, high-risk mothers and others (Keppler & Simpson). Some Mi'kmaq women in this study voiced concerns about being single, being alone and not knowing what to expect during pregnancy and labour. They identified that prenatal classes were a source of much needed information and support and would be especially helpful for new mothers. Jenny stated:

I was going through my pregnancy as a single mom and I felt alone. I don't know how other single moms feel you know like I wish I could have somebody else there with me, like telling me-like another single mom you know telling me that this is what you're going through. It's really hard you know, you need a lot of help to guide me through, you know what I mean.

Lesser, Anderson and Koniak-Griffin (1998) confirm that adolescents have a higher level of parenting stress than adults. Pillitteri (2003) adds that adolescents need an extensive amount of health teaching because they are less knowledgeable about care during pregnancy than older mothers. Adolescents have a need to be with their peers as companions but when they become pregnant they may be isolated from their friends. Many adolescents may appreciate the opportunity to participate in childbirth classes (Pillitteri).

Although only one of the participants in this study was an adolescent, many of the other participants raised concerns about other Mi'kmaq women being young and having babies. They were concerned that younger mothers may not seek prenatal information

from the Health Clinic in the community nor will they seek information from other resources, in order to be prepared for the labour and delivery experience. Two participants suggested that prenatal classes specifically designed for young teenagers having babies would be beneficial. Marie stated:

You know there are twelve and thirteen year-olds having babies who won't read. They are the ones that really need prenatal classes, even once a month for the ones that don't do research. ... When it comes to having babies, they don't know what's wrong with themselves, they are babies.

Elizabeth's views included:

I think we should have some kind of classes like even for the young girls, even if you take and just show them movies and stuff just to see.... I think they would probably want separate first, until they learn more... I find that they are kind of quiet. I know young girls that have kids like even thirteen.

Women and their families vary in their expectation of giving birth (Health Canada, 2003a). Designing a birth plan or having a discussion about wishes and needs of the women is one way of helping them to achieve their objectives (Health Canada). One participant, Joan who did not receive adequate information on labour and delivery commented that "prenatal classes would help...I didn't feel prepared. I didn't know the extent of pain I would have. I didn't attend any prenatal classes". Another participant responded that prenatal classes would be helpful but that scheduling it around high school would need to be considered. Wendy stated that she "would like to attend prenatal classes if they fit in"- in her high school class schedule.

A visit to the health care facility is recommended by prenatal educators because it helps to allay fears about hospital birth practices (Health Canada, 2000). Women and their families need to become familiar with the equipment such as birthing beds, squatting bars, birthing stools, infant warmers and other equipment unfamiliar to mothers

so that they know what to expect upon arrival to the birthing unit (Wong et al., 2002).

Orientation to the hospital setting is important to mothers particularly if they have not had a prenatal tour (Health Canada, 2003a). The majority of participants did not have a tour of the birthing unit. They described a lack of knowledge of pregnancy, labour and delivery, which also included being unprepared for the hospital-birthing environment.

Jenny described how overwhelmed she felt during initial admission to the birthing room:

When I first saw the room I was freaked out because there's the lights everywhere and the stuff for the baby. Yes this was all there and it was all covered, it was all sterilized and clean and stuff and I was looking around and I said, oh my God you know, I'm going to have this baby soon and I was uncomfortable at first... Yes, and like when I was in the labour room they were taking out stuff and I was oh my God what is that you know, am I having complications is there something wrong – I would go no forceps and all that and they were oh no, no we're just – just in case something happens ...I was freaked out like looking around the room and seeing everything is stainless steel you know.

Internal fetal monitoring is considered the most accurate method for assessing the fetal heart rate and uterine contractions (Pillitteri, 2003). In instances where there is difficulty in monitoring the fetal heart rate as a result of frequent maternal or infant movement, uterine contractions or maternal positions, a scalp electrode is applied to the fetus's scalp for continuous fetal monitoring (King & Simpson, 2001). One participant remarked that she was unfamiliar with the scalp electrode procedure used for internal fetal monitoring. Being more informed about this procedure would have made her feel at ease. Margaret described her experience as:

I was freaking out, plus she had two of those probes put in her...I don't even remember them putting that – whatever it is...Jeez two days later I noticed there's like two bumps on her head, I'm like, what is that? I looked, oh my God, there's um scabs on her head, so I got her godmother to come over and I said what will I do and she said just put lotion on it, rub it and keep rubbing it until its all off...

Contrary to western prenatal care practices, First Nations women do not regularly

receive prenatal care (Sokoloski, 1995). This study found that some women viewed prenatal care as important while others viewed pregnancy as a natural experience and relied on cultural traditions and practices to maintain a healthy pregnancy (Sokoloski). Hiebert (2003) debates whether antenatal care is culturally appropriate for Aboriginal women in western society. She suggests that further research is required to determine what Aboriginal women perceive to be culturally competent antenatal care. However, participants in this study reported they all received prenatal care including prenatal education from the community health nurse at the Health Center. From their responses, it was evident that this care was viewed as important for healthy birth outcomes. Their views are consistent with those of the dominant society and surprisingly different from the traditional practices of most First Nations people.

Fear Related to Safety

Pillitteri (2003) claims “fear of the unknown is one of the hardest fears to conquer” (p.545). Childbirth fear is common and generally women are able to conquer their fears (Bewley & Cockburn, 2002). Women are primarily concerned about the safety of their baby and their own health outcomes during this time (Rubin, 1984). In a study of women in high-risk perinatal situations, Stainton, Harvey and McNeil (1995) found that fear was generated from uncertainty as women waited during the pregnancy. Many Mi’kmaq women in this research voiced being afraid during labour and delivery and they were also concerned about health outcomes for themselves and their babies. For example, Lisa was concerned about developing diabetes when she became pregnant because she was aware of its complications as members of her family had the disease.

I have been overweight... Just being aware that there was a lot of diabetics in... both sides of my grandparents ...When I did get pregnant I was taking sugar tests

and I was diagnosed with gestation diabetes ... Yes – and I got to the point where I had to take a needle for it ... so that kind of scared me...

Kendrick (2004) asserts that women are generally anxious regarding their ability to accurately draw up the insulin and self-administer their insulin. One participant described her lack of knowledge and fear of self-administering insulin in the following manner: Margaret remarked “the first week I had that insulin I was shaking and crying giving myself the insulin. I was terrified of it”. Since childbirth outcomes are innately unpredictable, with some risk to the mother and baby, it is not unusual for women to be fearful of this experience (Bewley & Cockburn, 2002). Several participants expressed fear about their own and their babies’ health. For example, Angela remarked:

I wasn’t really aware of my condition... I was concerned about my freedom. I have fear of being a first time mother. At four months, I didn’t feel the baby move. I rushed to the hospital. I was scared of losing the baby at three months. My baby was cleared of being a Downs Syndrome.

Joan remarked “I had most fear about my baby. He was ok, healthy though.”

Elizabeth’s fear points to the need for greater knowledge of gestational diabetes. She stated “I was frightened my baby might have caught diabetes. She may have symptoms”.

Cathy recalled “I had fear about labour, my own health”.

Another participant was afraid to take her baby home from the hospital because she did not have a First Aid and Cardiac Pulmonary Resuscitation Course. Margaret suggested that these courses be offered in the community and possibly be included as part of prenatal classes to help women prepare for an unexpected delivery or the possibility of their baby choking. She stated:

When I first started going to the health care clinic in the spring, going to see the obstetrician there was lots of stuff on the wall like no smoking, go to counseling, to quit smoking or alcohol abusers or drug abusers – but there is no ... St. John’s course... I don’t understand why I wouldn’t need it... say the baby has like

breathing problems or choked down something or... Why wouldn't there be any courses for that... As I said I asked my husband if he knew he'd be taking care of little wee ones and he said he went to one and he showed me briefly like if she were to stop breathing this is what you would do,.... I noticed that on –like on the community channel they'd be courses that come out but there'd be only seats for fifteen people...

Not being prepared for the hospital was a significant stress for some participants.

This stress is reflected in the excerpt from Angela's narrative:

The nurse and the doctor came at about maybe 6:30 and they said they were going to have to start my labour. They were going to have to induce me, and so we were scared...

Preoperative teaching about the procedure and equipment to be used during the caesarean section provides women with appropriate information and helps to reduce fear (Pillitteri, 2003). Murphy, Pope, Frost and Liebling (2003) researched women's views on caesarean section in the second stage of labour. Results revealed that women felt unprepared for operative delivery and assumed the lack of preparation was due to their birth plan and prenatal classes being inadequate. Offering women debriefing on their intrapartum care and future pregnancies was suggested (Murphy et al.).

Medical interventions such as caesarean sections were a source of fear for some participants in this research. As Yvette noted, "I didn't know how to push him out. I was scared, scared of baby being too big. I was pushing for one hour, then caesarean section... The pain was very bad". Another participant was afraid to have a caesarean section because she was worried that the abdominal incision would not heal properly, a complication experienced by a family member. Wendy was also concerned about the baby experiencing fetal distress. She said:

I cried... Yes that's the only thing I was scared of. It's the healing part because I've seen my relative and it's really, really hard ... Yes because I seen her and she was open wide ... I had no choice because the baby was getting stressed.... He was

stuck on some bone...He was stuck there and they couldn't get him to turn, like he was kind of snagged... Yes and they couldn't get him to turn so they sent me to the OR... Yes my boyfriend, and my mother and his mother and I was crying...

Although the thought of going to the operating room for a caesarean section was frightening, one mother managed her fear by focussing on the health of her baby. Lisa remarked:

I felt all right about it – at first I was scared but I said you know this is better than going through all this pain and if I went to the c-section at least the baby would be safe ...

Another participant described her fear of being unable to deliver her baby vaginally. A disagreement about the method of delivery arose between the family doctor and the obstetrician. The family doctor urged the obstetrician to perform a caesarean section while the specialist was confident that this mother would deliver vaginally. This participant's fear was related to the baby being too large in size to descend into the birth canal. Jenny recalled:

I pushed for two hours, but I was exhausted and everything – two hours and fifteen minutes went by I looked at the clock and I told my doctor when she came in – I told her I don't think I could push anymore I'm really tired I just want to sleep I told her, so she said I think – first of all she wanted me to go to a c-section, and the doctor – the specialist I was seeing he was like no she can push him out – I was like no, my baby's too big and my doctor she kept telling the specialist you know I think she should go for a c-section because her baby's too big and she's tiny – and so I said yes take me to a c-section please, I said I'm scared because he's a big baby and he said no your going to push him out so I said OK...

Childbirth preparation is based on the principle that pain experienced during birth is a cycle process (Crechan, 2001). As women experience increased fear and anxiety during labour, their muscles tighten, there is more discomfort and uterine contractions become less effective. In preparation for labour pain, the aim of childbirth educators is to break the “fear-tension pain cycle” by educating women about what is occurring and by

using non-pharmacological and pharmacological strategies to lower labour pain (Creehan, 2001, p.423).

Some participants said they did not anticipate the degree of pain they actually experienced. This lack of anticipation is captured in Lisa's response:

Childbirth-I wouldn't –well-I want to say hard but there are some women that you know don't experience it-the pain part of it. ... I didn't think it was going to be this difficult, this painful, I didn't expect that at all. I was so surprised – you know intimidated, women go through it for childbirth Yes I thought it was going to be a vaginal birth and it was not going to be that hard I didn't, you know, I didn't expect all this anyway.

Similarly, Yvette noted “I had bad pain, cramps. I didn't expect this. My friends told me about this but I didn't listen”. Wendy described her fear of labour pain based on her past experience of being present during a relative's delivery.

I was nervous, because I seen my [relative]...she went into labour and I was in there with her and I could hear her screaming... we had the same doctor so the doctor didn't want me to be in there but I kept going in and going in and she was screaming and so she was really scaring me because of the way she was screaming...

Another participant diagnosed with preeclampsia during pregnancy described a fear that was realized after the birth. Angela recalled:

I went to visit my grandmother – and she told me that I might have died; that I nearly had to go – if they didn't – if they didn't calm down my blood pressure they would have had to perform an emergency c-section and they would have had to decide to take either me or my baby but thank goodness that we were both able to live. Yes – I was in such a bad - I guess I was in such bad shape that didn't even realize what condition I was in you now – it wasn't in my head.

Some participants described fears surrounding the care of the baby. For example, one participant conveyed being afraid of taking her baby home from the hospital because she was worried about the baby's umbilical cord. Margaret recalled “I was terrified taking her home, and she was bleeding a couple of days before it [umbilical cord] fell

off...”. The umbilical cord begins drying after birth and generally falls off seven to ten days after birth (Ladewig et al., 2002). If the cord is pulled or the cord clamp is not secured tightly, bleeding may occur. According to Dore et al. (1998), air-drying allows the umbilical cord to separate at a shorter rate than using alcohol or other antiseptic solutions. Providing education to mothers about cord care in hospital assists mothers to feel comfortable with caring for the cord before it falls off. This education also helps to increase mothers’ knowledge and confidence to care for their babies.

In this research, some participants acknowledged how prayer gave them comfort and decreased anxiety and fear during childbirth. Participants’ fear of labour and delivery was decreased by a number of strategies. Prayer helped one mother manage her fear in labour. Lisa remembered “I had fear in labour. What you pray for is a healthy baby and healthy delivery”. Another participant described one of the nurses as ‘a God’ whom she admired, and was grateful for the supportive care she received. Jenny stated “I wrote her a thank you card and told her that – you were an angel sent by God and there should be more people like you”. Jenny added that she was so thankful to the clergy for visiting her after the birth of her baby. She stated:

There’s a priest from out my way... he baptized me and he saw my parents... my mom went out to see my dad and my whole family and he was standing there and he says what are you guys doing here? She said [participant] had a baby, and he said can I see her and she went yes and when I was holding my son, he went up to my son and he blessed my son and he blessed me, I was so thankful, it was so beautiful to have my parents there, my new son and my old priest –my parish priest – my whole family thought it was so beautiful.

Margaret commented that “I heard every Sunday; there is a church service at 1000 o’clock. I didn’t get to go. ...I prayed in labour”.

Labour and delivery fear was allayed for Joan after viewing several birthing videos and sharing her fears with family and friends:

At first I was scared but then after talking to my family and my friends about how it will happen I was all right – well I sort of got over it. I said it's got to happen you know, he's going to come out – I got over it – it didn't take me long to get over it either it took me maybe a couple of weeks you know. They showed me a video... I watched that about ten times.

Potter, Perry, Ross-Kerr & Wood, (2006) agree that religious and spiritual beliefs have a major effect on how people deal with their health and illness, pain, life and death. For example in the Mi'kmaq culture, people have strong beliefs in a Supreme Being (Davidhizar & Giger, 1998). Traditional beliefs, values and practices are intertwined with the Mi'kmaq religion, the majority being Roman Catholic. "Being a parent is a privilege. Taking care of God's creation is an honor" (p.8). Since spiritual health is central to all modes of their health which includes physical, emotional, and mental health, it is not surprising the value that Aboriginal people place on praying to help them maintain good health (The Prairie Women's Health Centre of Excellence, 2004).

Feeling Prepared for Childbirth

Although the majority of women in the research voiced concerns about not being prepared for childbirth, there were two Mi'kmaq women who felt they had enough knowledge from various sources to prepare them for the birth. For example, one participant who had a prenatal tour of the labour/delivery unit in her last trimester described feeling more prepared for what to expect when she was admitted to the birthing room. Angela stated "so I was able to familiarize myself with what's going to happen and who's going to be there and like that"... Angela further explained how beneficial she found the resources at the Health Center. Her comments included:

The pamphlets that I got from here from the community health nurse and any questions or concerns that I had about having like the ways of having a baby I was young, I turned to [community health nurse] a lot – like I did and I would call her during her office hours and ask her questions and ask if I just could come in and talk to her and she did that so I didn't – like when I said I turned to my mom and my aunts and my friends and I learned about sex at school like – I didn't really learn much from them like about having a baby and I'd be like what should I do and all this because she's a nurse and she knows that kind of stuff so that's why I turned to her like if I had any questions or worries you know that kind of stuff, I would turn to [community health nurse] and ask her about this kind of particular stuff.

Similarly, Marie remarked “I had enough knowledge, did a lot of research, read what they gave me, watched birth stories, used internet and talked to people who already have babies”.

Mothers who read and sought out various sources of information, explained that they did not feel the need for structured prenatal classes. They were highly complimentary about the excellent information they received on the reserve from the Health Center. The community health nurse at the Health Center provided educational material and she was readily available to answer questions and provide supportive care. Pregnancy is a time when women are highly motivated to seek information because they want to ensure they have healthy outcomes for their babies and themselves (Reproductive Care Program (RCP), 2003). Prenatal education is vital to understanding the physiology of labour and delivery (RCP). Blackwell (2002) reported that primigravidas, in particular, view the prenatal experience as a time to receive reassurance from health care providers about their pregnancy progressing normally. The role of prenatal educators is to act as teachers and provide information on the physical, emotional and social components of the childbirth experience. Prenatal educator aims to enable mothers and support persons to develop coping skills, in addition to being an advocate for them. Receiving education and

support from the community health nurse in the First Nations Community was valuable to the participants in this study. For example, Allison commented that:

The community health nurse...gave me a lot, every month I think, every second month she'd give me different pamphlets and tell me how far I am and how the baby is and what it looks like and stuff like that.

Similarly, Lisa, another participant noted that:

The community health nurse was there and we'd get pamphlets and all kinds of reading materials and I learned a lot of stuff from reading material... I know what to expect and all that because I like reading all that stuff. You know and just about when I got pregnant I started reading a lot of stuff – material about it.

In addition to receiving education about pregnancy and childbirth, health care providers raised awareness of issues such as smoking. For instance, Wendy described her success on quitting smoking during the pregnancy. She said “The community health nurse and my mother, my friends that have kids already, she taught me a lot of stuff every time I came in she showed me – like pamphlets and other things”. When she was asked if any of the pamphlets stood out in her mind, she remarked “the smoking pamphlet was helpful”. “I was a smoker and I quit”. She refrained from smoking her entire pregnancy.

Continuity of care is important for women during pregnancy and childbirth, therefore care should be provided by the same health care person (Health Canada, 2000). Jewell and Russell (2000) report that minority women who receive coordinated prenatal care services tend to have earlier prenatal care and more comprehensive prenatal care than non-coordinated care for mothers. The community health nurse provided this type of care to the Mi'kmaq women throughout their pregnancy. It was evident from their positive responses that a trusting relationship had been established between the participants and the community health nurse during their pregnancy.

Summary

In this chapter, the three sub-themes associated with unpreparedness for childbirth for childbirth have been discussed. They included: 1) lack of knowledge; 2) three types of fear: a) safety of baby, b) safety of self, c) painful labour; and 3) prepared for childbirth were discussed.

Labour and birth are considered normal processes for women (Health Canada, 2003; Kendrick & Simpson, 2001), however first time mothers have no previous knowledge or experience with them. Although most women in the general population get along well with support and only minimal interference from health care providers (Health Canada, 2000), there is often no way of predicting when complications may occur. Research has shown that Aboriginal women are at higher risk for complications such as diabetes and hypertension, both of which compromise the health of mothers and babies, and increase the chances of morbidity and mortality. That being said, the participants required close prenatal assessment during childbirth.

Being informed about the process of childbirth can enable women to feel more confident and help them prepare for it. Solchany (2001) adds that first time mothers need to accept themselves as mothers and have the confidence that they will be able to carry out this role. Women and families need to be knowledgeable about issues around childbirth so that they can make informed decisions (Health Canada, 2000). Murphy, et al. (2003) assert that “antenatal preparation for childbirth aims to build women’s confidence in their ability to give birth and to care for their babies” (p.1134). Davis (1998) concurs that education can improve self-efficacy and raise individuals’ motivation and confidence level that will assist them to function at their optimum potential and improve health outcomes. Prior to labour and delivery, women often seek information on child-care and feeding methods (Perla, 2002). All participants in this research acquired prenatal information from the nurse at the Health Center in the First Nations Community or from family, friends and other sources. Although this information was useful, the participants voiced that they did not feel prepared, nor did they fully realize the potential risks associated with birth. Perla (2002) acknowledges that “transitions from childbirth or antepartum (labour) through delivery to follow-up care in postpartum recovery are areas of patient knowledge that are not fully developed for the new mother” (p.61). Therefore it is necessary that these participants be prepared as first time mothers.

Many participants voiced concerns related to fear of the labour and delivery process and healthy outcomes for their babies and themselves. Research has shown that anxiety and fear interfere with the labour and delivery process creating pregnancy complications associated with prolonged labour and may create the need for a caesarean section, and even may affect the mother-infant attachment (Bewley & Cockburn, 2002).

Women's feelings of fear need to be acknowledged (Health Canada, 2000). Although the women in this study appreciated the childbirth education they received, they realized it was not enough to make them feel adequately prepared for transition to motherhood.

Receiving nursing support in labor has been shown to improve outcomes for mothers and babies. Mi'kmaq women in this research valued the support they received from family, friends and healthcare providers during childbirth. Support was received in various ways such as passing on birth stories, being physically present during the birth, and providing childbirth educational material. It is evident from the participant's responses that Mi'kmaq families play a significant role in providing advice and support during childbirth. Additionally, first time mothers expect more support from nurses and doctors than they actually obtain (Tumblin & Simpkin, 2001).

Supportive care from families is not enough to support women in labour (Health Canada, 2000). According to MacKinnon, McIntyre and Quance (2005), women base their satisfaction with nursing care during childbirth on the support received and the nurse's ability to communicate and provide culturally competent care. Although some participants verbalized satisfaction with their care, other mothers did not express the same opinion of health care providers. The latter group felt that they were not given the priority of care, they should have received. Supportive care during childbirth helps to alleviate the anxiety and fear of women (Perla, 2002). During childbirth, women need to have confidence in their ability to give birth (Lothian, 2001). Nurses need to be culturally sensitive to the wishes of clients and families (Baker, 1998).

Community health nursing aims to protect and promote the health of individuals and families in the community (Potter, Perry, Ross-Kerr and Wood, 2006). In this

research, because the community health nurse was Mi'kmaq, she had greater cultural knowledge of the women's values, beliefs and traditions about childbirth. This facilitated the establishment of a trusting relationship with participants early in their pregnancy. As a result of her cultural knowledge and cultural competence, she was highly respected by the women and their families.

Stainton, Harvey and McNeil (1995) pointed out that “information mediates uncertainty, relieves anxiety and allows relaxation from the vigilance of seeking information to do a job” (p.39). Maestas (2003) found that childbirth education lowers a mother's fear of the birth process, reduces dependency on “powerful others”, and motivates her to be a more active participant in decisions about care during this time (p.21). Having a positive birth experience is critical to healthy and satisfying childbirth experiences for women, babies and families (Maestas).

Chapter V

Theme II: PROFESSIONAL RELATIONS AS SITES OF INVALIDATION

According to Health Canada (2003a), “giving birth represents a major transition in a woman’s life” (p.5.5) and memories of the birth experience remain with a woman throughout her life. Communication and collaboration between health care providers and mothers and families are most important at this time. Health care professionals providing prenatal care must uphold the principles of providing family-centered maternity and newborn care, which includes informed choice, continuity of care, respect and evidenced –based care (Health Canada, 2000). Providing perinatal care in an environment that recognizes cultural differences and provides culturally sensitive care is paramount (McNaughton Dunn, 2002). Nursing interventions will be more effective if culturally competent care is provided (Willis, 1999). Research by Baker, Biro and Joe (2000) describe hospital experiences of Mi’kmaq people. These researchers found recurring themes in the narratives of participants revolving around misunderstanding and feeling misunderstood, similar to the findings in this research.

The following are sub-themes associated with Mi’kmaq women’s encounters in the health care system. They include: relationship with health care professionals, medicalized care failed women, and communication barriers and miscommunications. These findings will be the focus of the discussion in this chapter. Literature will be incorporated into the presentation of these findings.

Relationship with Health Care Professionals

The relationship between Mi’kmaq women and non-Aboriginal health care professionals in this research study was sometimes unprofessional. When the needs and

the expectations of clients are not explored, dissatisfaction, non-compliance and poor health outcomes may prevail (Salimbene, 1999). Mercer (1995) reports that hospitalized pregnant women experience increased stress for several reasons such as separation from family and their home, emotional issues, family changes, health concerns and self-image problems. Often they describe feeling lonely, bored and powerless, in addition to feeling physical discomforts and loss of control. Women's concern for their pregnancy and the safety for their baby makes them feel vulnerable at this time (Mercer).

During hospitalization for hypertension and diabetes in pregnancy, one participant gave an account of her experience with a doctor on call, while her own doctor was away on the weekend. This encounter with the physician was experienced as bullying and disrespectful of her. Margaret consequently felt angry and powerless. She reported:

The doctor told me off, not even a hello or nothing, ...started telling me off, I said I don't know who you are, you were my [the doctor] when I was a teenager and I didn't like you then and I still don't like you. I apologize but I'm sorry...[the doctor] told me that my sugars got to come down, I said, I'm eating properly... you know it doesn't do it within five minutes of me eating and my blood pressure, I gotta quit smoking. [the doctor said] you got total bed rest, you don't even get any more for a cigarette... you'll get up maybe nine o'clock, one o'clock, and five or six o'clock three times a day... that's when I almost lost it, I wanted my doctor back, I didn't want this one telling me off; my doctor don't even talk to me like that...

In another incident during the same admission, this participant communicated that the doctor said to her "I hear you are giving the nurses a hard time". Margaret was offended by this remark. Another participant conveyed how angry she felt about being told by a physician that she was the "worst" patient. The mother was fuming with this remark. She was also angry at the reaction of the nurse when she was not sure that her membranes had ruptured. Her experience of receiving unprofessional care was demonstrated in the following example:

Yes, so I was like I'm not sure if my water broke, and she was like – you're not sure, and she kind of laughs and I said yes, and she says hold on, I'll get the doctor. So they send me to labour and delivery – and he said you didn't know your water broke? Yes, he even told me I'm the worst patient here (laughs), I said I can't believe you said that to me Yes – he said you're the worst patient I've ever had.

Simpkin (1991) found in her study of first time mothers giving birth that the manner in which health care professionals treat women during childbirth can have a lasting effect on how they feel for the rest of their life. Women are most vulnerable during this experience, with their private body parts exposed to the world and crying in pain to strangers (Simpkin). When women are not treated with dignity and respect or they are taken advantage of, the outcome is a negative permanent experience (Simpkin). On the other hand, if women are nurtured, treated with respect, and made to feel like an active participant, then a positive experience results (Simpkin). The participants in this research did not consistently feel respected, nor did they feel they were consistently part of an autonomous process.

In another situation a participant described the traumatic experience of having a caesarean section without adequate anesthetic, despite telling the physicians that she was feeling pain. Wendy described:

They gave me the epidural and it didn't work – because I felt the tugging – I felt them cut and I felt them tugging. I told them – I was crying and I was telling my boyfriend I can feel them and they weren't listening... They came to check on me a few days later and one of the doctor's says like she's doing pretty good considering she felt most of her – what happened to her in the OR.

Some participants remarked that the doctors failed to explain the caesarean section procedure or what to expect during their pregnancy and or the birth process leaving them feeling frightened and disempowered. Health care providers who offer explanations create a chance for clients to use their autonomy (Browne, 1995). Creating a healthcare

environment where there is effective communication and sensitivity to care will help clients feel respected and empowered.

At the time of the delivery, another participant disclosed that the doctor failed to explain that he was applying a vacuum extractor to help deliver the baby. Her perception of the experience was that he was cutting her open. Here is a narrative from Margaret: “I told my husband, is he cutting me open, like is he cutting my vagina, he said no – he’s putting a vacuum on.... Didn’t see vacuum. Wished they had of explained more”. In a similar study, Baker and Daigle (2000) conveyed that Mi’kmaq participants in their hospital encounters described feelings of insecurity because they did not understand the hospital routine nor what treatment to expect. When patients are not treated with respect, they feel devalued and inhuman.

In another situation a mother with preeclampsia was not given any reason about why she was being induced. Angela stated:

They didn’t tell me why I was induced. He [physician] put the gel in and I was connected to the catheter. Then sent me to labour and delivery. They would take my blood pressure and weigh me. Why are they doing this?

Angela also described the lack of being informed about the possibility of requiring a caesarean section, as a result of her deteriorating medical condition. She stated “ they didn’t tell me that they may have had to perform a c-section because it would have affected my blood pressure”. A friend of Angela’s had a similar experience of not being informed.

My friend when she had her [baby]... she had to go for a c-section and they didn’t tell her anything – they had to use clamps to take him [the baby] out... he had like a big lump on his head and they nearly broke his nose so I would say they would have - they should have asked her – like they probably do now but they should have consent – her boyfriend was pretty mad about that – about what happened to the baby but he’s fine now and the bump is gone.

Traditionally, parents experience feelings of anxiety and uncertainty when their newborn babies are ill (Hopper, 2000). Generally mothers and babies stay together in the same room after delivery. When a baby is immediately admitted to a Neonatal Intensive Care Unit following birth, women and families are separated from their baby leaving a shorter time for infant bonding and developing a relationship (Nystrom & Axelsson, 2002). Feldman, Weller, Leckman, Kuint, and Eidelman (1999) found that infants who were ill at birth requiring separation and whose mothers had anxiety and depression had more difficulty with mother-infant attachment. When principles of family-centered care are followed, parents have access to their high-risk baby and are given appropriate education and continually informed about their baby's progress (Zwelling & Philips, 2001).

A participant whose baby was admitted to the Neonatal Intensive Care Unit was not adequately informed about the baby's condition. As a result, the mother was deeply concerned about her child's condition, a fact that caused her undue distress. Yvette noted that "first they told me there was something wrong with the baby... I felt scared. I didn't know what was going on. ... I was worried...". While a patient in the Neonatal Intensive Care Unit, the baby developed hyperbilirubinemia. Hyperbilirubinemia is a condition where on the second or third day of life in about 50% of cases, the newborns' skin becomes yellow (jaundice) as a result of the breakdown of red blood cells (Pillitteri, 2003). Treatment using phototherapy (placing a baby under a light to help with maturation of liver enzymes) may be indicated (Pillitteri). Phototherapy has not been linked to any serious complications (Nash, 2001). Simpson, Thorman and Ropp (2001) note that all women have the right to be informed about benefits and risks to themselves

and their babies. Although phototherapy is essentially a benign procedure, this mother deserved to be accurately informed about the purpose for using phototherapy and given ongoing updates on her baby's condition. Failure to inform the mother about her baby's progress created a feeling of uncertainty and anxiety. Minimal interactions between the neonatal staff and the mother made her feel dehumanized and not valued- this illustrates another example of invalidation. Yvette remembered:

[the baby] was in the unit for more than five days...waiting for the baby to eat better. They were teaching me how to feed. He had yellow jaundice. They put him under lights and covered his eyes. ...They [nurses and physicians] didn't explain things.

This same participant also described another encounter in the Neonatal Unit where one nurse did not hold her baby tenderly and with care. Although the literature describes that the easiest way for parents to wash their baby's hair is to hold the baby under one arm over a basin just as you would hold a football, (Pillitteri, 2003) many mothers may not be aware of this hold. Some parents may perceive this procedure as being incompetent and placing the baby at risk for injury. Yvette stated that "there was one lady [nurse] who held my baby like a football. Just the way she did it did it was rough. This bothered me, just watching. The other nurses didn't do this".

Health care providers failing to listen, was another frustration for a number of mothers, which communicated lack of respect for patients. Allison recalled:

I kept asking her if I was doing it right. She [physician] was nodding her head but not listening, in a way, only kind a listening. I kept screaming I feel her coming down, and then when I finally like I felt it...No I didn't really feel – but I felt from inside of me I felt her she was ready to come out – and the doctor's didn't believe me and they kept waiting and I still pushed it out.

Another example of failing to listen was evident in the remarks of Marie, another participant.

The nurse didn't believe I was ready to push. When they did check me, I was ready. I was ready but they weren't listening, they were going by other women. They were taking their time. They don't really believe me. They pissed me off. Listen to the mother. They don't do enough of listening. Everybody is different. Every woman is different.

A lack of respect was also described by participants as characterizing their interactions with nurses. Joan described a lack of accommodation for a family member.

The nurses got mad at my boyfriend because...the first night we stayed there they didn't ask him to get a cot so...he ended up sleeping on the other bed next to me and the lady came in the next morning and she you know she got mad at him and he was pretty mad that you know because they told him you could have asked for a cot but they didn't ask him...

Participants' interactions with nurses were important sources of support or invalidation. Supportive nurses answered participant's questions and communicated respect. In contrast other nurses were described as mean and insensitive and thus invalidated the participant's own experience of childbirth. Wendy responded:

There were some nurses that were not too nice but there was... Well there was this one nurse that was always mean – I don't know she was just mean and there was the other nurses – they were so kind like checking on me and checking on the baby and always there answering my questions and making sure that I'm very comfortable but I think there was only one bad one....she like screamed at me. Yes a loud voice – not screaming but she had a loud voice. Well, I couldn't get up one day – and she was like well you have to get up and she said I went through this and there was no problem so you have to get up, and I'm trying to get up and finally when I did...she escorted me to the washroom and she told me I could go and then one time well I couldn't lay on my side and she goes well I went through a section before and she said I had no problem laying on my side afterwards, and I said, will I'm a different person, I said I can't do this, and so she left....Yes, she had a section and whatever and because she got through it so easily she expected me and I didn't like that.

Jenny recalled that when she was receiving an epidural she felt disrespected:

...I know there was one doctor that gave me a hard time – one nurse gave me a hard time, she was like – like I kept asking her questions, what's going on nurse, just put your head down on the table you know like I was getting my epidural. But there was a few nurses yes meaning only a few that were not respectful.

In another situation Margaret remembered the nurse yelling at her. She described the experience:

But if you do what they are telling you to do, sometimes it's hard, like I told you she was stuck in the birth canal, I was breathing hyper-ventilating, the nurse came right up to me – you can't breath like that, I told you. I keep forgetting but the pain like – I know the pain she says, just breath through it...she was yelling at me – the more you breath like that the more pain you're giving yourself, you give the whole breath to you and the baby it will go away, so I was fighting to get that.

Labouring women rely upon healthcare providers to ensure they have a safe outcome for their babies and themselves (Mozingo, Davis, Thomas & Droppleman, 2002). Often their initial reaction is fear and even terror at the possibility of complications occurring during birth. When women receive insensitive childbirth care or when there are poor interpersonal interactions between the client and the health care provider, feelings of anger arise (Mozingo et al., 2002). The results of (Mozingo et al.) research revealed that women felt angry when their expectations of trust, power, control and being informed were not met. Their experience of anger echo similar responses of Mi'kmaq women.

Another participant reported that because the nurses seemed too busy to approach, she did not feel comfortable asking them for things. Joan also commented that the nurses “didn't ask you if you needed anything”.

With health care reform, there was no consideration of the impact on gender especially on women, patients and health care providers. One of the results of health care reform, indicated that in hospitals, nurses have been asked to cut back on their interactions with clients in areas such as labour and delivery further compromising health care to minority women (Spitzer, 2005). Reduced time as a result of the restructuring of health services has reduced the chances of developing trusting relationships with minority

women and women in general (Spitzer, 2005). Some of the Mi'kmaq women in this study, commented that nurses and doctors were insensitive to their needs, which may be attributed partially to the limited time care providers had to listen and interact with their patients.

In another situation, Yvette described how the nurse did not explain the reason she was hanging 'the drip' [meaning to augment labour]. The participant's mother, who was sitting with her, said that the drip would be painful, making her feel even more anxious. In this scenario, the participant described the interaction as dehumanizing because she and her mother were not provided adequate information about treatment being given in labour. Similarly, in a study conducted in a First Nations Community in Northern Manitoba by Browne (1995), participants described that "interactions became dehumanizing when patients were not offered explanations and information concerning their well-being" (p.105).

The nurse was...timing my labour pains and the machine wasn't catching it, and that's when they finally said you've got back labour and that machine is not picking up your contractions and I was like I know I've been saying that all day. So she's sitting there with her watch and I was trying to read a book and finally it was four o'clock and she said we're going to have to put you on a drip and I said OK, I really don't know what a drip is, they put me on a drip, and my mother goes a drip is painful.

Another instance of insensitive and dehumanizing care was experienced by a high-risk mother. Angela, who had preeclampsia during pregnancy, was frustrated with the lack of explanation given as to why she had to remain on medication [for preeclampsia] after delivery, delaying transfer to the postpartum unit. Lack of sensitivity to the mother's feelings was evident in the following response.

I was in labour and delivery after I had my [baby] I got sent to the like – a

room ...in the hospital the next day, like I wasn't moved right away because I think – I'm not sure because I don't remember but I think I was on different – I was on medication that they had to keep an eye on so then the next day... and my grandfather came in...and he told me why aren't you in a room yet? And I said I think I'm on medication but I'm not really sure...a nurse came – yes a nurse came over to change like the bed pad there and like there was a pad on me but like I wasn't wearing panties but it was there and they went like that to my stomach – like they pressed on it to try to get the uterus whatever [assess firmness of fundus].

Becoming a mother whether as a primigravida or multigravida, has a powerful effect on family and generally a woman's life (RCP, 2004). This experience can be emotionally overwhelming (Pillitteri, 2003). Moreover, women's perceptions of their birthing experience are affected by the clinical interactions they have with the healthcare professionals (RCP). One participant described being afraid of a nurse. The impact that insensitive nurses had on this participant was significant. Jenny: "One nurse was really mean. I kept talking to her but she didn't like me. I was scared. It is my first baby". Being a mother in labour for the first time can be a frightening experience. Lack of sincerity during interactions between the nurse and the participant was evident. Brown (1995) noted similar findings, as informants sensed when the provider was not sincere through verbal and nonverbal behavior. Women want to be assured that nurses are genuinely concerned. Insensitivity to her feelings and the lack of interest conveyed by the nurse gave a strong message that she did not care. The participant felt angry because she did not receive the respect she expected.

Issues around having control in choosing to take medications, and /or epidurals, and having persons present in the delivery room were some of the concerns for some participants in this research. According to Michaelson (1988), debate around choice and

control during childbirth means receiving appropriate education in order to make informed choices.

For the participants in this research, lack of control also included a lack of choice regarding a family physician and the management of labour. This is captured in the narrative from Allison. She recalled that “I didn’t have a choice in a family doctor. The doctor I had was a beginner. I really wanted someone experienced. I felt like [the doctor] was doing an experiment on me. That really scared me. I was worried”. Similarly, Cathy noted “I didn’t have a choice. All pregnant women see the same doctor. No choice”.

Marie described lack of choice in the following manner:

I didn’t have a choice, no choice, doctor came in without telling me I am getting induced. My labour started but it wasn’t heavy, nothing yet. They induced me again. ...Grabbed a toothpick, they didn’t tell me they were breaking my water.

People in positions of power such as governments, health care agencies and professional groups recognize the importance of culturally competent care, yet health care facilities often fail to provide culturally appropriate care (Smith, 1998).

Choice of health care providers depends on the size of the community and the physical location and resources (Health Canada, 2000). Although the Mi’kmaq women were disappointed about not being able to choose, it is not uncommon to have minimal choice in health care providers in rural areas.

Medicalized Care Failed Women

Maestas (2003) states “birth is seen by some women as a frightening and potentially dangerous event” (p.17). Although childbearing is an exciting milestone in the lives of many women, it is a frightening and potentially terrifying experience for some women (Maestas). For many women, the only way to ensure a healthy outcome for

themselves and their babies is to rely on health care providers to make decisions regarding their care. With the physician being the gatekeeper, women may become passive in their role and thus feel helpless and frightened of their childbirth experience (Maestas, 2003). Consequently, some women view the use of medical interventions as a means of ensuring a safe birth.

First Nations women believe pregnancy to be a natural and normal process with no interference (Sokoloski, 1995). However, non-medicalized care is not the standard perinatal care practice in most healthcare facilities. Sokoloski reports that technological interventions in pregnancy are considered by many First Nations women to be harmful, and they are afraid of them. They believe that procedures such as ultrasound may create problems in the baby's development and therefore should be avoided. Similarly, during labour and delivery, First Nations women believed that medical induction of labour, fetal monitoring, pelvic examinations, the use of forceps and other procedures may cause harmful results to their baby (Sokoloski). However the participants in the study did not outwardly object to any medical interventions. They were of the understanding that the medical procedures used were necessary to ensure healthy outcomes for their babies and themselves. Savage (2002) adds that the standard for medical care in today's society isolates the family, by placing them in "austere rooms of porcelain-coated furniture" where women are restricted to bed, and subjected to intravenous therapy, forceps deliveries and other hospital routine procedures (p. 8).

Lothian (2001) agrees that standard hospital practices such as confinement to bed, frequent use of oxytocin and epidural anesthesia significantly alter the natural childbirth experience. Many of the participants in this research study experienced varying

degrees of medicalized care. Having said this, many of the women were informed by medical and nursing staff that this type of medical care was the best care for them. For example, epidural anesthesia was considered the norm and many participants thought it would relieve anticipated labour pain. The experience of epidural anesthesia however did not live up to one participant's expectations. Jenny said:

I was really exhausted. The epidural didn't work... they put the needle in again the second time; the freezing whatever the numbness went to my leg, my thigh it didn't numb me here at all ...It didn't do anything I felt everything. The doctor that does the epidural needle he said I know I put it in wrong he kept saying. I said how can you put it in wrong. You know I was freaking out and stuff but I said it's OK you know, is there anything else you can give me for pain? And they were like no – if that don't work then nothing is going to work

Marie, another participant described the degree of her labour pain and frustration with the epidural anesthesia as:

I expected less pain. I hope the epidural works the next time... The pains were really, really bad. I didn't get medication until two am. I felt nauseated so they gave me gravol. Lying there, I dilated to five or six cm. I received an epidural. I had asked for medication because I was tired and exhausted. The epidural only worked for twenty minutes.

Labour pain is unique to every woman so only women can know the degree of their pain (Pillitteri, 2003). Creehan (2001) affirms that women's choice of pain management is individualized where they may base their pain experience upon what they learned in prenatal classes, listening to families, past pain experiences and other advice. While some women in this study described the pain as tolerable, others described excruciating pain during labour and delivery. Most participants received epidural anesthesia for pain relief, however some conveyed that it was not an effective labour relief intervention.

Maestas (2003) reports that women who are given epidural anesthesia have the highest amount of fear, more dependence on others, and assume a passive role in their

care. In North America, Hodnett (2002) reports that although epidural analgesia is common practice, there is no literature to indicate whether it has an effect on childbirth satisfaction. Hodnett adds that although continuous nursing support decreases the need for pharmacological pain relief interventions, some mothers do seem to benefit from epidural analgesia. However, there is no guaranteed success with epidural use as pointed out by Creehan (2001) as an epidural catheter can move out of the epidural space thereby eliminating the pain relief effect. Having to wait two hours for an epidural was upsetting to one of the participants. Margaret described her labour pain:

[the anesthetist] did one patient and left ... I was ripping from 10 o'clock, he came back at a quarter after twelve I was just ripping because at the time he was putting the epidural in me he had to put it in three times before he found the right spot and I got three contractions within the half an hour that he was trying to put it in and I was screaming and I was crunched up in a ball...he finally got the epidural inserted but he was in too much of a joking mood. I didn't find it funny.

This participant did not feel that her pain was acknowledged or taken seriously. During the epidural insertion, the participant described the experience:

I'd say what's... the hold up I was furious, ...I'm in pain and you guys are laughing I said, the guy that's putting the epidural on, and ...I said how long does this epidural take, they said it takes ten seconds, well that's how long it's taken us to find the spot you're supposed to get it in....

Another participant was disappointed that her doctor did not arrive in time to order an epidural. Yvette described her experience as "I was five centimeters when I got there [birthing room]...They turned me on my side and my water busted. I wanted the epidural needle but [the doctor] was too slow...I was too late for the needle".

Contrary to popular belief, several studies have shown that women, who report higher levels of satisfaction with labour and pain control, choose natural childbirth over epidural analgesia in labour (Kannan, Jamison, & Sanjay, 2001). A study by Kannon et

al. found women who requested epidural analgesia for pain in labour report being less satisfied with their childbirth experience even though their pain intensity is less. The findings from their antenatal survey reveal that women choose natural childbirth because they do not want an epidural and are afraid of the adverse effects of it; they want to actually experience the labour and birth, and want what is best for their baby. Natural childbirth is defined as “labour and delivery without the use of epidural analgesia for pain relief” (Kannan et al., p.468). According to Johanson et al. (2002), in order to change the birth environment to a more natural process, teamwork and support from healthcare providers, clients and others are required.

One participant described labour as feeling like her back was snapping in half. Although pain medication was offered, she opted for natural childbirth. She wanted to deliver her baby without any pain medication. Wendy described her labour pain:

...At four o'clock they said we're going to put you on the drip, ... I said OK but said but before you do I said, can you wait until I have a contraction so I don't think it won't be that painful, so she goes OK, so I remember I had a contraction and she timed it and she said that one lasted four minutes, I said oh my God – and again one of the nurses turned to me and asked, do you want anything for the pain. I said no I think I'll be ok... she goes are you still having a contraction and I was just on my back and she said how do you feel, and I said it's like somebody is like snapping me in half, and I was nearly falling off the bed and my mother was holding me and she calls another nurse over, and she's like – I said I'm in pain, she said do you feel like pushing, I said I don't even know, that's how painful my back is...they were putting like hot towels on my back so finally she said, when was the last time we checked if she's dilated and they said we never checked her so anyways when they checked me I was at 10.

Although a number of participants did not report pain relief from epidural analgesia, one participant described the comfort it provided to help cope with labour pain. For example, Joan noted:

I took the epidural, I didn't feel nothing then I didn't walk or nothing. I just laid in bed the whole time and waited... I couldn't feel the contractions...they [doctor

and nurses] had to tell me to push...like I'd close my eyes and I could just dream that he was already out and when I'd open them to push and I'm like oh my God he's not out yet so I had to keep pushing...It was pretty comfortable.

Another participant noted that although the degree of her labour pain was more than she anticipated, it was worth it. Here is how Margaret described her labour experience:

I told her, I got the needle at first I'm crying – I remember crying like 15 minutes, I'm timing my needle when it will work so I knew it was working because I couldn't cry no more I had all I can do, just little gasps really, I fell asleep, the next day all over again in the morning... It was worthwhile, it was a lot of pain but it was worthwhile. I really thought it was something really scary before I had her, after I had her I was like just happy to be through it, and it's true if you don't know how to breath through your pains you do more damage to yourself...It was pretty good considering some of the stories I've heard about childbirth, yes, I was thinking the worse before. I swear to God I told my husband I'm going to die through this experience – that's what I was thinking I'm going to die.

An episiotomy, a surgical incision of the perineum used to prevent tearing of the perineum, minimizes pressure on the fetus's head during birth and shortens the second stage of labour (Pillitteri, 2003). Although it is a common medical procedure used to minimize perinatal trauma during childbirth, there have been no benefits demonstrated (Kendrick & Simpson, 2001). Approximately 30-50 % of women receive an episiotomy, even though statistics indicate a decreasing trend (Pillitteri). The decision to perform an episiotomy rests with the physician as he/she bases this decision on personal beliefs, education and experience instead of evidence (Low, Seng, Murtland & Oakely, 2000).

Allison, one of the participants described her painful experience of receiving an episiotomy in the following words:

They kind of helped me out-they cut me a little bit, like they cut me too much... Yes, I don't think they really needed to cut me up because I just needed a little help; but I felt her like cutting me and every time she did like-I could feel it...It was kind of making me feel uncomfortable because it was like a burning feeling and I was scared if I pushed I will hurt myself but I had to do it, I was scared.

Another participant described a vacuum extractor being applied to the baby's

head by the doctor to assist with the birth. At this stage she was exhausted and wanted to expedite the labour and delivery process. However, this medical procedure failed to work and the participant agreed to have an episiotomy performed. Although Jenny agreed to both procedures, she was not aware of any alternatives to birth. She notes:

I was getting sick and stuff, so he helped me out with the vacuum and it wouldn't work, he wouldn't come out at all ...so he says OK we're going to have to cut you open, I said OK anything – and he said just give me two pushes and I said that's all I got if you tell me two it's going to be two – I said I can't give you four, you tell me two it's going to be two, if you tell me to give you twenty I'll give you twenty but don't tell me your going to want more than two you know it's going to be two, because I was really tired, I had my eyes closed, I couldn't lift up my legs, my arms or anything, I couldn't even talk hardly I was so exhausted, I said OK just two pushes, I gave him two pushes and he arrived...

Many women expect labour will be painful but do not anticipate the pulling and discomfort from perinatal sutures (Pillitteri, 2003). One participant described her fear of having a bowel movement the first time after she delivered the baby. She had an episiotomy as most mothers did in the study, and she was afraid that her sutures would open. This form of medicalized care created unnecessary anxiety and fear for this participant. Joan described the feeling in the following words:

My bowel movements won't come- like the hospital kept telling me like eat oatmeal and dry toast and I was eating them and eating them and they wouldn't come and I kept drinking water and they finally came and then what you call it- my boyfriend he told me –he called the doctor over and the doctor told me it was- like don't worry about the stitches-its going to come and he said it will come out normal and stuff. So I was scared of that. ...I put- I think it was tea... Yes somebody told me it brings the swelling down...

Similarly, Joan also expressed some concerns regarding the side effects of the epidural on breastfeeding. She recalled:

The epidural made him sleep like for two days...Because I was trying to breast feed and he wouldn't wake up to eat like we had to wake him up and usually after they do the blood work from his foot that's the only time he would be up and that was the only time to get him to go and get milk.

There is strong evidence suggesting that breastfeeding brings positive health benefits to women and babies (Dennis, 2002). However, Dennis advises that hospital practices such as restricted feedings, disruption in feeding routine and supplementation affect breastfeeding success. Walker and Creehan (2001) add that analgesia given during labour may possibly interfere with establishing an early breastfeeding pattern for babies early in the postpartum period. Because of the side effects of analgesia on breastfeeding, nurses need to help women initiate breastfeeding after delivery, ensure women and babies remain together and educate women about infant feeding (Walker, 1999).

Johanson, Newburn and Macfarlane (2002) argue that medicalization of childbirth has gone too far. Although medical technology and medical interventions are required in selected cases, it should not be accepted as standard obstetrical practice. Johanson et al suggest that a way to stop the growth of medicalization of childbirth is to end blaming others (Johanson et al). More emphasis needs to be placed on working as a team with a shared philosophy of respecting one another. Understanding women's fears and recognizing the importance of choice for women is a way of developing women centered care. The authors acknowledge "Childbirth without fear should become a reality for women, midwives, and obstetricians" (Johanson et al., p. 894).

Communication Barriers and Miscommunications

Communication challenges are one of the many barriers to providing culturally competent nursing care. Effective communication requires sincere commitment of health care providers to understand what the client is saying (Callister, 2001). Davidhizar and Giger (1998) suggest that although communication barriers exist when people speak the same language, the barriers become greater when people speak different languages.

Therefore, nonverbal and verbal communication become equally important and need to be considered during interactions with clients (Davidhizar & Giger, 1998).

Some of the women described situations in which interactions with health care professionals were characterized by misunderstanding and miscommunication. Cathy described how she misunderstood her doctor's request to be admitted to the hospital in the following manner:

Yes, so I really listened to [the doctor]. I thought I'd go home – like he says your water broke oh OK. Well I'm not in labour so I started putting my clothes on and he was like where do you think your going? I said I'm going out for breakfast, I'm going out and I'm going to go back home; and he said no you're not, I said I'm not in labour and he goes, you can't go home your water broke, and I said oh, well I'll be back then I said, I wasn't actually ready to come in

Brown (1995) states that providing information to clients is interpreted as showing respect and assisting them in making decisions related to their health. Because Mi'kmaq women receive childbirth care in a hospital setting and from non-aboriginal health care professions, they often feel, not only misunderstood, but also have difficulty understanding why they are ignored. Campinha-Bacote (1999) emphasizes the importance of health care providers being particularly conscious of their nonverbal communication because they may come across as being insulting although not intentional. Margaret described how there was miscommunication between her and the health care professionals (nurses and doctors).

I should have been more informed. They need to include the mother-to-be in discussions about having the baby. They pressure more about quitting smoking. The things I don't know about is CPR. I felt I was being ignored. I think it is miscommunication. I am coming in the hospital for three weeks and then walking out. I wonder that nurses don't take the time to care...

Cathy stated that her friend was upset every time she went to see the doctor during the pregnancy because of what the doctor said to her:

My friend is pregnant. She is always upset after going to that doctor. 'I know she was telling her what I'm doing. Listen to the baby's heart beat, say hi to your baby and say you're sorry for smoking'... I told her once I was aware of what I was doing. I could kill her.

Another time, the same participant, who was a gestational diabetic, wanted to attend the diabetic clinic in the health center on the reserve to have her blood drawn rather than drive to a diabetic clinic in a provincial health care facility forty-five minutes away. She could not understand why the doctor was not aware that registered nurses worked in the local health center. The doctor's remarks reflect a lack of knowledge about the qualifications of health care professionals and facilities available within Mi'kmaq communities. Cathy stated:

The doctor said to me: do they even have a nurse in ... I said of course they have nurses. [The doctor] didn't know they had certified nurses, that is registered nurses. I hate to drive to Sydney. Doctors have to be made aware of the services away.

Greeting and knowing a few words of a woman's language and using cultural customs helps to develop the relationship (Callister, 2001). Some participants in the research who were unable to speak English fluently identified communication with healthcare professionals as an issue, especially when they did not have an established rapport with the health care provider. The essence of this barrier is captured in this excerpt from Cathy's story. She recalled:

I'm not like comfortable talking English. You must realize now like there's like a lot of words I'm having a hard time with – a hard time expressing myself...and most of the time I won't say. I don't know how. Well like the nurses [on the reserve] even like the white nurses because they've been here so long, I think most everyone is comfortable... Yes as opposed to like – you – see now I'm having a hard time again, I'm not scared of being stuck with a thought but with you I kind of am.

Preserving Mi'kmaq language was important to another participant.

I find now our elders and our youth especially our children is to preserve our language that's what's most important now and with the tradition of powwow's we would like – we would just gather around and enjoy being with each other, enjoying our culture that once was integral ...my grandparents they went to Shubenacadie school and they were scared to – they weren't scared but because of what they make you do, they weren't able to talk Mi'kmaq to my mother and her brothers and her sisters like my aunts and my uncles and now they don't even barely speak the language because my grandparents like they went through such a hard time during that period

Participants who described being cared for by helpful, respectful nurses were less intimidated by a language barrier, and they were more apt to ask nurses questions, despite some discomfort speaking English in the hospital environment. Since a number of women only speak Mi'kmaq, speaking another language was difficult for some of the participants. Here is how Jenny described the challenges posed by not being fluent in English:

I didn't start to speak English until I was 4 and I was in school...I still speak Mi'kmaq at home ...It's really hard...to read something in English, it's really hard to understand it so...You speak Mi'kmaq but you have to read in English – that's really hard...It would be helpful to have some pamphlets translated into Mi'kmaq -for some people yes – that could read.... but [some people] have a hard time understanding the words in the books...If we had somebody speaking Mi'kmaq all the time it would be a lot more comfortable, having somebody at the hospital speaking Mi'kmaq, it would be easier.

Providing culturally competent care includes being aware of changing trends in language and making an effort to include them in everyday language in health care (Callister, 2001). Callister suggests avoiding medical terms and jargon that are difficult for clients to comprehend or explaining them. Although English language was not an issue for one mother, she could understand why other Mi'kmaq women may have difficulty understanding the medical jargon. Jenny explained:

Some people.... can't speak English very well but what I'm thinking you know probably scared and the doctors and nurses were talking the medical. Yes, and they're like freaking out probably....and I said oh my God what are they saying

you know – oh they are just saying you know they have to take this out just in case and when the baby is born they have to use this and that ... I think that it would be really scary...

Another participant remarked that it would have been helpful to have a Native nurse for a birth coach during labour/delivery. In addition to understanding Mi'kmaq language, she would also have the benefit of understanding the Mi'kmaq culture in relation to birth. Lisa noted:

It would have been nice to have a Native nurse there or you know just to help me deal with all this what we were going through...Just support..., understand you and you know what you're going through you know... there are some things that you express that are in the Native – to a native person whereas sometimes you can't find the words to tell this to a non-native person ... My sister was there – help me through what I had to go through and to communicate with their nurse or the doctor ... she would tell the nurse what I'm going through... You know just expressing myself in Mi'kmaq to my sister.

Given the lack of Mi'kmaq nurses, participants believed they would benefit from women Mi'kmaq interpreters who had experienced birth and who therefore knew what they were going through. Jenny suggested that:

If the [Health Institution] had at least like a couple of people on shift – women that have already had babies – interpreting;...because if I didn't read anything or if I didn't ask questions I wouldn't have known anything, I would have probably been freaked out even more....I think if they have somebody there like a Mi'kmaq interpreter to help with you, that knew you know how it felt to be in labour, it would be good so she could tell them now this is what you're going to go through next, this is what's happening, you know you have options, like you can have an epidural, you know you don't have to have an epidural or you know like...when I was in labour and I got my labour pains my God it's not that bad you know people were like telling me I was going to die or something – I was freaking but it would really be interesting if somebody was there to help us – I mean translate for us.

For this participant, being able to speak and understand English meant also understanding the labour and delivery process and options available to assist her.

In the absence of Mi'kmaq nurses, one participant acknowledged that it would be welcomed and beneficial if non-aboriginal nurses learned to speak Mi'kmaq. Margaret recommended:

It would have been nice to have a nurse that speaks Mi'kmaq instead of that interpreter that comes around like twice a week. One of the students was saying that one of the white nurses are learning Mi'kmaq.... I think that should be more. It's like we learn French in school and why not pick up Mi'kmaq... We have been here for several hundred years.... We need nurses that speak Mi'kmaq.

Marie, another participant, suggested the use of other community resources to address the issues of language barrier. She stated:

Native women or native interpreters are needed. There are some women that can't understand the language. If no family is there, a single mother would have support from native women...after discharge from the hospital.... I wouldn't mind having a native nurse or councilor. Someone will be there for you...

According to Baker, Biro and Joe (2000) Mi'kmaq clients refrain from voicing their concerns or asking questions about their care. Baker (1998) attributes this behavior to having lived on reserves, where there is a feeling of uneasiness when communicating with others outside of the community. Many of the Mi'kmaq women in this study did not feel fully comfortable in communicating with health care providers. They found it difficult to express their feelings at times because of the language barrier. More interpreters, especially women who had experienced labour/delivery, would have made birth a more positive experience on the whole. Battiste (2000) acknowledges that Aboriginal languages provide the most effective means of communicating their human experiences and it is essential to the survival of their people.

Summary

Childbirth experience has a powerful effect on women and the experience can have either a negative or positive impact on them for the rest of their lives (Simpkin,

1991). Simpkin asserts that caregivers have a tremendous influence on the way women remember their birth experience and therefore “a good memory should guide their care” (p.210). MacKinnon, McIntyre and Quance (2003) assert that there is no right way to give birth and suggest it should be the way that is best for mothers and consistent with their beliefs and values. Healthcare providers must be consistently respectful and supportive to women and families. Many participants in this research were not treated with respect during their encounters with health care providers. Participants expressed feelings of anger, and disappointment with health care providers due to a lack of sensitivity and a sense of being devalued by health care professionals. Such perceptions and feelings are characteristic of invalidation.

Women embrace such perceptions and feelings with different views on birth, culture, families and others (Health Canada, 2000). Although women share different philosophies on life, they all expect to receive support and be respected (Health Canada). Betancourt (2004) asserts that “cultural competence is not a panacea that will improve health outcomes and eliminate disparities, but a necessary set of skills for physicians who wish to deliver high-quality to all patients” (p. 954). If we agree with this concept, cultural competence will not be regarded as an insignificant movement but something that is part of everyday practices in society (Betancourt). Healthcare providers must strive to provide culturally competent care to clients (Campinha-Bacote, 1999). They must be motivated to work with various diverse cultural clients (Campinha-Bacote). Given the range of diversity, it is impossible to be knowledgeable about all cultures (Willis, 1999). However, having a basic awareness of cultures and cultural sensitivity are minimum expectations of health care providers (Willis). Raising a person’s

consciousness about cultural awareness increases the chances that clients will receive culturally competent care (Purnell, 2005). Findings in this research indicated that some Mi'kmaq women did not receive culturally competent care. Negative interactions with health care providers made women feel devalued and angry.

Being informed about childbirth allows women the freedom to make choices and be aware of the alternatives to care (Michaelson, 1988). Having the freedom to decide what is best for themselves, their babies and families gave women more control over the birth experience, a fundamental right for all citizens and this is critical to health outcomes for mothers, babies and families (Michaelson). Participants reported having limited or no choice regarding the number of family members who could present during labour in the hospital. Hospital practices which limit visitors contradict Mi'kmaq family beliefs and traditions about the importance of family being present during birth.

Medicalized care was another area that participants described as not meeting their birthing expectations. Many Mi'kmaq women were informed by doctors and nurses that epidural analgesia would provide pain relief in labour. However, this form of medicalized care did not provide adequate relief and in some instances women described it as not working. Other participants described having to wait hours in labour for this procedure to be done. Additional medical procedures such as scalp electrode application, episiotomies, and caesarean sections also created discomfort and anxiety for women. Although active and aggressive medical practices are still found in many obstetrical units, there is a growing trend towards women and families taking a more participatory role in making decisions about their birthing experience (Savage, 2002). Many advocates of natural childbirth for low risk pregnancy would question whether these medical practices

are beneficial to all women. However, there are some women who can not have natural childbirth because of a medical condition such as severe pregnancy-induced hypertension, fetal distress and other conditions warranting immediate attention. In such cases, medicalized care is indicated to help to ensure healthy outcomes for mothers and babies.

Communication barriers were identified as another concern for Mi'kmaq women during childbirth. Although most of the women spoke English, they were not totally fluent in this language. Many of them spoke some Mi'kmaq at home and during my interviews with women in their home, many family members communicated with each other in Mi'kmaq. Language barriers pose serious problems as it affect clients' communication in hospital, and may continue to be a problem following discharge, when women have to navigate through the health care system. This can impact on them receiving quality health care (Alexander, 2002).

Chapter VI

Theme III: ACCESS TO HEALTH CARE

Access to care is an important consideration for pregnant women. Morse (1990) states “as communities (reference to Northern Communities in Canada) demand services so women may give birth in their own communities, nurses recognize, in normal circumstances, that normal birth is a not a medical risk, and should not be considered as such” (p.88). Having a baby is a family event and removing the mother from her community poses increased hardship on mothers and families. These hardships include lack of social support, vulnerability to the language barrier, and separation from family resulting in ineffective family coping.

The following are sub-themes associated with access to health care. They include: physical location of the health services, birthplace preferences, cultural competence and cultural attitudes of providers. These findings will be the focus of discussion for this chapter. Relevant literature will be incorporated into the presentation of these findings.

Although improving access to prenatal care is a priority, including addressing the financial barriers to care, there is no guarantee that all women will access that care (Bloom et al., 2004). Vulnerable populations tend to experience poorer health outcomes as a result of barriers to accessing care service, especially those who depend on other people for care (Potter, Perry, Ross-Kerr & Wood, 2006). Cass (2004) suggests that effective primary and secondary care initiatives for Aboriginal populations are needed to improve health outcomes. Improving access to prenatal services and screening for diabetes in pregnancy, promoting breastfeeding and physical activity are just some

initiatives that can improve health outcomes. Five of the eleven participants in this research had pregnancy complications, which meant that they required closer prenatal monitoring and/ or hospitalization in the event of further complications.

Physical Location of the Health Services

Blackwell (2002) found that access to prenatal care services, particularly for nutritional services, childbirth education, social services and prenatal assessment located within the same area is important to women. Women value their time and want to use it efficiently. Prenatal care services scheduled over several days with long waiting times and in different locations are frustrating and do not meet the client's needs (Blackwell).

Despite diabetic care being available in the participants' home community, one participant was referred to the Diabetic Clinic a 45-minute drive away. This caused undue hardship and stress as reflected in this narrative by Cathy:

So I'd have to get up at 6:30, take a shower, drive ...go there and wait and my pressure would always go up and my sugar and they're like, what's ...what's stressing you and everything, I told them – coming here... then the fasting because I'm hungry and I said I don't like coming here so it took them a while to refer me to the [local] Diabetic Clinic and the doctor...I had to ask – I asked like three times... it's bad enough I'm going to the doctor every week, I'm going to blood work every week, and it would always be on different days, it wouldn't be one day.

Driscoll (2001) describes how women in the third trimester ask more questions and verbalize their concerns about labour and delivery. In addition to their physical discomforts, Driscoll claims they worry about what will happen when labour begins. Women may envision themselves as failing to progress in labour and/ or fear harm coming to their baby. Increased anxiety may also occur, as a result of listening to other women's birth experiences. Therefore, women's concerns about labour and delivery need to be validated (Driscoll).

Participants also voiced fears of delivering on route to the hospital 45 minutes away. For example, Allison recalled:

They checked me out – I wasn't dilated so they sent me home, and I was still having contractions so I was home over night and I stayed at home and they were coming closer by the hour and at like nine o'clock in the morning they were like ten minutes apart... so I told my boyfriend and my mother that we had to leave because they were closer and closer and then they started going six minutes apart before we took off, so we had to drive really fast. It was scary.

Even the ambulance was not comfortable according to Joan:

I had contractions but I didn't know they were contractions and...then I went to my boyfriend's mother and I told her that something's coming out you know – so she called the ambulance I guess she like really panicked and called the ambulance, because she said she'll drive me but I guess she thought it was ready to come out but it wasn't.... the ambulance...took me to the hospital and it was a long ride a really bumpy ride.

During the third trimester, women begin to think about possible hazards such as slippery road conditions, accidents from driving at high speeds, and other forms of carelessness placing the mother and baby at a greater risk for injury (Solchany, 2001). These are valid concerns as weather, road conditions, and distance from the hospital, are realistic obstacles that may seriously affect women arriving in time before the birth (Klaus et al., 1993). In this research, participants discussed the dangers of driving in bad weather and driving fast and of being unattended should they “not make it” and experience a birth complication, which would endanger them and their baby. As Cathy noted, “it was a long distance to travel in winter...” Similarly, Margaret described her experience in the following narrative:

I was supposed to go in [hospital]...for an ultrasound, but there was a blizzard that day... I called the [doctor] and said I missed my appointment, the roads were too bad... ... and [the doctor] said well just go into the hospital, so I didn't go into the hospital until about three the next day.

Bloom et al. (2004) found that there is minimal data available on what women

perceive to be barriers to receiving adequate prenatal care. Studies have shown that low-income women find transportation, long waiting times and family and social issues to be a factor influencing prenatal care (Bloom et al., 2004). Many of the Mi'kmaq women in this research identified lack of transportation as a major obstacle to obtaining prenatal and intrapartum care in the tertiary health care setting, located 45 minutes from the reserve. For example, Angela indicated that her friend delivered at home because "they [didn't make it, the reserve] being secluded is really dangerous. If the phone is out... Women could see a wet nurse-midwife, someone to contact"]. Joan said that "my friend lost a baby. The cord was around the neck". Lack of transportation was a concern for Marie, another participant. Marie recalled that "accessibility is a problem. Hospital taxi is not reliable... Not everyone has transportation".

Accessing health care presents challenges to other women living in rural areas, similar to the findings in this study. Although the Canada Health Act supports that all Canadians should have equal access to health care (Potter, Perry, Ross-Kerr and Wood, 2006), living a distance from health care services presents transportation and financial difficulties for some women and families. Services for women accessing care needs to be organized in a useful way to reduce the barriers to health care (Health Canada, 2000).

A lack of transportation for participants and families was voiced as a concern because many people living in the First Nations Community do not have cars. In addition to women having to travel away from their community, to give birth, Mi'kmaq women have also had to travel a long distance to the hospital to access prenatal care. This care is now available on the reserve and a physician comes to the reserve once a week. The

positive impact of accessing respectful medical care on the reserve was voiced by Jenny, who noted that:

We don't have a full time doctor, a prenatal doctor and the thing was I started seeing a prenatal doctor [off the reserve]...so I started seeing her, everybody ...was seeing her, she was taking us on as her patients... and she's a caring doctor. She really is and um and when I went to see her I introduced myself and she introduced herself and I said OK she's a really nice doctor and from that first visit you know usually you don't trust anybody just like that – but from that visit I trusted her with my life and my baby's life so I felt – she had a nice face and she had a nice voice and she was talking to me really nice so I started seeing her... so there was too many of us ... native women having babies going to see her... but most of them didn't have cars so what she did – she's so special enough she's so caring, she called ...our health center and asked if she could show up on Wednesday's at our health center because she's such a caring doctor.

Jenny also added that having prenatal care facilities in the First Nations Community reduced travel time and gas costs. She recalled:

I would have to get ready, go to town, it took me forty-five minutes to get there and another half an hour to go see her and another forty-five minutes back and you know and the gas money there was a lot of ...so it's convenient for us here – I wish everything could happen here – the child labour and deliver and all that.

Participants raised financial burden as another area of concern. Many of the participants were single, attending high school or university and therefore had limited financial resources. Margaret noted “there is a lot of women who can't get hitches. It costs \$30.00 round trip”.

Birth Place Preferences

When participants in this study were asked where they would prefer to deliver their babies, three responded that they would prefer to deliver at home or on the reserve and eight participants wanted to deliver in the hospital in the event of complications occurring. Lothian (2001) reported that many people tend to believe that birth can only occur in hospitals with routine standards of care to make birth safer for women and

babies. However, Lothian (2001) acknowledges that evidence does not necessarily support this viewpoint. Maestas (2003) found that women who choose home-births had less fear of childbirth, were less dependent on others and wanted to be actively involved in the childbirth experience. Alternate birthing centers or individual rooms in the hospital setting provide women and families a homelike environment where there are an unlimited number of persons present, and allow options for different positions and procedures for labour and delivery. Free-standing centers outside of a hospital are even less formal, giving women more options for their birth experience (Michaelson, 1988).

Participants who preferred to give birth in their local community affirmed the freedom it would provide in relation to having their family members present. For instance, Cathy said:

Well for me personally I hate being in the hospital... Yes but I would have been nervous something would happen if she delivered at home or in a birth center but she said that if everything was set up I would be happy to deliver at home with my family present.

Margaret commented that she would want to deliver at home. She was concerned about the possibility of acquiring infections in the hospital. She would prefer a home birth but wants medical technology and care that is available in the hospital.

I figure if I had it at home I know what's been washed... Well probably because there's no difference having a baby at home or at the hospital, no difference other than having the technology, but we have that portable fetal heart monitor, you have portable stuff that can come with them when they come (meaning the healthcare providers)... Maybe that just ruins it for me because I was in the hospital for a month, and now I'm out of hospital... I prefer at home but that's- if I end up at the hospital, I end up in the hospital.

Elizabeth, one of the participants wanted to deliver her baby in the community in a birthing center. She noted:

Even if they just had like a little building, even if you know like just for mothers

to go there, just if they had to go in early and just a couple of beds and stuff, that would be nice. It would be better to have the services on the reserve.

Although many of the mothers identified disadvantages to having to travel a long distance to the hospital, they actually preferred to deliver there in the event of complications and because they perceived that birth alternatives were not available.

Jenny said:

I would want to have my baby at the hospital because just in case of any complications but I don't know if you saw it on TV like home delivery or the shows. They have them in water and stuff ...I wanted to look into that method but I was like there's no way I'm sure like I can get that done anyway around here can you? Like I didn't have the information on that.

Lisa remarked "I think the hospital is ideal for the baby – for safety reasons if anything should happen for a mother just the safety precautions". Yvette commented that her friend had a baby at home. However she would not have wanted to have her baby at home because of the risk of birth complications. She explained that "I prefer the hospital. They have more experience [doctors and nurses] My friend had her baby at the house. She didn't talk about it. All went well. I would have been scared if that was me".

One mother and her fiancé had different opinions about where it would be best to deliver their baby. Marie said, "actually, I prefer the hospital. They have more equipment if complications occur. Easy access to get help. My fiancé would prefer in our own community. It's close to family".

Some of the participants were separated from their babies for the following reasons: the baby was transferred to the Neonatal Intensive Care Unit [NICU] for observation and treatment, or because the mother was recovering from postpartum medical conditions such as preeclampsia post delivery, or discomfort from having a caesarean section. Yvette recalled:

I was separated from my baby in the Neonatal Unit for 7 hours...My boyfriend took him to Neonatal to be observed. I was thinking I wouldn't be able to feed him. I was going to bottle feed. I was able to feed him 2 days later. I watched the nurses feed him. That helped...

This separation created a feeling of uncertainty for Yvette. She conveyed that she was “scared” and “worried”. Similarly, in a study by Nystrom and Axelsson (2001) with women, whose babies were treated in NICU, findings revealed those women experienced feelings of being an outsider, lack of control, despair, and anxiety. As a result, Yvette, like many women, felt disappointed because she was not able to care for her baby immediately after delivery.

Cultural Competence

Ottani (2002) states that communication may be the greatest barrier to health care professionals providing culturally competent care. Campinha-Bacote (1999) describes five constructs, which she believes must be addressed by health care providers. Cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire all play an important role in providing culturally competent care. Salimbene (1999) asserts that health care providers must discard the assumption that all clients will evaluate the care provided to them by the same criteria that was developed for basically mainstream society. Instead health care providers need to change the way health care is delivered by increasing cultural awareness (Salimbene).

Participants described several instances where the nurse lacked knowledge of Mi'kmaq culture. For one participant, the expression “feeling sick” was not understood by her nurse in the assessment and in the meaning of the word “feeling sick” in the Mi'kmaq culture. This participant could not understand why a nurse would not believe she was in labour and sent her home. Wendy recalled:

I went in and the nurse that was there to help me did not believe me I was having contractions because the machine that she put on me wasn't picking them up and she was going to send me home and I said well I don't want to go home because I'm really sick – and I said well I'm getting one right now and she pushed on my stomach and she noticed and she looked at my mom right scared and she goes OK let me try this again and as soon as she tried it out that's when she found my contractions – and they kept me for a little bit and they told me you can go home but come back if they get closer, so I went home that night and went back the next morning.

Browne (1995) noted similar findings in her research with Cree-Ojibway participants in a northern First Nations Community. Her study reported that nurses overlooked their perception of the problem, which made participants feel not respected. This negative clinical experience led to feelings of misunderstanding (Browne).

Another participant described a cultural gap between her perception of time and the rapid scheduling of appointments at the hospital based diabetic clinic. As a consequence, this participant felt rushed and stressed. Cathy explained:

I felt better in my own community; it's nice to know the nurses, I find it wasn't – like you weren't rushed, like when I was...I find it was like rushing you like they say you have an appointment at eight and somebody has an appointment at 8:15 and within that time frame... they're like rushing you to getting you out. But here...I would go in because they didn't come in until 8:30 or 9:00 and I was just able to go in relaxed.

Culture is the milieu for understanding and valuing people's experiences (Potter et al., 2006). Since values, beliefs and traditions are passed on from one generation to another, members of that culture may show ethnocentrism. Having stated this, health care providers who disregard other persons' beliefs, and hold their own as superior are exhibiting ethnocentrism (Potter et al.). According to Purnell (2002), ethnocentrism may be a huge barrier to providing culturally competent care. One participant perceived that the local health care available on the reserve was not valued by health care professionals (physicians in the city). Cathy described her feelings as “so I was even kind of offended

by the doctor when I was saying that I wanted to go to the ...Clinic [Health Center in the First Nations Community] and he was like questioning like if it's good enough".

When participants were asked if they had any cultural traditions, beliefs and values that were important to them, the following responses were provided. Jenny replied:

No but I'll tell you one thing there's a difference between native moms and non-native moms and I thought I'd mention this and I swear every one of my friends that have had their children the nurses would mention to all my friends, every time when a child is born, a native child is born the first thing the mother does she'll smell the baby, and then she'll kiss it's heart (the child?) and the nurses even said a non-native mom will just take the baby and kiss the baby, she's looking at the differences between the non-native and the native.

Margaret commented that "I have no knowledge of herbal stuff, medicine or medicinal stuff, but I have friends – I have a friend that learns and knows more knowledge about that kind of stuff than I do...". Yvette responded that she did not have any special cultural preferences. I said what I thought. There was nothing I preferred".

Cultural Attitudes of Providers

Hodnett (2002) states that "Culture and ethnicity appear to play a role only insofar as they affect caregivers' attitudes and behaviors toward women, in particular their ability to communicate with women and involve women in decisions about their care" (p. S166). Baker, Biro and Joe (2000) suggest that "members of cultural minority groups may find themselves surrounded by people whose values, beliefs and interpretations differ significantly from their own during hospitalization" (p. 8). Participants in this study received childbirth care in the hospital setting from non-Aboriginal professionals. Although they were accustomed to caring for Mi'kmaq women, the nursing care provided did not always reflect a sense of caring and sensitivity characteristic of cultural

competence but rather a cold, detached feeling was perceived by many of the participants.

Baker (1998) emphasizes that nurses need to realize the importance of the extended family and how they may want to be involved in health decisions about their loved ones. Some participants in this study felt that they had little or no choice regarding visitors and they were unhappy with the limited number of support persons allowed in the labour/delivery room. For example, Joan recalled that “I felt I had no choice- The rules for the family limited two people throughout the labour. This really bothered me”. In addition, Wendy noted:

Family, that’s a really big thing because they limit the people in the delivery room. If it were our – like my way – all my aunts would have been there and it would have been like crowded. Yes it’s hard like having a limit of two because there’s so much people that show up...

However, she also described some flexibility in the number of visitors when her plan of care changed from vaginal to caesarean birth. Wendy remembered:

Well there was two at a time...But after they told me I had to go to a c-section they were all allowed in, they were trying to calm me down and tell me it’s best for the baby that you go so that he’s all right and so I finally you know – I had no choice.

She found the presence of family members reassuring, especially given the sudden change in her plan of care.

Benner (2004) emphasizes the importance of establishing caring nurse-client relationships so clients feel at ease disclosing their fears and discomforts. When clients feel rushed or when care is focussed on nurses completing tasks, they may be reluctant to share their true feelings (Benner). Swanson (1991) shares similar views on caring. She believes that nurses need to understand what client’s value as important caring behaviors,

which in turn will help them, become more competent in care giving. In contrast, nurses caring for participants in this research did not recognize issues of significance. For example, a nurse failed to recognize the importance of allowing a mother to touch the baby's head at delivery. Margaret remembered:

She [nurse] said she's had this contraction for seven minutes and then they checked me and oh my God there's the baby's head. I was trying to touch it and she was like what are you doing and she moved my hand away and I wanted to touch it, I wanted to feel it – I don't know why, it was just like – I saw it on TV – Baby Story...And that woman actually felt her baby coming out, so I said I want to do that.

Discrimination is a form of treating people unfairly because they represent a minority group (Boyle, 1995; Potter et al, 2006). Although people may not be conscious of this stereotypical behavior (Potter et al.), this behavior means that clients receive inequitable care. Jenny stated:

Just with the one nurse because she – I don't know she was like she really didn't care like she made me feel uncomfortable, she made me feel I don't know stupid or weird – she made me feel really low, that one nurse.

Evidence of marginalization and discrimination were evident in the following remarks by Marie:

There are nurses that won't even say hi. Is it because I am native? She [the nurse] is teaching like she is judging you without any interaction. You want that care, know you are safe, protected and supported. They need to make an effort to get to know you, who you are, and make you feel comfortable. You need to feel that you can depend upon her to be more understanding of what you're going through instead of just thinking of what it is just another woman having a baby. Some nurses won't talk to you.

This was consistent with the findings of Browne and Fiske (2001) who reported that First Nations women living in their community in northwestern Canada experienced discrimination during similar clinical encounters making them feel marginalized from society. This mistreatment made women feel alienated from the health care system.

White middle-class women may also experience similar feeling of discrimination, lack of choice and control during childbirth, however they may not experience it at the same degree or frequency as minority women. Lazarus (1997) found in her study about childbirth, there were considerable differences between lay-middle class women and poor women with the latter group having less access to birth knowledge and control. Poor women experienced more barriers to separate and unequal care than middle class women.

Summary

Barriers to health care have serious ramifications for Mi'kmaq women during childbirth. The participants recalled the stress of having to travel for some prenatal care and intrapartum hospital care, which was a 45-minute drive from the reserve. Geographic location, transportation difficulty, limited finances, lack of culturally competent care and discrimination were perceived as barriers to Mi'kmaq women receiving acceptable, convenient and respectful childbirth care.

Participants had varying views on where the best place was to deliver their baby. Some preferred the home/community setting but stipulated that they would need to be assured that medical expertise and appropriate equipment would be present. Others preferred delivering in the hospital where they knew there were qualified health care professionals present to care for them.

Nurses need to be more cognizant of the importance of culture in shaping clients' needs and in their response to care received (Salimbene, 1999). A commitment on the part of health care providers is needed. Cultural competence can be achieved through increased knowledge, sensitivity and awareness of culture and effective communication strategies (Salimbene). Individualized care translates into clients feeling respected as they

receive professional medical and nursing care. Spector (2004) states that health care providers must understand health from the patients' perspective. Being close-minded and insensitive to clients' views on health only perpetuates misunderstanding and creates barriers to health (Spector). There are no specific patterns as to how families view their health and practice their health care (Spector). All persons must be given individualized care. Spector recommends that improved access to health care can be achieved by working together collaboratively with communities to address cultural issues.

Young, Reading, Elias and O'Neil (2000) suggest that health care professionals need to adjust treatment protocols and education in a manner that is culturally and socially appropriate to Aboriginal people. Knowing how Aboriginal people interpret their illness will help non-Aboriginal professionals in planning care (Young et al.). Utilization of the health care resources is also influenced by gender. Options about health care treatment may be shaped by the person's gender and issues around access to care and social support all contribute to less than optimal health outcomes (Spitzer, 2005).

Chapter VII

Theme IV: SUPPORT DURING BIRTHING

Women need to be reassured that they can have trust in the birth process (Lothian, 2001). Therefore the role of the perinatal nurse must be to provide nursing care that “promotes, protects and supports women’s efforts to give birth normally and naturally” (Lothian, p. 18). Increasing women’s confidence in the childbirth experience and helping them to feel they are supported emotionally and physically during this time is an important responsibility for nurses (Lothian).

In this chapter, Support During Birthing will be presented. Sub-themes associated with support identified in this research include: support by family and friends, and health care professionals’ support. These sub-themes will be discussed in this chapter.

Approximately 20 years ago, women were perceived to assume a passive role during childbirth and the need for community support systems was considered low priority (Manogin, Bechtel & Rami, 2000). With the increase in induction of labour, caesarean section rates and epidural analgesia in the 1990s, nurses were given more technology to monitor, thus taking away from actual time spent with patients (Tumblin & Simpkin, 2001). Much has changed over recent years as health care providers and women realize that both groups must share knowledge and have a greater understanding of the childbirth process (Manogin et al.).

As the place for childbirth changed from home to hospital, so have the birth practices (Klaus, Kennell & Klaus, 1999). Although effort has been made to make practices more humane, such as encouraging fathers to be present, there is still a missing link and Klaus et al. (1999) suggest that “childbirth is now lonelier and more

psychologically stressful”(p.3). They add that women who are left alone during birth experience isolation.

Support by Family and Friends

Farley and Widmann (2001) suggest that if a person were to type in the words ‘birth stories’ on the internet, over two million resources would appear indicating the wish for women to share their childbirth experiences. In this research about the birth experiences of Mi’kmaq women, participants are highly receptive to sharing their birth stories. Mi’kmaq women value prenatal and birth advice passed on to them from their mothers, sisters, grandmothers and friends. Anderson (2004) comments that storytelling has always been a forum for Native people and therefore processes need to be created to facilitate storytelling. Passing down stories is critical to development as Native people (Anderson). Sharing birth stories with others gives meaning to the experience and helps to explore and manage emotional reactions (Farley & Widmann, 2001). Since there was a lack of childbirth research in the Mi’kmaq population, participants were asked if their mothers and other family members passed on birth stories. They all responded that their family provided valuable childbirth information.

Angela, one of the participants noted:

During my pregnancy, if I didn’t have my mother, I would have been in trouble...My mother passed down birth stories but she couldn’t tell me about pushing but my aunts told me. My mom had caesarean sections. I would trust her [my mother] point of view.

Nelson (2003) reports that when many first-time mothers become pregnant, they search for birth stories from family and friends in order to be more prepared for the birth. Some women feel that birth stories are beneficial, even if it is an account of an unpleasant experience (Nelson). This is consistent with the experiences of some participants in this

study. A number of participants said they learned about childbirth from their mothers, sisters, grandmothers, friends, prenatal care as well as television. For instance, Cathy said “I thought your baby comes out of your belly button until I was like seventeen or eighteen, until my sister had a baby. She was seventeen when she had her baby...”

Wendy described her mother’s birth experience in the following manner:

Her experiences, she had seven...She was telling me stories how it was to have me and my other brothers and sisters...she didn’t want me to take an epidural or no medication. She didn’t take nothing but I took something. Yes and she would love to have more but she can’t.

Sololoski (1995) describes the advice a First Nations pregnant woman received from an elder “take care of yourself as the way that the creator would want you in order for your child to be healthy... You don’t drink, you don’t smoke, you eat properly...”(p. 95). First Nation women’s philosophy on promoting a healthy pregnancy is to take care of themselves (Sololoski).

One participant regretted not listening to her mother’s advice. Angela recalled:

My mom was the one my source...when I told her that I was in a serious relationship with my boyfriend,... and we started to have sex ...she just told me you should go on birth control and I didn’t even know what birth control was so – and so I didn’t listen...my mom just told me when you get pregnant you’re going to have a hard time... but she just told me like having a baby is something that is going to change your life and with the pamphlets that I got from here...and any questions or concerns that I had about ... the ways of having a baby. I was young...

It is not only the mother herself but the mother’s relationship with her own mother that plays a large role as she enters motherhood (Bartell, 2005). The importance of knowing what to expect and having their mothers present during labour and delivery was significant for some participants. For example, Angela described “My mother because

she really is a great woman. Her experiences, well and my boyfriend's mother, she told me a lot too".

Similarly, another participant conveyed how appreciative and comforting it was to have her mother drive her to the hospital when labour began. Yvette commented:

My mother drove me to the hospital. I didn't think I was going to have my baby. I was three weeks early. It seemed normal. I had pains in the car and my mother told me to say when I had the pain and she would time it.

When Yvette was in labour in the hospital, she described how her mother and boyfriend were a comfort and support to her. She conveyed "My mother was telling me to push. She put facecloths on me...I know them good. I didn't feel scared with them present". Then she remarked how happy she was to have her boyfriend with her in the operating room (OR). Yvette remembered "I couldn't push anymore; I was tired. They sent me to a caesarean section. I was in the hallway [OR] while they [nurses] were getting stuff ready. They let my boyfriend in [OR suite]". Women described various family members as being supportive of them in labour. According to Mercer (1995), "the father is central to the woman's support system" (p.73).

Angela valued the support she received from her mother, and boyfriend's mother during labour. She said:

...My mom...was so worried and she was so scared like – I wanted her by my side so much because you know it's my mom and my boyfriend was there just freaking out and like didn't really know what was going on you know what I mean...he stood on the other side while his mother was on this side – he was rubbing my back but like I didn't really feel supported by him because I think he was too scared...[boyfriend's mother] was just concerned about me...she only focused on me...she was just by my side holding my hand.

Another participant was grateful to have her boyfriend and mother present during labour and delivery. Allison stated "he just held my hand. It made me feel good".

Marie described how comforting it was to have her mother and boyfriend present:

My mother and fiancé were there. I felt comfortable, safe and secure. My fiancé was fluffing my pillows, held my hand. It seemed long... What I was told and what I experienced was hard. Some go quickly, some take forever. I heard this from friends and family.

Mercer adds that if there is upheaval between the husband/partner and wife near the time of delivery, there may be a similar turmoil between the mother and child relationship. Therefore the father's support has a positive effect on the childbirth outcome. Similar findings in a study by McVeigh (1997) on motherhood experiences of first time mothers support the significant role that partners play in providing support following childbirth. In addition, pregnant women learning about birth from mothers, they also learned from other members of the family, acquaintances in classes, and others in various settings (Farley & Widmann, 2001).

Marie commented that her sisters were an important source of information and support. She said:

My sisters, mostly my sisters, my mother told me some. They didn't get pain killers. However they got it so easy. They informed me mostly what to expect, how it feels when you want to push and just what 'happens down there'. The way they explained and what you experienced was totally different. It was harder.

Family, friends and the community health nurse were all a great resource for another participant. Joan remarked:

Well mostly my family, my friends and the ... [community health nurse] she gave me like a folder... and usually my friends that have babies they used to talk about it like what happened to me and I was like oh my God and usually it doesn't exactly happen what happened to them doesn't happen to me. Yes because my sister – her experiences now are really different from what my seven weeks were like I'll tell her what to do and she'll be like, no mine's different so it's pretty different usually.

The same participant added:

A few friends told me a few things like if I had a question during pregnancy or before pregnancy like they'd tell me about it but I'd want the true facts, so I'd go see the [community health nurse] at the Health Center and ask her to give me some pamphlets and papers and books and stuff like that and she gave me a lot of information to read and I read all of that information

Joan described the advice she received from family as:

Mostly carrying the baby and the morning sickness, what to eat like stay away from the fatty food and take-out food mostly that...like you know the ones that are older told me that they didn't take epidural like stuff like that, no they didn't take that so and like some of my family they said that they made it to the hospital like you know how far it is – well they made it to the hospital and they dilated like they didn't have time to take an epidural so they had to start pushing when they get there and it was pretty hard for them...

Although many of the participants described their own mothers as supportive during labour, one participant felt she was better able to cope with labour in the absence of her mother and sister. Allison described how the personal time she had with her boyfriend helped give her inner strength to deliver her baby.

He [boyfriend] was beside me all through...He just held my hand...It made me feel good...My mother, and my sister kept popping out, but I didn't want – every time I seen my mother come through that door, I felt like had to give up – my mom's here she'll be – I don't know I just felt really... I gave up because I'd feel sorry for myself, every time I'd see my mother I'd want to cry and I didn't want to try any more so I kept telling them, please leave the room, it made me stronger without her being around me.

In instances where women are married, white and middle class, extended family support may not be considered vital (Lauderdale & Greener, 1995). However, other cultural groups such as Native Americans, Asians, Hispanics and African Americans may hold different views, as the family, particularly grandmothers and other maternal relatives, are heavily relied upon for advice and support (Lauderdale & Greener). This is due to the fact that some cultural groups consider the support of family members during

childbearing as the norm. Also, childbirth in some cultural groups is traditionally viewed as women's domain. Mi'kmaq women desire to have their extended family involved in their care (Baker, 1998). Limiting visitors to the immediate family does not make Mi'kmaq people feel valued (Baker). One participant revealed how she did not feel welcomed when she and her aunt were present with a friend during labour. Marie expressed her disappointment in the following words:

The staff wasn't happy that we were there. I am the only one...held her hand, put facecloths on her... I comforted her....She was emotionally upset. Nurses weren't giving her support. I was kind of happy that she wasn't alone.

Health Care Professionals' Support

According to Health Canada (2003), nurses caring for families need to have the necessary knowledge, clinical skills and experience to provide high quality care to mothers and babies. Creating and maintaining a supportive environment for women and their families is critical at the time of labour and delivery. Carr (1994) agrees with the importance of support from nurses and adds that physical and psychological support measures may help women to cope with pain rather than rely solely on medication to alleviate their pain. Nurses must be competent to properly assess a woman's needs, consider her cultural background in addition to traditions and beliefs, and provide support in order to have a positive birth experience. For example one participant, Allison, described how she did not feel properly coached in labour:

They didn't really help me out much, because I was in labour for like almost an hour and they didn't tell me I was pushing wrong, until my boyfriend told me that he heard them like whispering that I was doing it wrong, so when he told me that then I tried something different and when I tried something different she came out....It made me like – they were wasting my time.

Perla (2002) recommends that women be informed about their labour progress to lessen their fear and offer positive feedback. Instead of helping to alleviate her fears, one participant described how the nurses actually magnified her fear about labour pain. Instead of providing comforting measures, nurses increased this participant's anxiety and convinced her to accept the epidural as a means of coping with the pain. Jenny explained:

I didn't want to take that epidural needle I didn't want it, but as my pain got worse – and I was saying I can handle pain, I can tolerate it, but the nurses were like freaking me out. They were telling me it's going to get worse you know your pain is going to get really bad and I was like freaking out – like really? OK give me that epidural then... I took the epidural like it slowed down my - how I dilate it slowed it down, so they induced me.

Labouring women coming to the hospital are undergoing major body changes such as losing their body image, coming from a different environment and having limited mobility (Chen, Wang, & Chang, 2001). These losses and sudden changes during labour can create a feeling of being vulnerable (Chen et al.; Simpkin, 1991). These changes are compounded by single-parenthood. Some single mothers feel vulnerable as a result of a lack of consistent supportive care from their family and friends (Mercer, 1995). One participant commented that some birthing mothers might be more vulnerable than others. Marie noted that “the way they [nurses] talked to you. Single mothers coming in [to hospital] feel disrespected. They need more support”. Driscoll (2001) emphasizes the importance of psychosocial care during pregnancy. As women progress through the various stages of pregnancy and birth, the perinatal nurse needs to provide education and guidance for the physiological, psychological and spiritual journey (Driscoll). Women, particularly in the third trimester of pregnancy, may feel anxiety about signs of labour, coping with labour pain, changing role responsibilities and others,

leaving them feeling worried and afraid. Validating women's concerns and supporting them as natural is important (Driscoll; Stainton, Harvey & McNeil, 1995).

Although most of the participants had some negative experiences in this research, one participant described an experience in which the nurses, with one exception, were supportive. Here is Wendy's description of that experience: "Oh yes the other nurses were great – it was just that one bad one. They should be really nice; they should meet your needs when you're in the hospital". Similarly, Baker and Daigle (2000) point out those participants in their study perceived negative healthcare experiences as the exception to the rule rather than the norm. One of Baker & Daigle's participants stated "there's always one bad apple in the bunch" (p.18).

While lack of support during childbirth was disappointing for some Mi'kmaq mothers, others reported satisfying birth experiences in which they felt cared for and supported. Social support is considered a prime factor in women adapting to their pregnancy, which leads to healthier maternal and infant outcomes (Michaelson, 1988). According to Stainton et al. (1995), "caring for the woman with a high-risk pregnancy often includes caring for an apparently well-person with a serious potential for loss of an expected full-term healthy infant" (p.1). Providing continuous support during labour and delivery can actually reduce the need for interventions and complications such as requiring epidural anesthesia and caesarean section birth (Lothian, 2001). Simpkin and Bolding (2004) define continuous labour support as "non-medical care of the labouring woman throughout labour and birth by a trained person" (p. 490). Labour support means having someone physically present, who can provide emotional support through reassurance and guidance and use comforting techniques such as touch, heat and cold,

positioning, facilitating communication and providing information as a means of comforting the women (Simpkin & Bolding, 2004). A meta-analysis of randomized control trials revealed that support to women during childbirth reduces the length of labour, medical and psychological complications (Hodnett, 2003).

Lothian (2001) affirms that perinatal nurses play a pivotal role in assisting women through the obstetrical maze to make birth feel like a normal experience. Some mothers felt supported. These feelings are demonstrated by one of the participants. Jenny stated that “yes so but this younger nurse – her name was ...she helped me all the way through it – she made me feel so comfortable and so welcome and I was happy and relaxed and calm”. She further described the nurses’ caring and supportive manner and what it meant to her. Here is Jenny’s description of that experience:

I wrote her a thank you card and told her that – ‘you were an angel sent by God and there should be more people like you’ I told her – I told her how she made me feel... because she was really special to me – because all the nurses – the other nurses didn’t do anything for me. They were freaking me out instead and you know I was really scared. But this certain nurse made me feel really special and really calm.

Another participant, Jenny recalled:

I told her [the nurse] you’re an angel, she had tears in her eyes-I said if there were more nurses like that were here, this place would be beautiful, you’re a beautiful person...She [the nurse] really made me feel comfortable and she explained everything to me- do you know what an epidural is...do you know what’s happening to your body.

Browne and Fiske (2001) report instances where First Nations women share stories of exceptional care. They describe the caring attitude demonstrated by mainstream health care providers during clinical encounters. A feeling of trust is created when the participants feel health care providers sincerely care. Baker and Daigle (2000) also cite an instance where a Mi’kmaq woman nicknamed her nurse “the angel” because

of the kindness and general concern she bestowed on the woman (p.19). Similarly, in this research, Jenny's perception of caring is illustrated in the following example as she describes her nurse as an angel:

I was uncomfortable until one of the nurses walked in. She was a really nice nurse and she sat there with me and she held my hand and she was rubbing my back and she would talk to me. She talked to me and she asked me questions or she'd tell me about her story, her childbirth or her children...She told me it's going to be a beautiful experience after I have my child and I'll look back on it someday. ...She really made me feel comfortable, I felt welcomed and I'm sure she was an angel.

She further described how the nurse stayed on beyond her shift to provide support:

And every time I had a pain she'd hold my hand and she'd rub my back you know like – the nurses I had before her she walked in – they were quite – they didn't like care, I felt like they didn't care about me but I asked if she could stay with me through my whole labour and delivery and she was there until two o'clock the next day. She left me 20 minutes after I had my son – she was so exhausted, she was tired from working all night long – and she said I have to go home, she said I'm really tired.

Reassuring words comforted another mother. Elizabeth said that “one of the nurses, she just told me not to be nervous and that everything would be ok”. One participant, Margaret described how helpful a nurse was to her during her prenatal admission to hospital.

She was good to me. I had known her since I went in [the hospital]..., she brought me the TV and VCR and she brought me like ten movie tapes from her house, she said watch those.

Sincere caring described by participants in this research is congruent with Swanson's (1991) theory of caring in the context of perinatal care. Swanson's theory of caring demonstrates the effectiveness of nursing interventions on mother's health and the power which caring has to promote healing and help women have a better understanding of their health.

Nurses' support of participants also extended to include nurses being readily available as resources. Wendy stated that "the other nurses – they were so kind like checking on me and checking on the baby and always there answering my questions and making sure that I'm very comfortable".

One of the participants was pleased to receive education and support with breastfeeding from nurses. Joan recalled:

She give me all these papers and another folder and said if you ever need help just call me and we could schedule sometime to go if you need more help...The nurse wouldn't let me leave until...the milk was pumping all good ...It took four days...

WHO (1990) affirms that breastfeeding is the most cost-effective and the best means of ensuring babies receive adequate nutrition to promote good health. Breastfeeding needs to be promoted before the mother actually leaves the labour and delivery unit (WHO, 1985). Dennis (2000) maintains that inconsistent, inaccurate and insufficient knowledge about breastfeeding can negatively impact breastfeeding success. Breastfeeding support includes providing consistent information and recommendations to mothers (Dennis).

Another mother although reluctant to breastfeed, described her success with breastfeeding. Jenny credited the hospital nurses, community health nurse and doctor with her decision to breastfeed.

When I was pregnant I said no I'm not going to breast feed...people around here I find that breastfeed are – like you don't need to breast feed ...it's just a hassle...you're going to have to be out in the open...OK then – I'm not going to breastfeed...that day I had him I said no I'm not going to breastfeed at all I'll just put him on Similac... Three days later I was in the hospital still and I asked my doctor, can I try breast feeding? I have all the information I know about breastfeeding... I read about it but can I try it? [The doctor] said 'yeah try it'...I tried it and [the baby] latched ... and I enjoyed it, I loved breast feeding...and my [baby] loved the breast milk ...she [hospital nurse] told me 'why don't you try the breast pump' you know, 'see how much milk are you producing it – colostrum...'It was really beautiful, [community health nurse] encouraged me too

at our health center... she was helping me and explaining everything to me – ‘listen you’ve got to try it girl’.

Six out of the eleven participants in this research attempted to and/or breastfed their baby for a short time with one participant nursing for a total of three months after. According to Kroeger and Smith (2004), women who are unsuccessful with breastfeeding either had no early initiation or their babies received supplementation in hospital. Assessing babies for a good position, latch, and suck is critical to successful breastfeeding. Women, who are separated from their babies due to maternal or infant complications after delivery requiring close monitoring, are even further compromised. Walker and Creehan (2001) maintain that when mothers and babies stay together, mothers can sense and see infant cues and place the baby on the breast when he/she is awake and alert. Late initiation of breastfeeding, supplementation, no rooming in, lack of feeding on demand, and use of pacifiers place mothers at risk for terminating breastfeeding (Kroeger & Smith, 2004). One participant, Jenny described her sense of failure with breastfeeding in the following manner:

I breast fed ...when I was in the hospital... When I got home ...I tried to latch [the baby] on and I had gotten kind of frustrated – like I felt like a failure as a mother because I couldn’t even feed my baby...[The baby] didn’t like getting into it. We know how to make a bottle but [the baby] was crying so much because [the baby] was hungry. [The family] were starting to panic ...frustrated and ...arguing at each other. [A family member]...took [the baby] warmed...bottle and fed [the baby].... I went to sleep. ...I tried for like maybe a week in between bottles...and I had a breast pump. [The baby] drank my milk but I wasn’t able to... breast feed...because [the baby] wouldn’t latch on ... I felt kind of bad...I was so stressed. ...I read that the best thing a mother could do is breastfeed...I felt like I failed. After a while I just gave up breast feeding and...just bottle fed.

One participant felt more content with the nurses than the doctor. She (Jenny) commented: “They [the nurses] were worried about my health care. My relationship was closer with the nurses than the doctor”.

Women should be able to choose their own support and their choices should be respected (Health Canada, 2000). Hodnett (1996) identified five categories of support that women report to be helpful to them when labour begins. These supportive interventions include emotional support, comfort, advocacy, support for the husband /partner and information (Hodnett, 1996). Hodnett claims that these support activities will help to improve health outcomes for mother and babies. For example, some participants in this research described feeling calmer, and better able to cope with labour when nurses provided comforting measures in labour. Allison explained how the comfort the nurse provided made her feel calmer and gave her an inner strength to cope with labour pain.

The nurse, one certain nurse...She was keeping me calm... She passed me the face cloth, she told me to go on my side, and she gave me like hints on how to – she told me like - she gave me advice on how to take the pain – so she was pretty good...she stayed the whole time.

When her baby was born, Allison described how she immediately felt when her baby did not cry at birth. She was worried that there was something wrong, however she quickly felt relieved when the doctor and nurse offered reassurance that her baby was healthy and doing well. She described the support received in the following manner:

She [the nurse] was there... they [the nurse and doctor] went to clean her first, but when she came out she wasn't crying, and I said is she all right? And they were like she's fine and when I looked over they put her down and they were cleaning her off, and when I asked them well how come she wasn't crying, did they have to do anything to help her out – her breathing and or anything like that, they said no, she was looking around, she didn't cry, so she was just looking around, as soon as she came out her eyes were wide open looking everywhere, so that made me feel good...She [the baby] was all right.

One participant described how pleased she was to have only women [nurses] present at the birth. This was particularly helpful since the doctor did not arrive in time and the nurse had to deliver the baby. Margaret described this experience as:

The childbirth was like so calming almost like serene – it was like peaceful – that’s all I can say about my childbirth because it was like – I was surrounded by women and they were all like OK just breathe in, there’s not men barking in the background, push, push...I think having women only – even if the doctor is waiting outside – just coming in making sure everything is ok...

According to MacKinnon, McIntyre and Quance (2005), nurses’ presence in labour includes three components: being there (physically present) being with (emotionally) and being for (advocacy). In an exploratory study by Mackinnon et al. women valued the support of the intrapartum nurse and even challenged the assumption that biomedical, administrative and legal issues are superior to women’s support. These researchers suggest that nurses need to be aware that other technical responsibilities compete with supportive care in labour and they recommend that maybe more than one nurse is required to provide the support women require during childbirth.

Providing comfort measures to women in labour can be considered empowering, and may lead to women feeling a sense of control and accomplishment over the birth process (Manogin et al., 2000). Nursing care gives women the capacity to endure labour pain (Rubin, 1984).

Summary

Receiving nursing support in labour has been shown to improve outcomes for mothers and babies. Mi’kmaq women in this research valued the support they received from family, friends and healthcare providers during childbirth. Support was received in various ways such as passing on birth stories, being physically present during the birth, and providing childbirth educational material. It is evident from participants’ responses that Mi’kmaq families play a significant role in providing advice and support during

childbirth. Additionally, first time mothers expect more support from nurses and doctors than they actually obtain (Tumblin & Simpkin, 2001).

Supportive care from families is not enough to support women in labour (Health Canada, 2000). According to MacKinnon, McIntyre and Quance (2005), women base their satisfaction with nursing care during childbirth on the support received and the nurse's ability to communicate and provide culturally competent care. Although some participants verbalized satisfaction with their care, other mothers did not express the same opinion of health care providers. The latter group felt that they were not given the priority of care, they should have received. Supportive care during childbirth helps to alleviate the anxiety and fear of women (Perla, 2002). During childbirth, women need to have confidence in their ability to give birth (Lothian, 2001). Nurses need to be culturally sensitive to the wishes of clients and families (Baker, 1998).

Community health nursing aims to protect and promote the health of individuals and families in the community (Potter et al., 2006). In this research, because the community health nurse was Mi'kmaq, she had greater cultural knowledge of the women's values, beliefs and traditions about childbirth. This facilitated the establishment of a trusting relationship with participants early in their pregnancy. As a result of her cultural knowledge and cultural competence, she was highly respected by the women and their families.

Dissemination of Findings

Dissemination of the preliminary findings of this research at the provincial and national events has been ongoing. I attended a National and Provincial Graduate Student Conference in 2005 where I presented my initial preliminary findings. In October 2005, I

was invited to present my research findings at The Association for Research on Mothering 9th Annual Conference on Mothering, titled Race, Ethnicity, Culture, and Class, held at York University in Ontario. These findings will continue to be presented at peer reviewed conferences and workshops, interested groups in universities, health care settings, and other communities for the purpose of increasing knowledge about Mi'kmaq childbirth and culturally competent care. Also, a presentation of the research findings and a copy of the research report will be given to the Mi'kmaq participants.

The results of this study will be published as a research thesis and a copy will be given to the School of Nursing at Dalhousie University. Copies of the research study will be given to all of the participants in the study, the Health Center, the Chief, and the Band Council in the First Nations Community where the study was conducted. Also, a copy will be presented to the Mi'kmaq College Institute, Cape Breton University, Nova Scotia.

Chapter VIII

DISCUSSION AND IMPLICATIONS

The findings in this research suggest that Mi'kmaq women and families encounter situations that create barriers to them receiving culturally competent health care during childbirth. I have identified four themes that describe the experiences of women giving birth in a non-Aboriginal health care setting. They include unpreparedness for childbirth, professional relations as sites for invalidation, access to health care and support during birthing. The meaning of their childbirth experiences was influenced by a number of factors. These include: lack of culturally competent care (where women felt devalued and discriminated against), accessing health care, and inadequate childbirth support. Instances where participants reported positive childbirth experiences such as one nurse being described as an angel, and nurses giving appropriate prenatal education will also be addressed. In this chapter, I will discuss implications for education, clinical practice, future research, and conclude with my final remarks.

According to Michaelson (1988), “in every culture, the birth of a baby – the coming into being of a new member of society-is greeted with wonder, and usually joy”. (p.1). Pregnancy is an emotional time when women need to feel valued and able to safely disclose their feelings, without being judged. Validation and emotional support from family, friends and health care providers are essential to attaining and maintaining a healthy mental health state during childbirth (Driscoll, 2001). Anxiety, a common phenomenon during childbirth, is often due to women feeling uncertain about having the capacity to cope with labour (Creehan, 2001). Knowledge, realistic expectations and maintaining control in labour account for positive outcomes (Mercer, 1989). Feeling

afraid and vulnerable is not exclusive to any one culture; women from a variety of cultures experience similar feelings. Since every childbirth experience is unique, care must be individualized to meet each woman's needs.

The Mi'kmaq women in this research described childbirth in varying ways such as a beautiful experience, a miracle, a painful experience, and one of fear of labour and delivery. Prenatal health conditions during pregnancy and/or potential complications contributed to Mi'kmaq women feeling uncertain, fearful, and vulnerable during the childbirth process. Some women expressed concern about the possibility of either dying themselves or their baby dying. Rubin (1984) describes the fear as a dread of delivery, but there is also relief from the burdensome pregnancy, hope for the child and fear the baby would not exist if there were no bonds of physical and fantasized experience. Mi'kmaq women felt connected to their babies and wanted to ensure healthy outcomes. Many of these first time mothers were apprehensive because of past stories they heard about birthing, combined with a lack of knowledge about what to expect.

The Meaning of Childbirth

While some women felt empowered by the support they received from family, friends and health care professionals, others were afraid and anxious about the birthing process. Modern medicine and technology have replaced women's ways of knowing about childbirth and substituted it with fear (Savage, 2002). This goes against the beliefs of Canadian First Nations women who view childbirth as a natural process requiring no interventions (Sokoloski, 1995).

In my analysis, I used the Aboriginal Health Model described By Murdena Marshall, a Mi'kmaq educator in Chapter II of this study, to gain a better understanding

of the Mi'kmaq women's views on health and how their health is connected to their childbirth experiences. For example in order to better understand relationships with health care providers, I referred to Marshall's (1993) unpublished manuscript. She stated "the baby feels everything the mother goes through. If the mom is angry or resentful, the baby will be born with an attitude since all emotions are passed down" (p.3). She adds "the elders believe that a baby shouldn't know or feel anything unpleasant but rather come into the world with feelings of peace and balance on humanity". Similarly this dichotomy was evident in the experiences of the participants of this study as some experienced anger while others expressed joy and happiness during childbirth. Since there is limited research on Mi'kmaq women's childbirth experiences, Marshall's view on health provided valuable insights in this study.

Rothman (1994) claims that something has happened to the "cultural understanding of motherhood in America" (p.139) as evident in the rise in caesarean section rate, and sample packages of infant formula being given to mothers with reference to helping mothers succeed with breastfeeding. Motherhood in America has been shaped by the ideologies of patriarchy, technology and capitalism. In order to understand it, Rothman says we need to stand back and look at the historical evolution of motherhood. The ideology of patriarchy is best understood by acknowledging that "women's reality is not the dominant ideology, and women's view of the world is overruled by men's view" (Rothman, 1994, p.140). Morse (1995) agrees that men dominate women, and the system that supports and authorizes this oppression is patriarchy. The implication that having a baby cannot occur without the use of technology is essentially a bizarre and inhumane thought. The issue is that, women

participants' beliefs regarding wanting to birth in a hospital with technology are evidence that they too buy into the dominant ideology that birth is a medical problem that requires technological intervention. A contradiction is that participants were often dissatisfied with the technology. They did not experience pain relief, labour was prolonged, and some required a caesarean section or invasive procedures such as internal fetal monitoring, all contributing to a technical birth experience. Even more ridiculous is the idea of capitalism, where the family unit is primarily used for economic reasons.

Under capitalism, work and products are not equally valued; wealth and power are the main concern. Here, the mother represents the labourer and the child symbolizes the product. Rothman suggests we are heading toward children becoming a commodity and motherhood becoming recognized as one symbol of the working class in society. According to Rothman, these three areas represent Western society's worldviews on motherhood. From research on Mi'kmaq women, the ideology of patriarchy and technology are alive and thriving. Mi'kmaq women described negative encounters during childbirth with male doctors. Unpleasant memories included painful labour and having to wait hours before receiving epidural anesthesia. One woman described feeling the doctor make an incision in her abdomen during a caesarean section. Another mother conveyed her anger when the doctor told her she was the worst patient. These are just a few examples of how these women felt devalued, disrespected and how some received substandard medical care.

Medicalized birth practices emerged with the increase in medical technology and medical interventions (Johanson, Newburn & Macfarlane, 2002). Hiebert (2003) notes that these birth changes occurred as science and medicine began to dominate childbirth

practices. Clarke (1990) asserts that the greatest impact of medical birth practices is evident in aboriginal communities in Canada, as pregnant mothers have been required to leave their home community to give birth in an urban center. For instance, the decision to move all women from Keewatin in the Northwest Territories to southern hospitals in the 1980's quickly brought about the medicalization of Inuit childbirth (Kaufert & O'Neil, 1993). The medicalization of birth practices has essentially taken birth away from women; it is no longer part of their domain. Waitzkin (1991) views medicalization as a means of controlling women's bodies and society in general, by strengthening social patterns that tend to control human behavior in ways that are considered socially acceptable. Feminists suggest that there is a lost emphasis on participation, collaboration and empowerment of women (Patton, 2002).

In medical school, medical students develop an authoritarian mannerism as part of medical school indoctrination (Clarke, 1990). Therefore, the superiority-based behaviour of physicians is not surprising. Physicians have become more powerful with great financial compensation (Clarke) and Canter (2001) warns that it is not a simple task to shift power from the physician to the client. Reproductive health and mental health are the areas greatest affected by medicalized care. Clarke further explains that, because women live in a male dominated world, characterized by unequal opportunities, women are likely to suffer emotional hardships. The oppression of women has led them to feel less informed about their bodies and powerless to take action (Clarke). Canter points out that health care professionals need reminders that they "do not hold a privileged position" and a framework outlining sensitivity in power would be a productive step toward providing patient centered non-oppressive care (p. 414).

Knowledge about pregnancy and childbirth encompasses more than the biological changes the body undergoes (Lazarus, 1997). Issues around choice, such as deciding on a doctor or what services the health care system can provide are other key concerns for women, which Lazarus refers to as social knowledge. Therefore, birth knowledge consists of biological knowledge of childbirth and social knowledge (Lazarus). Social knowledge includes the medical procedures that occur during childbirth, decision making and clients' rights to health care. According to Lazarus, women "feel responsible for the events of birth but they in fact have only limited influence over the medical procedures" (p.132). People know some medical information; however, their degree of knowledge varies as they learn through life experiences. Lazarus explains that medical knowledge, similar to most knowledge, is associated with social relationships. Lazarus claims, "it is unequally distributed, therefore, and connected to matters of power and control" (p.138). As is seen in the doctor-patient relationship, power dominates, thus the patient becomes dependent. Choosing a family physician, which is a common practice for many non-Aboriginal populations, was not an option for the participants in this study. In the absence of choice, one physician provided prenatal care to all women on the reserve.

Women in this research described instances where they received childbirth information from the community health nurse, which helped them feel good about the experience. These participants found the information useful in preparing for labour and delivery. Having the Health Center in the First Nations Community was convenient because they had minimal distance to travel and the community health nurse was accessible to them for additional questions and provided support when needed. All of the participants remarked on how valuable it was to have the community health nurse

available to them for prenatal and postnatal education and care. They respected and valued her knowledge and did not hesitate to contact her about health related issues. Another participant, Jenny described her doctor in the First Nations Community as “she is a caring doctor...she’s a really nice doctor and from that first visit...I trusted her with my life and my baby’s life...”. Jenny also remarked on how helpful the breastfeeding nurse and the mother baby clinic at the hospital. She remarked: “if you are curious about anything [breastfeeding], just go see [the nurse] at the mom/baby clinic...I went in and...I still call her up [the nurse]”. Supportive care is a large part of the care that nurses give to patients (Miltner, 2002).

Women want to feel in control of their childbirth and therefore, they want the freedom to make decisions about childbirth practices. Choice, one of the values of the Code of Ethics, (Canadian Nurses Association, 2002), is based on the principle of autonomy and respect (Keatings & Smith, 2000). Having autonomy means that women can make informed choices based on their own beliefs and values (Lothian, 2001). Autonomy, one of the ethical principles, implies that individuals are capable, knowledgeable and free to determine their own plan (Keatings & Smith). However, this was not the situation for most of the participants in this research. Findings indicate that for the Mi’kmaq women, negative emotions resulted from their lack of being involved in decision-making and having limited or no choice about obstetrical care, leaving them disappointed. These findings are consistent with those reported by VandeVusse (1999), who conducted a qualitative study on primiparous and multiparous midwestern women in Wisconsin to determine how decisions are derived by examining women’s birth stories. VandeVusse found that as health care professionals took control over labour, women

were less involved in decisions about the labour and birth, contrary to their desire to be active participants in their care. Bourgeault, Benoit and Davis-Floyd (2004) state that many advocates of the women's health movement support that health care "should be deinstitutionalized, deprofessionalized, and put back in the hands of women" (p. 8).

Childbirth education has evolved as childbirth educators have focused on meeting the specific needs of families. Wong et al. (2002) notes that all adolescent mothers, or single mothers, first time mothers, those having twins and others all have varying degrees of health needs. Although, one-on-one prenatal information at the health center was helpful, many participants in this research would have preferred to participate in formal prenatal classes. Maestas (2003) claims that most women seek prenatal education before they have their first baby so they can be more prepared for the birth experience. Women find that prenatal classes provide education and support that they can rely on during and after birth. The classes also provide a forum for women to openly express their feelings and concerns about any aspect of the childbirth experience (Wong et al.).

Having said this, the researcher recognizes that many First Nations women view childbirth as a natural process. As mentioned earlier in this study, some First Nations women view prenatal care as important, while others view pregnancy as a normal process with no medical interventions necessary (Sokoloski, 1995). Mi'kmaq women, like other women, are often influenced by Western knowledge and convinced that following Western practices ensures a safe birth. It has to be acknowledged that while some information from Western research has been valuable in improving health outcomes, Mi'kmaq women also value the importance of receiving childbirth education through birth stories passed down from their mothers, sisters, other family members and friends.

Despite this valuing, my analysis of the participants' accounts, illustrated that the meaning of childbirth was greatly influenced by the context of structures and processes that shaped their experience. These included: hierarchical structures and medicalized environment dominated by medical and administrative persons within which women gave birth. Participants often experienced lack of control and choice about childbirth options. They relied on health care professionals to ensure they would have healthy birth outcomes. The participants' believed that if they did not follow the "white man's way" of giving birth in a medicalized environment, harm would come to them and their babies. Spector (2004) points out that the "health care delivery system fosters and maintains a childlike dependence and depersonalized condition for the consumer" (p. 172).

It was only about 30 years ago that the notion women should be active participants in their health care and that women's knowledge of their bodies was not only accurate but could replace medical knowledge. This notion was introduced by the Boston Women's Health Collective (Warren, 2000). They suggested that women would no longer need to remain passive in receiving health care, but rather they needed encouragement to take action (Warren). During this time, it seemed promising that feminists could change the medical system. Although women have made some strides in becoming active participants in their health care, resistance still exists from the health care profession. Mi'kmaq women still face challenges and many remain passive participants in the childbirth care process.

Effectiveness of Care

Health care encounters and the politics that shape these encounters for First Nation's women are important to examine as they represent and construct social,

economic, political and philosophical relations (Browne & Fiske, 2001). Clinical practice environments are common arenas for experiencing cultural encounters, where a dominant group provides health care to a minority population (Browne & Fiske). O'Neil (1986) points out that the relationship between Aboriginal communities and the dominant culture has evolved as a result of colonialism. Battiste eloquently describes colonialism as a "triangle of power in which people at the top claim they have the right to control the bottom" (p.43). Ing (2005) defines colonization as a "foreign power or nation superimposes its values upon another nation or exploitation" (p.6). Battiste (2000) claims that colonialism should have ended at the end of World War II, when the British Colonies such as Canada, Australia and New Zealand became independent. Although independence has become a reality for most people, Indigenous peoples have not shared the same fortune. From the childbirth experiences described by the participants, there is evidence to suggest that knowledge about cultural beliefs, traditions and values of Mi'kmaq people have largely been replaced by mainstream western medical beliefs and sensitivity to providing culturally competent care by health care providers is seriously lacking.

The structure of health care institutions is such that health care professionals often assume they are the experts who know what is best for clients (Campinha-Bacote, 1999; Ford & Van Wagner, 2004). They use strategies such as persuasion or coercion as a means of influencing clients to think that the dominant society's teachings are superior. Enang (1999) claims "there is a tendency for many professionals to assume ethno-cultural minority groups are irrational, primitive and less scientific" (p. 131). Macionis & Gerber (2002) suggest that much of the misunderstanding occurs as a result of misinterpreting

Darwin's theory on evolution. The authors add that western Europeans were taught that people around the world had different views. They associated this difference with biology instead of culture. Many concluded that less technological societies were less human (Macionis & Gerber, 2002). Unfortunately, such ethnocentric thinking helped rationalize global colonialism.

Neocolonialism, meaning "new forms of colonial ideology" are deeply rooted in health care practices such as racism in health care facilities, limiting opportunities for access to health care, education and economics prospects (Browne & Fiske, 2001). Although neocolonialism may not be as overtly evident as older colonial practices, these racial practices still exist in health care institutions. Cultural competent care offers an effective means of addressing these discriminatory ways by helping health care professionals recognize the importance of providing health care that respects the traditions, beliefs, and practices of Aboriginal people.

Cultural competence is defined as "the ability of a health care provider, agency, or system to respond to the unique trends of the populations whose cultures are different from that of the mainstream or dominant society" (Murray, Zentner, Pangman & Pangman, p. 45). According to Salimbene (1999), cultural competence involves "not only an expanded knowledge base, but also a change in the attitudes, beliefs, assumptions, and practices that have been developed both professionally and personally over a lifetime" (p. 34). Establishing cultural competency is a timely process. Cultural and linguistic competence means that the health care providers are sensitive and respond appropriately to the needs of clients (Spector, 2004). Because health care environments in North America have become more diverse, clinicians are seeing patients with a variety of views

on health (Betancourt, 2004). Research has also shown that effective communication between health care providers and clients is associated with better health outcomes. However, when differences in sociocultural factors exist between clients and health care providers, patients are often unable or unwilling to adhere to medically prescribed treatment resulting in less than acceptable patient outcomes (Betancourt). For example, Betancourt found that in the case of a Hispanic woman, her perception of hypertension revealed that she did not have an accurate understanding of this disease creating difficulty to control. Once the health care professionals became aware of her lack of understanding, they were able to reeducate this woman about her health condition.

Meleis (1996) adds that providing culturally competent care is not a luxury but it is an essential component of health care. Since culturally competent care deals with issues concerning “diversity, marginalization, and vulnerability due to culture, race, gender and sexual orientation”, it seems as though it would be the best approach to use in ensuring Mi’kmaq women’s traditions, beliefs and values are upheld during childbirth (Meleis, p.2).

Nurses need to be more cognizant of the importance of culture in shaping clients’ needs and the response of clients to the care they receive (Salimbene, 1999). Cultural competence can be achieved through increasing knowledge, sensitivity, and awareness of culture and developing effective communication strategies (Salimbene). Individualized care translates into clients feeling respected as they receive professional medical and nursing care. Understanding culture helps give health care professionals more understanding of their own values and those of other people and assists them to be conscious of their own biases (Andrews & Boyle, 1995).

Several models for teaching cultural competence are described in the literature. However, many of these models are limiting because they assume if followed, culturally competent care is provided. For example, Camphina-Bacote (1999) discusses five constructs, which include: cultural awareness, cultural knowledge, cultural skill, cultural encounters and cultural desire. The Purnell Model for Cultural Competence, developed by Purnell (2002), is another model that addresses culturally sensitive care and raises one's consciousness of cultural diversity. A third model developed by Davidhizar and Giger (1998) is a framework for providing transcultural nursing. Although these models identify essential components of cultural competence, there are limitations. The models provide a cultural framework useful for nursing education however, they are prescriptive in nature and not broad enough to get at the underlying issues of racism and discrimination. However, Meleis's (1996) definition of culturally competent care, previously mentioned, is a more inclusive and appropriate model, because it takes into account the issues around diversity, marginalization, and vulnerability as a result of culture, race and gender, similar to the issues described by some Mi'kmaq women in this research. Education in cultural competence needs to include more awareness of disparities in health care and the effects this can have on race and ethnicity in making clinical decisions (Betancourt, 2004).

Issues around cultural competence are complex. Since neocolonialism is entrenched in health care practices, minority populations (Browne & Fiske, 2001), such as the Mi'kmaq, will continue to face problems with racism and discrimination, thus decreasing their chances of receiving equitable care if these issues are not addressed. According to Health Canada (2004), "with the transfer of control over health care

services to First Nations communities, and the growing acceptance of the value of traditional forms of medicine, there is reason for (cautious) optimism about the future direction” of Aboriginal women’s health” (p.8). Health care reform has made some strides towards placing an emphasis on health promotion and providing community-based services (Ross-Kerr & Woods, 2003) such as the establishment Health Center in the First Nations Community. However, there is an urgent need to develop an appropriate cultural competence model that will address issues concerning discrimination and inequitable health care for minority populations.

Delivering a baby in a health care facility where the parents and families do not feel supported and cared for goes against the philosophy of family-centered care. Willis (1999) states that “family-centered care can only be provided within the client’s cultural system of values, beliefs and life ways” (p.56). The family-centered maternity care approach acknowledges the importance of family beliefs and values and a primary concern is involving parents and families in planning care in a manner that is empowering (Zwelling & Phillips, 2001). A genuine caring and supportive environment is one that supports a woman’s personal power (Manogin, Bechtel & Rami, 2000).

Although some participants agreed they received supportive care, many Mi’kmaq women felt isolated, alone, and relied on family during hospitalization. From this research it was evident that Mi’kmaq women value family support and view it as an integral part of the childbirth. However that sense of empowerment was often a missing link for Mi’kmaq women delivering in a non-Aboriginal health care setting. Using a feminist approach helped the researcher understand the Mi’kmaq women’s experiences of lacking support

during childbirth and feeling disempowered, a view described by (DeMarco, Campbell & Wuest, 1993).

Although there were instances when the participants described not feeling supported and respected during childbirth, eight participants responded that the hospital was the ideal place to deliver their baby. Some Mi'kmaq women felt many of the nurses genuinely cared about their babies and them. One participant who was admitted in the last month of pregnancy for gestational diabetes and hypertension described how a maternity nurse who brought her 10 video-tapes from home to view. The nurse was concerned about her finding the time long in the hospital. Another participant described how a nurse made her feel comfortable in labour by holding her hand, rubbing her back and talking to her. She described this nurse as an "angel".

Despite the prolonged labour and labour pain experienced during childbirth, many participants described childbirth as a beautiful experience. In this study, Mi'kmaq women described their childbirth experience as being something very beautiful and meaningful. Jenny responded: "There's only one word, it's beautiful ... It's amazing I couldn't believe it ... being pregnant, the feeling... was beautiful. I really enjoyed it. I loved it. It's a little miracle growing inside of you ... ". Another participant, Angela recalled: "It's the most beautiful experience a mother could ever experience... women are gifted to bring children into this world; nobody else could do it... It makes us extraordinary people in this world because we bring life into the world..."

As previously mentioned in Theme I, Unpreparedness for Childbirth, five of the eleven participants had gestational diabetes and three had pregnancy induced hypertension with one participant having both medical conditions. Also three participants

required a caesarean section. Since these participants were high risk, a tertiary health care facility was the best place for them to deliver their babies. These women required closer assessment and medical interventions that could not be provided in their First Nations Community. Complications during pregnancy are unpredictable and sometimes there is minimal or no warning (Poole et al., 2001). Safe and effective perinatal care requires the work of a highly qualified health care team. Because Aboriginal women, like the Mi'kmaq, are at a higher risk for health problems such as diabetes and hypertension than the general female population (Health Canada, 1999), these women require health care from highly competent health care professionals.

Hall, Stevens, and Meleis (1994) states that “access to care and culturally competent nursing decisions for vulnerable populations require conceptual frameworks and research methods that recognize and incorporate gender, sexual orientational, racial, cultural, social, political, and economic diversity” (p. 24). Understanding marginalization will help nurses to be aware of and comprehend the linkages between vulnerability and health (Hall et al.). Developing and expanding nursing knowledge about vulnerable populations and how it is linked to health care of diverse populations is critical.

Hall et al. (1994) define marginalization “as the process where persons are peripheralized on the basis of their identities, associations, experiences, and environments” (p.25). Having no voice is one of the main properties of marginalization. Evidence of marginalization was observed, as many Mi'kmaq women did not feel their voices were heard during their childbirth experience. Hall et al. explains this form of suppression as a hierarchical power that recognizes the dominant culture and encourages the language in that culture, thus devaluing other persons' voices. Reinharz (1992)

supports the idea of “the feminist ideal of letting women speak for themselves” (p. 228). In this research, Mi’kmaq women were encouraged to describe their birth experiences without much prompting or any interference. In this way they were able to recognize the value of having a voice and the importance of having an opinion without feeling suppressed.

As diverse populations continue to increase in North America, Campinha-Bacote (1999) recommends that health care providers and health care organizations prepare for the challenges of providing care to them. Campinha-Bacote’s model consists of cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire “as constructs of cultural competence” (p.203). A cultural competence model is designed to specifically address the cultural needs of the populations it serves. A model, which uses specific theoretical approaches and assessment guidelines, will be better suited to the cultural needs of clients. Health care providers can use this model as a framework for developing culturally appropriate health care. This will mean that there will be effective communication between clients and health care professionals and clients will feel a true sense of caring.

Lack of education and language barriers compromises Mi’kmaq women’s opportunity to access equitable health care. Culture and language are factors that influence how clients access and react to health care. They also impact how health care providers provide care (Spector, 2004). Spector claims that language differences create the greatest barrier to clients receiving care. Ineffective communication means that clients lack being adequately informed and miss out on receiving valuable education. Language barriers between health care providers and clients can affect care, even when the clients

and health care providers speak the same language (Boyle, 1995). It may be that both have different understandings. Mi'kmaq women, identified language as a barrier to communicating with healthcare professionals. In this study, some women also described the challenges posed by not being able to speak English fluently.

Many First Nations people prefer oral tradition to written tradition (White & Jacobs, 2002). Written tradition symbolizes one person's perspective, while oral tradition represents the consensus of everyone concerned where there is ultimate respect for everyone. Because consensus is an integral component of decision-making, it is understandable why the extended family plays a role when problems arise and solutions are needed. Understanding the significance of First Nations law helps non-Aboriginal people know what is expected of them in helping Aboriginal people deal with problems. The importance of family in Mi'kmaq women's lives and the involvement of family in decision-making were evident in this research. Many women relied solely on family to support them through the birth experience, some acknowledging that they could not have done it without the loving support of family.

Spector (2004) maintains that language differences are likely the greatest barrier to providing culturally sensitive health care. In instances where clients do not understand the language, interpreters should be requested either from the family, an agency, or the community (Davidhizar & Giger, 1998). Davidhizar and Giger emphasize the need for interpreters to not only translate literal meaning but also to ensure that the nonverbal messages are well understood.

Cultural chauvinism, the assumption that the dominant culture's values are superior and other culture's are inferior, may be the underlying cause of the genocide of

First Nation's culture (White & Jacobs, 1992). A prerequisite of First Nations people receiving appropriate services is the recognition, acceptance of, and the embracing of cultural differences by mainstream society.

Being aware of the power relations and social positions between care providers and clients are essential (Grant, Giddings & Beale, 2005). Clients are considered vulnerable in health care institutions, which affect their hospital experiences. Grant et al. comment that the "social justice discourse of nursing care" that is part of nursing education in Aotearoa, New Zealand includes cultural safety (p.500). According to Anderson, et al. (2003) and Smye and Browne (2002), cultural safety is a concept that originated from Indigenous Maori nurse leaders in New Zealand. It was designed to understand the health beliefs of diverse groups of people, primarily focusing on power inequalities, discrimination issues and the dynamics that exist between people in health care. The intent of cultural safety is to "provide a critical lens to examine health care interactions between the Maori people and white settlers" (p. 197). Cultural safety enables clients to identify the care they prefer to receive and covers many social aspects including gender, socioeconomic status, age, religion, ethnicity and others (Grant et al.) Respect for cultural difference is an important attribute of social justice. A similar education system ensuring cultural safety would be a possible consideration for the Canadian health care system and particularly beneficial for Mi'kmaq women during childbirth.

Marginalization of Mi'kmaq Women

Social, political, and economic factors prevent Mi'kmaq women from receiving the same privilege as many other women in society. Aboriginal peoples have suffered

extreme stress for generations as a result of the social, cultural, political and economic strain of colonization (Barlett, 2004). In addition to the burden of colonization, Mi'kmaq women like all women and minority women in particular, experience marginalization in patriarchal society.

In order to understand marginalization, I have introduced bell hooks, a well-known African American feminist writer, teacher and scholar who has spent much of her life researching and educating people to move against racism, sexism, and classism to reach freedom. Although her work stems from her experiences of Black women, there are some similarities with some of the experiences of the Mi'kmaq women in this research. For example, one Mi'kmaq woman described the nurses as failing to believe that she was in labour and sent her home, leaving her feeling misunderstood. Another participant reported that the nurses would not say hi to her in the hospital, making her feel discriminated against. One participant recalled the doctor yelling at her, making her feel angry, powerless and disrespected. hooks (1989) refers to her personal experiences of being ignored, misunderstood, treated with disrespect, silenced, dehumanized, and powerless; feelings experienced by many who were affected by domination.

hooks (1989) describes how she values a Native American Indian poem because it expresses disapproval of betrayal, and exemplifies what is most important, which is being truthful. hooks further notes that colonization and imperialism are evidence of lies and dishonesty experienced by Native American people. This parallels Aboriginal Peoples' experiences in Canada as a result of colonization. Battiste (2000) points out that isolation is a devastating outcome of colonization. Aboriginal people were isolated from outside

information and barraged with misinformation such as how they were so backward, weak, and unimportant and lucky to be colonized (Battiste).

Spitzer (2005) asserts that “marginalization, economic disadvantage and gender are closely related, and social exclusion engendered through low income, culture, gender, ability or geography can have deleterious health effects” (p. S85). In Canada, Aboriginal peoples among the members of the visible minority are marginalized (Spitzer). As a result, Aboriginal peoples have limited opportunities and varying experiences that may not contribute to good health. Marginalization as experienced by Mi’kmaq women in this research is associated with inequitable access to health care resources and culturally incompetent health care both of which are necessary to attain and preserve health. hooks (1994) claimed that she too felt like a marginalized person teaching in university where the majority of the students were white, similar feelings that she experienced when she was a Black university student. Being left out was just enough motivation to make her create a classroom environment that engages all students.

During this research, many issues related to marginalization were evident. For example, Mi’kmaq women voiced concerns about not having access to formal prenatal classes, a service available to non-Aboriginal women during pregnancy. Hall et al. (1994) claim that marginalized environments may lack access to appropriate health care resources. Since prenatal education is an integral component of childbirth care, identifying barriers that affect women from accessing prenatal education programs is essential (Health Canada, 2000).

During the research, some Mi’kmaq women felt uncomfortable asking nurses’ questions because they seemed busy. Other participants reported that nurses and doctors

did not listen to them, and sometimes ignored them. As a result, some participants chose to limit their communication with the health care providers. Hall et al. (1994) notes that marginalized people are often silenced in the dominant society. hooks (1989) provides insightful information about silence from a feminist perspective. She said that “within feminist circles, silence is often seen as the sexist ‘right speech’ of womanhood-the sign of woman’s submission to patriarchal authority” (p. 6). Keddy (1992) proposes that nurses cannot begin to make changes to their profession without facing their own oppression and their own privilege. In fact, oppression needs to be understood from the nurses’ perspective before they can begin to address the oppression of others. Oppressed people encounter situations where options are reduced to a small choice with consequences (Fry, 1983). To raise nurses’ awareness of oppression, gender, sexism and racism, ideologies based on social construction will be examined in this study.

Gender refers to a person’s traits and social position in society that are attached to being female or male (Macionis & Gerber, 2002). Since gender is a component of social organization, there is a strong association between how we interact with people and how we look at ourselves (Macionis & Gerber). Furthermore, gender includes hierarchy where men and women are categorized differently in regard to power, possessions and other opportunities. Smith (1987) acknowledges the prevalence of men in organizations of power where equality and neutrality are suppressed by discrimination and bias. As a result, gender restricts opportunities and creates inequality for women in society (Macionis & Gerber). In this research, many of the physicians that cared for Mi’kmaq women were men who held powerful positions in the hierarchical structure of health care.

It is not surprising that Mi'kmaq women did not feel they had choice or a voice during their birthing experience.

“Gender inequality-the devaluation of ‘women’ and the social domination of ‘men’ ” has social implications (Lorber, 1994, p.35). Lorber posits that Western societies are organized according to race, ethnicity, class, and gender, with women assuming a subordinate role to men. Enang (1999) explains that devaluing and oppression in society stems from the fact that dominant beliefs such as people’s values, attitudes and beliefs are used to benefit some, while those who remain silent are disadvantaged. Although women are major health care consumers (Hills & Mullett, 2002) they are often under-represented in decision making, with minority women such as the Mi'kmaq women in this research, having less input. Hills & Mullet advocate for a women-centered approach where women’s experiences in articulating their problems and health goals are valued.

To attain a healthier society, we need to examine sexism since gender is the basis of sexism. Macionis and Gerber (2001) define sexism as “the belief that one sex is innately superior to the other, the ideological basis of patriarchy” (p. 322). Sexism is complex because it is not just about a person’s attitudes; it is rooted in institutions in society. Sexism prevents women from being creative and being successful in life according to Macionis and Gerber. Men however, being driven by patriarchy, look to take control of everything, including women (Macionis & Gerber). Clarke (1990) claims that sexism is a concern based on the fact that social theories tend to stereotype women and there have been no plans to change. For example, in the study of health, illness and medicine, there is an overly high emphasis on women receiving healthcare and a trend to generalize all women based on one woman’s illness (Clarke). Also women are portrayed

as being less healthy because of their reproduction functions and more obsessed with health problems than men (Clarke).

hooks (1989) points out that Black women in the United States, in South Africa and people of colour around the world experience the “pain of whitesupremacy oppression and exploitation that comes from resistance and struggles” (p. 112). The introduction of social policies, which were thought to end racism, ironically have served to perpetuate white supremacy. Racism is often further complicated by its intersection with gender issues (Spitzer, 2005). Although racism was not formally identified as a barrier to Mi’kmaq women’s health, comments from the participants suggested that racism and classism created obstacles to the care received during childbirth. As previously mentioned, one participant remarked: “There are nurses who won’t even say hi. Is it because I am Native”? Another participant reported that the nurse yelled at her during labour, while another described a nurse as being “mean” to her during labour. Physicians were also identified as being unprofessional as one participant recalled being told that she was the worst patient the doctor had ever cared for. Another participant described the horrifying experience of having a caesarean section without adequate anesthetic. As I listened, I realized that women were not simply recalling their experiences but reliving the birth event. Some women were teary-eyed and others looked sad. At the beginning of this study, I informed the participants about the availability of counseling services in their community. I explained that it is often helpful to discuss their feelings because it may help them gain a better understanding of their experience and it will help validate their feelings. Many of the participants were aware of this service in the community. These findings are congruent with Simpkin’s (1991) research, as she

described first time mothers reliving their birth stories and concluded that the manner in which women are cared for during childbirth by health care providers may stay with them forever. Browne and Fiske (2001) reported how First Nations women in a community in northwestern Canada were dismissed by doctors and nurses because it was assumed that there was nothing seriously wrong with them. Some participants attributed dismissal from health care providers as being due to these First Nations women being Native. A positive health care experience described by Baker and Daigle (2000) noted that a nurse enriched a Mi'kmaq woman's life by being kind and attending to her health care needs. These examples help to reinforce the importance of providing culturally respectful and loving care.

Hills and Mullett (2002) point out that health policies and programs need to be more specifically designed to meet the needs of women in today's health care system since gender is a major determinant of health. Health care professionals are responsible to ensure that health policies are interpreted and operationalized in the clinical and organizational settings (Hills & Mullett). Some Mi'kmaq women in this research would like to see improvement in policies and procedures on minority population's health needs and equal access to care. Although the participants did not state the word policies or procedures, such changes were implicit in their recommendations for enhanced accessibility to care in their community and for information regarding medical conditions. The women also recognized change was also needed for respectful and sensitive care. These findings regarding improvement in policies and procedures were similar to Enang's (1999) study on the childbirth experiences of Nova Scotia African women.

Although class is often thought to be about money or material goods, it is much more; class has an effect on values, attitudes and relationships with people (hooks, 1994). Gray & Thomas (2005) assert that one of the signs of power and privilege in society is the establishment of a class system. Macionis and Gerber (2002) point out that “Native Peoples occupy disadvantaged positions within social and economic structures in Canada” (p.279). This phenomenon may have been a factor in the participants’ experiences. Only when we face the realities of sex, race and class, that separate and isolate women, and work toward effective strategies to improve living conditions, will women be able to take part in a feminist revolution (hooks, 1988).

Feminism did not emerge as a result of women realizing they were “victimized by sexist oppression”, and feeling powerless to change their life (hooks, 1984, p.1). An indication that people are victimized is that they accept the status quo without questioning or being angry (hooks). Similarly, in this research, Mi’kmaq women voiced concerns about their care such as not receiving adequate pain control, lack of respect, insensitive and inequitable health care, misunderstanding, discrimination, yet they were outwardly willing to accept this care. They chose not to “complain” or “challenge” their care givers due to power relations. However, they did voice their discontent to the researcher, revealing their thoughts and potential power. Although two participants expressed anger about their childbirth, the majority of participants accepted their birth experience as normal despite the failed medicalized care and lack of culturally competent care. Rather than complain to appropriate personnel about their care, Mi’kmaq women chose to remain silent, an indication they are a victim of the health care system.

Feminist research was an appropriate methodology for this study because it values the importance of gender in human relationships and in the way people are influenced by societal processes (Reinhartz, 1992). Feminist scholarship, a method to cross-examine the institutionalized power relations that emerged from the personal experiences of women of colour. Moreover, Weber (2006) asserts that power relations occur when dominant groups have power over others and use their power to gain resources such as money, material goods and access to health care. Power relationships can occur at the macro level of institutions where some persons benefit while others feel disadvantaged, or the micro-level, which may include family or friends. Feminist scholarship driven by the desire to attain social justice uses subjectivity and reflexivity to reflect through the research process and values the researcher and participant collaboration. Patton (2002) adds that “understanding comes from trying to put oneself in the other person’s shoes, from trying to discern how others think, act, and feel” (p. 49). I found that using a feminist approach helped me to understand and reflect on women’s experiences and come to better understand it from their perspective. There was a sense of comfort and trust during the interview process between the Mi’kmaq women and myself.

Caring is a fundamental part of nursing (Swanson, 1991). Swanson’s theory of caring identifies five categories. They include knowing, being with, doing for, enabling, and maintaining belief. These dimensions of the care process are interconnected. Although caring is not a new concept to nursing, individuals who have never experienced caring, may find it hard to provide care to others (Potter, Perry, Ross-Kerr & Wood, 2006). Understanding clients’ perspectives and experiences can provide insight about concerns that may influence nursing decisions and interventions (Browne, 1995).

Mi'kmaq women encountered situations where they perceived that nurses and doctors did not listen or care about them.

Hall et al (1994) proposes that since marginalized persons have been silenced by mainstream society, nurses need to identify other ways of capturing their expressions. Gaining knowledge through feelings instead of words, verbal actions rather than textbooks, caring rather than solutions to normal questions may be effective strategies. Often, marginalized people use narratives to tell their stories. Hall et al. claims that this is a much more effective way of learning about a person's culture as compared to structured questionnaires. Narratives provide a means of "self-inquiry that allow for the sharing "power in research and practice" (Hall et al. p.19).

Benner (2004) views the nurse-patient relationship as an opportunity for patients to feel comfortable in disclosing their true feeling and concerns. When nurses are too rushed or focused primarily on tasks, there is a tendency for clients and families to hold back their feelings (Benner). The hospital experiences of Mi'kmaq women during childbirth varied, however a number of common perceptions were identified. Misunderstanding, lack of respect, no autonomy, lack of choice, unprofessional care, devaluation, discrimination and insensitive care generally characterized their birth experiences. Some participants were vocal about their feelings others were reserved and shy. These findings are congruent with Baker and Daigle (2000) and Enang (1999) who reported that misunderstanding minority women, specifically from a First Nation's community in New Brunswick as well as African Nova Scotia women, experienced discrimination and feelings of being lessened as persons. Participants however appreciated when health care providers showed they genuinely cared.

In summary, there are a number of challenges with multiculturalism in health care (Smith, 1998). One concern that has been identified by Smith is the notion that most professionals do not think of themselves as being bound by their culture. Many people fail to realize that their ethnic and cultural roots influence them. Culture influences how people think and practice, their identity, socialization, perspectives, learning patterns and goals. The challenge is to learn to interact in an effective manner with people of diverse cultures.

Health care providers must understand health from the patients' perspective (Spector, 2004). Being close-minded and insensitive to clients' views on health only perpetuates misunderstanding and creates barriers to health (Spector). Spector reminds us that there are no specific patterns as to how families view their health and practice their health care. Therefore all persons must be given individualized care. Although Mi'kmaq people have been influenced by Western lifestyle, they still view themselves as having a separate cultural heritage and nurses caring for them need to be sensitive and respectful to their culture (Baker, 1998; Baker & Daigle, 2000).

Implications for Education

Since Canada represents a multicultural society (Potter et al., 2006), educational standards need to include cultural diversity and culturally competent care. Emphasis needs to be placed on increasing minorities in educational programs particularly in health care. For instance, some Mi'kmaq women preferred to have a Mi'kmaq nurse with them during their birthing experience. Educating individuals from the same culture would mean that nurses from the same ethnic background would have a better understanding of their cultural traditions, values and beliefs.

Prenatal education is designed to help women understand their health and their babies' health during pregnancy, as well as prevent prenatal complications (Reproductive Care Program, 2004). Many of the participants in this study suggested having formal prenatal classes because they thought it would give them more information about the physiology of labour, potential complications such as diabetes and hypertension, and other medical conditions and strategies to prevent or minimize complications. A suggestion to help fill the gaps in prenatal education and support would be for Mi'kmaq women to meet at a central location, such as the Health Center in their community to begin discussion on what they think would meet their prenatal educational needs. Staff members such as the community health nurse, diabetic clinic nurse, and other health care professionals could also be invited to these meetings to act as resource persons and help with developing these classes. Although some Mi'kmaq women may prefer to attend formal prenatal classes, others would still have the option of one-on-one sessions with the community health nurse. In this way, women would have a choice in receiving education, which is more in line with Sokoloski (1995), who states that some First Nations women

do not regularly attend prenatal care because they view pregnancy as a natural process with minimal interventions required.

Childbirth education should be designed according to the needs of Mi'kmaq women and their families. Prenatal educational material should be available in the Mi'kmaq language and in English. Spector (2004) agrees that patient related material including post signage should be written in the language of populations commonly using the services.

More education in the area of gender studies and gender equity would be beneficial beginning in the school system, followed by undergraduate and graduate education. Arbuthnot (2001) contends that "education is needed to facilitate a greater understanding of how the social construction of gender impacts on women's lives, and consequently the effect that different health care delivery models have on them" (p.108). Currently, the Canadian Government is committed to and has a "Federal Plan on Gender Equality" to address issues on racism and discrimination against women (Spitzer, 2005, p.589). Because these issues on racism and discrimination are deeply rooted in society, it will take a concentrated and committed effort to extricate them from society (Spitzer).

Morse (1995) supports the premise that nursing students need to receive education on gender, class, race, sexual orientation and age, as well as feminist views. Medical-surgical nursing textbooks use research done on white males with a biomedical focus. If there is going to be "an emancipation transformation" in nursing curricula, a feminist viewpoint must be the guiding principle (Morse, p.275).

Implications for Clinical Practice

The importance of providing culturally competent care cannot be overstated in this study. Providing culturally competent care means acting in ways to respect and build upon ethnic and sociocultural diversity (Lynch & Hansen, 1998). Diversity is so broad that being knowledgeable about every culture is not humanly possible, but having a basic understanding of the level of competence and being sensitive to the target population is expected (Willis, 1999). When clients recognize that the general beliefs and values of their culture are respected and incorporated into the nursing care plan, cultural competence has been achieved.

At a recent cultural competence workshop I attended in Halifax in June 2005 several health care professionals including the Nova Scotia Minister of Health, Honorable Angus MacIsaac met to discuss developing 'A Cultural Competence Guide for Primary Health Care Professionals in Nova Scotia'. The Diversity and Social Inclusion in Primary Health Care Initiative is part of a three-year plan to raise awareness that will lead to the development of culturally inclusive policies and guidelines for culturally competent delivery of primary health care (Nova Scotia Department of Health, 2005). This meeting marked the final phase of the project. As a result of this collaborative endeavor, it is anticipated that the Nova Scotia Department of Health will adopt cultural competence guidelines in the spring of 2006. These guidelines will provide a framework that will assist health professionals in providing culturally competent care to the clients they serve. It is anticipated that culturally diverse populations will welcome this commitment to the provision of appropriate and sensitive care.

Individuals are unique because they all have different cultural attributes that guide their behavior in society (Leininger, 1978). Since culture is a learned process, it affects how people deal with health issues and what lifestyle choices they make. Leininger maintains that “culture is a blue print for human behavior and can be a significant determinant of human thought and actions” (p. 85). Therefore a cultural assessment, which is a means of assessing and examining an individual, family or community, is essential. Nurses need to anticipate the ethnic group they are going to care for and use a cultural assessment in clinical practice (Potter et al., 2006).

Although nurses are proficient at meeting the physiological needs of mothers and babies and providing education on maternal/newborn care, they often do not articulate or validate women’s feelings of their childbirth experience (Callister, 2004). From this research, it is apparent that Mi’kmaq women valued the time nurses spent listening to their concerns and providing care in a sincere manner. Recognizing the effectiveness of listening and demonstrating genuinely care can make a significant difference in the level of trust and collaboration in the nurse/client relationship.

Listening to women’s birth stories has a positive therapeutic effect. Semenic, Clarke, Callister and Feldman (2004) found in their study on birth experiences of Jewish women in Canada, that incorporating women’s childbirth experience into the framework of their present life has the potential to increase self-actualization and assist women in their transition to motherhood. Semenic et al found the interview to be not only a nursing assessment tool, but also an effective intervention. The interview gave the Jewish women an opportunity to express their feelings about the birth experience to a caring nurse.

Giving women a voice within the context of their birth experience helps women derive meaning from this life-changing occurrence (Semenic et al, 2004).

Respect is one of the primary values of the nursing code of ethics that guides nursing practice (Canadian Nurses Association, 2002). Although there is little research done on the concept of respect from the client's perspective, there is literature to support that respect is an essential component of the caring process (Browne, 1995). By exploring the childbirth experiences of Mi'kmaq women, the study was able to emphasize the value of respect in clinical encounters for these participants. This finding is similar to Browne who reported that the Cree-Ojibway informants in a First Nations Community in northern Manitoba valued respectful clinical interactions with Western health-care providers. This study on Mi'kmaq women illustrates the importance of nurses, physicians and other health care providers being aware of how their verbal and nonverbal behaviors affect their relationships with clients. Browne (1995) advises that if health care providers are perceived as disrespectful, their behavior may endanger the efficacy of health-care relations.

The findings of this study highlight the importance of supportive care during the birthing experience. Family, friends and health care providers play a significant role during this time. Hodnett (1996) refers to labour support as "the cornerstone of intrapartum nursing care" (p. 263). Nursing support serves to improve birth outcomes and decrease the chances of complications (Hodnett) and increase women's satisfaction with the birth experience (Tumblin & Simpkin, 2001).

An additional recommendation for clinical practice is to increase the number of interpreters. In this study only one interpreter was available to meet the communication

needs of all Mi'kmaq patients. Participants' accounts indicate that there were insufficient interpreters available to the Mi'kmaq women and their families during childbirth. Some participants recommended that interpreters be present during the birthing experience so that someone familiar with the culture could provide more in-depth explanations about medical procedures and nursing care. An interpreter was only available during the post partum period and then only for a short time.

Implications for Research

Further research is needed to explore with Mi'kmaq women what they envision as an appropriate environment in which to give birth. It may be helpful to include women from other Mi'kmaq reserves in Nova Scotia to gain a broader perspective. Although some participants stated they would prefer to deliver in a hospital to ensure the physical safety of their baby and themselves, a small number of participants felt strongly that Mi'kmaq women should have the choice of delivering at home or in a health care facility located on the reserve surrounded by competent nurses, physicians and midwives.

Further research is also required as to whether Mi'kmaq women would prefer informal or formal prenatal classes since there were differing views on this point. Some participants were satisfied with the prenatal care including education they received from the community health nurse in their community because they tended to be avid readers and sought education when needed. However, the majority of participants would have preferred structured prenatal classes where they could ask questions and have group discussion.

. Pidgeon and Hardy Cox (2002) point out that it is important to follow the Aboriginal determined guidelines and practices on how to conduct research with

Aboriginal Peoples. In Nova Scotia, The Mi'kmaq Ethics Watch (1999) principles and guidelines are required for researchers conducting research with, and/or among Mi'kmaq people. Using these guidelines helps to ensure that confidentiality is maintained, harm is avoided and that data obtained is trustworthy. In this research, the guidelines also provided an opportunity for Mi'kmaq women to gain a better understanding of their childbirth experience and give them a voice. These guidelines helped to reassure the participants that the researcher had full approval from the Mi'kmaq Ethics Watch to carry out the research and that the Mi'kmaq women would be invited to participate in the interpretation of the data and review of conclusions. In this way, the participants would feel they were active participants in this process.

It is interesting to mention that although the medicine wheel is a widely popular symbol and respected by many Aboriginal people, the participants did not mention it in this study. Since the medicine wheel did not come up as discussion by the Mi'kmaq women, I did not use it in the discussion of women's childbirth experiences. However, since I plan to continue my research in Aboriginal health, I will include the medicine wheel in future work.

Another recommendation for further research would be to explore with health care professionals their perspective of culturally competent care. A lack of cultural knowledge (seeking and obtaining information), cultural awareness (purposively becoming sensitive to values and beliefs of others) and cultural sensitivity (increases as one appreciates and values cultural differences) (Campinha-Bacote, 1999; Rosenjack Burchum, 2002), was apparent in this study. Increasing one's consciousness of cultural

diversity increases the chances that health care providers will provide culturally competent care (Purnell, 2005).

Health Policy: A Step Closer

All health care professionals are trained to provide the best possible medical care based on evidenced-based research. However, many are less proficient in understanding societal issues that create barriers to women receiving appropriate childbirth care. Minority women such as Mi'kmaq women experience marginalization, sexism, racism, classism and discrimination, all of which create oppression in their daily lives. Wuest (1993) states that "women's health can only be understood within the context of their lived experience of social inequity, medicalization, and family caregiving" (p. 407). In order for health policy to be effective for women, those engaging in research must keep in mind that women's lives are complicated (Wuest). Esposito (1999) advises that researchers must continue to record women's voices in order to comprehend inequities they experience in healthcare.

Health policy changes will only be effective and meaningful if Mi'kmaq people have an active role in the research process. Removing barriers to health care and developing culturally competent guidelines can only happen if Mikmaq people are involved. Spector (2004) suggests that improved access to health care can be achieved by working together collaboratively with communities to address cultural issues

Conclusion

Using feminist methodology provides a means of understanding women's issues both from the clients' and the providers' viewpoints, and also from a broader perspective apart from gender, race, sexual identity or culture (Im & Meleis, 2001; Weber, 2006).

Feminist research recognizes that women are similar in some ways and different in other ways and takes pride in diversity (Reinhartz, 1992). In this research, a feminist approach was appropriate because it provided a means of examining structured power relations within institutions that shape knowledge and social inequalities in health care (Weber). hooks (1989) maintains that women will only be able to take part in changing the world and eliminating patriarchal domination when the concepts of sex, race and class are explicated in terms of the way they marginalize people, and the way these problems are resolved.

It became evident during this research that the Mi'kmaq women's childbirth experiences are complex. Issues regarding accessibility to health care, one of the major themes identified in this research may be due to many factors as outlined in this study. However, health care providers are well educated and appropriate individuals assume a leadership position to effect change through healthy public policy. Mi'kmaq women like many minority women want the best possible health care for their families yet they face many barriers such as access to health care, language barriers, racism, and discrimination, creating a feeling of isolation.

This research revealed the importance of education on childbirth. Although a number of women would have preferred to attend formal prenatal classes, they appreciated the limited childbirth education they received from their health center. Mi'kmaq women, like other Canadian women, experience fear during labour and birth. Being prepared for childbirth through prenatal education decreases women's fear in childbirth, lowers their dependence on health care providers and enables women to be

more active participants in care (Maestas, 2000). In this way transition to motherhood is more easily attained and women feel a sense of control.

Promoting health and well being of people is the first and foremost concept in the nursing profession (Reynolds Turton, 1997). Therefore, instead of imposing the Western biomedical way of knowing that is hierarchical and medicalized, healthcare professionals need to learn the Aboriginal ways of knowing about health (Reynolds Turton).

Medicalizing childbirth was evident in this research. Birthing occurred in the hospital, an environment that was considered high-tech. Fetal monitoring equipment, epidural anesthesia, and other aspects of the environment conveyed a cold and non-comforting atmosphere. During this time, the participants' experienced unprofessional encounters with health care providers, primarily physicians and nurses, leaving them feeling devalued and lessened as a person. Many of the participants were disappointed with the disrespectful treatment and lack of insensitive childbirth care. Support was mainly received from family, friends and the community health nurse but in their view was deficient from the other health care providers.

If one has power over another and is truly committed to empowering the other, the most effective approach is to relinquish some power to that person (Zavis, 2003). Hopefully health care providers will recognize the importance of empowerment and the need to listen to Mi'kmaq women's voices. For Mi'kmaq women, active participation in decision-making about their health care is paramount and until this happens, Mi'kmaq women and other minority women will continue to experience marginalization.

It was also apparent that Mi'kmaq women did not consistently receive culturally competent care during childbirth. They, being first time mothers, did not know what to

anticipate during childbirth. Moreover, they expected health care professionals to demonstrate that they truly cared. Comforting and supporting interventions would have made the difference between a satisfying birth experience as opposed to one that was frightening and disappointing as voiced by some of the participants. Hawley's (2000) view is that "Nurses are supposed to alleviate discomfort, not inflict it" (p.20).

The findings in this research affirm that issues concerning gender, sexism, racism, and class affect the lives of Mi'kmaq women and their families during childbirth. To provide accessible and culturally competent health care to minority populations during childbirth, health care professionals must understand the impact that these issues can have on minorities.

The lack of generalizability of these findings, given that this data comes from only one First Nations Community, and cannot be generalized outside that community may be identified as a limitation. However, like the findings of many qualitative studies, the findings from this study are not intended to be generalizable, instead they offer valuable insights into the childbirth experiences of Mi'kmaq women delivering in a non-Aboriginal setting. Future research is needed to explore the experience of other First Nations women. These experiences can be compared to the birth experience of women from other visible minorities and other Canadian women, to determine similarities and differences. Volunteer bias was a limitation of the study, as women who volunteered to participate do not necessarily represent a cross section of the population.

I believe that health care providers strive to provide the best possible childbirth care. However, it became apparent that many physicians and nurses lacked knowledge in cultural awareness and cultural sensitivity, key attributes necessary to providing

culturally competent health care. Making education on culture mandatory in universities, nursing and medical schools would be a beginning. Continued collaboration and commitment from stakeholders including governments, health professionals and administrators, academics and communities are required to address and improve health inequalities for Mi'kmaq women and families and other minority cultures. Science has made huge advancements in so many ways from sending astronauts to the moon, to developing computers, to saving human lives and even cloning people over the past century, yet social policies making everyone feel included and cared about seems neglected. I look forward to working with Mi'kmaq women and others interested in influencing social policy to improve health care for Mi'kmaq people and other minority groups in Canada.

Appendix A

INFORMATION LETTER TO POTENTIAL PARTICIPANTS

Thesis Title: Mi'kmaq Women's Childbirth Experiences

Researcher: Joanne Whitty-Rogers

Hello,

My name is Joanne Whitty-Rogers. I am a nurse educator teaching nursing students at St. Francis Xavier University and a mother/baby nurse with experience in labour /delivery, postpartum and neonatal care. Currently, I am a Graduate Student at the School of Nursing, Dalhousie University. I am interested in learning about the childbirth experiences of Mi'kmaq women living on a reserve in Cape Breton, Nova Scotia within the health care system.

I would like to do a qualitative research study with five to eight Mi'kmaq women who are nineteen years or older living on a Mi'kmaq reserve in Cape Breton, Nova Scotia. The women will be first time mothers, having given birth within the past two years, at a hospital in a city geographically separated from the reserve.

The purpose of this research study is to provide new knowledge about Mi'kmaq women's childbirth experiences, which occur in a health care center outside their rural Nova Scotian community.

This research will be conducted on a Mi'kmaq reserve in Cape Breton, Nova Scotia. You will be interviewed in a private area of your home or another area mutually agreed upon by you and the researcher, away from interruptions. If you wish to be accompanied by a friend or family member he/she also will be asked to sign a confidentiality agreement. I will be conducting in-depth interviews as well as focus group discussion. The interviews and focus group will enable me to obtain information in order to gain an understanding of your situation. Each interview will last from one to one and one half-hours. The interviews will be scheduled when it is convenient for you to meet with me, either following the baby's feeding or when the baby is sleeping.

Those who wish to be a participant in the study will be asked to sign a consent form. Five to eight women or greater will be interviewed. As well, a focus group meeting will be held, four to six weeks following the completion of all individual interviews so that I can present my preliminary findings from the interview data and have you determine accuracy of my description of your experience.

I have attempted to design this study in a way that does not risk your well being in any way. If you do not feel comfortable discussing your experiences during the interview(s), you are free to refuse to answer any question or withdraw from the study anytime without

being penalized. At the end of the interview, I can provide you with names and contact information for counseling/support services in your area if you feel you need it.

I am not sure what personal benefits you will gain from the study engaging in the study. However, you will be given a chance to discuss your experiences, in addition to perceptions and feelings regarding your childbirth experiences to me without being judged. This study may help you gain further insight into your childbirth experience.

If you choose to participate, please complete the form enclosed and mailed it to me in the stamped envelope provided. We will then schedule a time and place convenient for you for a private discussion on your childbirth experience. Please indicate at what number I may contact you and if you do not have a phone, please indicate how you may be contacted. Also if you would like further information you can contact me by phone at any time at 902-867-3629 (w) or 902-863-6797 (h) or my Co-supervisors Professor Josephine Etowa at 902-494-6534 or Dr. Joan Evans at 902-494-2391.

Thank you for interest in this research study. Information from this study will be valuable in helping to improve perinatal care for Mi'kmaq women.

Yours truly,

Joanne Whitty-Rogers

Appendix B

STATEMENT OF PARTICIPATION IN THE PROPOSED STUDY

Thesis Title: Mi'kmaq Women's Childbirth Experiences

Researcher: Joanne Whitty-Rogers

If you wish to participate in this study, please complete and sign this form.

I have received a copy of the information letter to potential participants regarding the above study and I wish to participate. **My name is** _____

I can be contacted at **Address** _____

Phone Number _____

If you do not have a phone, please indicate how I may reach you.

Appendix C

PARTICIPATION CONSENT FORM FOR INTERVIEW

Study Title: Mi'kmaq Women's Childbirth Experiences

Principal Investigator: Joanne Whitty-Rogers, BScN, RN
Master of Nursing Student, Dalhousie University

Co-Supervisor : Josephine Etowa, PhD (C), MN, RN, RM, IBCLC
Assistant Professor
Dalhousie University, School of Nursing
Telephone: 902-494-6534
Email: josephine.etowa@dal.ca

Co Supervisor: Joan Evans PhD, RN
Associate Professor Director Graduate Program
Dalhousie University, School of Nursing
Telephone: 902-494-3487
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Reader: Adele Vukic, MN, RN
Assistant Professor
Dalhousie University, School of Nursing
Telephone: 902-494-2207
Email: adele.vukic@dal.ca

Reader: Charlotte Loppie, PhD
Assistant Professor
Dalhousie University, Health & Human Performance
Telephone: 902-494-6620
Email: charlotte.loppie@dal.ca

Contact Person: Any questions, concerns, additional information, or clarification about the study procedure can be forwarded to Joanne Whitty-Rogers at the above address, phone number, or email address at any time. Also you may contact my co-supervisors Professor Josephine Etowa or Dr. Joan Evans at the phone numbers, addresses and email listed above.

Funding sought- Non applicable

Introduction:

I invite you to take part in a research study titled: 'Mi'kmaq Women's Childbirth Experiences' at Dalhousie University. Your participation in this study is voluntary and you may withdraw from the study at any time. The quality of your health care will not be affected by whether or not you participate. The study is described below. This description tells you about the risks, inconvenience, or discomfort, which you might experience. Participating in the study might not benefit you at the same time of your participation, but we might learn things that will benefit others. You should discuss any questions you have about the study with the person, who explains it to you.

Purpose of the Study:

The purpose of this study is to generate new knowledge about Mi'kmaq women's childbirth experiences which occur outside your rural Nova Scotian community in a health care center. The study will provide a greater understanding of Mi'kmaq women's childbirth. The knowledge learned from this study will help ensure that the care Mi'kmaq women receive is culturally appropriate.

Study Design:

Participants will be asked to participate in a one-on-one in-depth interview, that will be audio-taped at a time and location that is convenient to you. Approximately five to eight Mi'kmaq women or more women living on the reserve will be interviewed. The interview will last approximately one to one and half-hours. During this time, you will be asked to respond to some questions related to your childbirth experiences at a health care center outside your reserve and your perceptions about what you believe to be an optimal birth experience. The audio-taped interviews will be transcribed at verbatim. The responses from the interviews will be explored in greater detail with participants in a focus group discussion that will provide an opportunity to converse with each other and share your experiences. A copy of the research study will be given to you.

Who Can Participate in the Study:

You may participate in this study if you are a Mi'kmaq woman, nineteen years or older, living on the reserve in Cape Breton, Nova Scotia. The participant will be a first time mother having given birth within the past two years at a health care center geographically separated from the reserve. If you are not fluent in English or need some assistance in understanding some questions in the interview, a Mi'kmaq interpreter will be present to assist with interpretation if you agree.

Who Will Be Conducting The Research:

The principal researcher is Joanne Whitty-Rogers, BScN, RN. She is a registered nurse with experience in labour/delivery, postpartum and neonatal care. She is doing this study as part of her Master of Nursing Degree at Dalhousie University.

What will you be asked to do:

As part of agreeing to participate in this study, you will meet with Joanne Whitty-Rogers for one interview for one to one and half-hours in order to discuss your childbirth

experiences. For example you will be asked to talk about your childbirth experience; how you felt about being in a hospital away from home; your expectation of the birth experience; how your culture affected your birth; and how you felt about the care you received. With your permission, the conversations will be audio-taped and note taking will occur during the recording. This will ensure that the information is accurately recorded. The tape will later be transcribed by someone who has not been given the names of participants and is bound by confidentiality. The interviews will be conducted at a time and place mutually agreed by you and myself, away from interruptions. Upon completion of all of the interviews, Joanne Whitty-Rogers will share with you and other participants what she has found from the interviews in a focus group discussion that will be held to clarify information that the participants expressed and for the purpose of ensuring that she has heard the information correctly. During the focus group session, I will present the information found during the interviews and ask for discussion to determine if I have interpreted the data correctly and that it fits with your experience. Questions will be asked to clarify and validate the key points you described during the interview. You can refuse to participate in the focus group discussion, and the researcher will meet with you privately. The research study will take place over approximately one year. There is no preparation for the interview or focus group discussion.

Possible Risks and Discomforts:

There are no anticipated risks to being a participant in this study. If participants do not feel comfortable discussing their experiences during the interview(s), they are free to refuse to answer any question or withdraw from the study anytime without being penalized. If any feelings of discomfort or issues arise or problems of physical or emotional nature occur, the researcher can provide names and contact information for counseling /support services in your area. Also, although it is expected that the interpreter, your family and friends who participate respect your privacy and keep all information confidential, I cannot guarantee this. However emphasis will be placed on confidentiality throughout the study. According to Canadian law, any information that is disclosed to the researcher that suggests the occurrence of child abuse must be reported to the appropriate authorities. Also any other information disclosed that may suggest imminent threat to individuals must also be reported.

Possible Benefits:

Your participation in this research may benefit other Mi'kmaq women, by contributing to the knowledge of childbirth issues. This study may help you gain further insight into your childbirth experience. No benefits can be guaranteed.

Compensation/ Reimbursement:

There is no compensation for participating in this study. You are free to opt out of the study at any time if you feel uncomfortable about disclosing information. Your health care will not be affected at the Health Center if you withdraw from the study.

Confidentiality & Anonymity:

Your identity will be protected at all times. A pseudonym (made up) name will be used to conceal your identity. Approximately 60 to 100 Mi'kmaq women deliver each year and

some are well known to each other. While reasonable precautions are being taken to ensure your anonymity and the confidentiality of your statements, you should be aware that there are particular limits to confidentiality where family, friends or an interpreter is present. Although it is expected that the interpreter, your family and friends who may be present during the interview respect your privacy and keep all information confidential, I cannot guarantee this. However, emphasis will be placed on maintaining confidentiality throughout the study. Your names will not be identified in my thesis, publications, presentations or report as a result of the study. No information that could identify you, your family, friends or the Health Center will be provided. Any information discussed with the researcher or the researcher's supervisors for the purpose of developing the thesis will not have any identifying factors. All materials collected during the study (documents, audio-tapes) will be kept in locked storage, and accessible only by the researcher during the study. These materials will be destroyed as per protocol of the Human Ethics Review Committee, Dalhousie University five years after the study is completed. The transcriber, interpreter and friends or family members will sign a confidentiality agreement.

Questions:

If you have any questions, concerns, additional information, or clarification about the study you can contact Joanne Whitty-Rogers at 902-867-3629 work or 902-863-6797 home at any time or my Co-supervisors Professor Josephine Etowa at 902-494-6534 or Dr. Joan Evans at 902-494-2391.

Summary

You will receive a copy of the consent form for your records and information at the beginning about the study. Joanne Whitty-Rogers will write a final report describing what she heard during the interviews. This information will be presented to all of the women interviewed in a focus group discussion. You and all of the other women interviewed will be invited to attend this session. The purpose of this meeting is to ensure that the researcher has accurately included all of the information provided during the interviews, and that she has a good understanding of your childbirth experience. If you wish to meet with the researcher instead of in a group, she will be happy to do so.

Problems or Concerns

"In the event that you have any difficulties with, or wish to voice concern about, any aspect of your participation in this study, you may contact Patricia Lindley, Director of Dalhousie University's Office of Human Research Ethics/ Administration, for assistance: (902) 494-1462, patricia.lindley@dal.ca".

Signature:

"I have read the explanation about this study. I have been given the opportunity to discuss it and my questions have been answered to my satisfaction. I hereby consent to take part in this study. However I realize that my participation is voluntary and that I am free to withdraw from the study at any time."

I hereby consent to be a participant in this research study. However, I realize that my participation is voluntary and that I am free to withdraw from the study at any time.

Study Title: Mi'kmaq Women's Childbirth Experiences

Participant (Print name) _____

Participant (signature) _____

Date _____

Researcher (print name) _____

Researcher (signature) _____

Date _____

I hereby give consent to use direct quoted in any published works, with the understanding that no identifying information will be included, and that my identity will not be disclosed.

Participant (Print name) _____

Participant (signature) _____

Date _____

Researcher (print name) _____

Researcher (signature) _____

Date _____

Study Title: Mi'kmaq Women's Childbirth Experiences

I hereby give consent to audio-taping the interview, with the understanding that no identifying information will be included, and that my identity will not be disclosed.

Participant (Print name) _____

Participant (signature) _____

Date _____

Researcher (print name) _____

Researcher (signature) _____

Date _____

Appendix D

CONFIDENTIALITY AGREEMENT FOR INTERPRETER

Thesis Title: Mi'kmaq Women's Childbirth Experiences

Researcher: Joanne Whitty-Rogers

I, _____ have agreed to keep the information for the above research strictly confidential. I will not relate any segment of this information to another person, nor will I discuss the information with anyone other than the researcher for the purposes of clarification in the interview(s).

Interpreter (Print name) _____

Interpreter (signature) _____

Date _____

Researcher (print name) _____

Researcher (signature) _____

Date _____

Appendix E

CONFIDENTIALITY AGREEMENT FOR FAMILY MEMBER/FRIEND

Thesis Title: Mi'kmaq Women's Childbirth Experiences

Researcher: Joanne Whitty-Rogers

I, _____ have agreed to keep the information for the above research strictly confidential. I will not relate any segment of this information to another person, nor will I discuss the information with anyone other than the researcher or participant in the study for the purposes of clarification in the interview.

Family Member/Friend (print name) _____

Family Member/Friend (signature) _____

Date _____

Researcher (print name) _____

Researcher (signature) _____

Date _____

Appendix F

FOCUS GROUP CONSENT FORM FOR INTERVIEW

Study Title: Mi'kmaq Women's Childbirth Experiences

Principal Investigator: Joanne Whitty-Rogers, BScN, RN
Master of Nursing Student, Dalhousie University

Co-Supervisor : Josephine Etowa, PhD (C), MN, RN, RM, IBCLC
Assistant Professor
Dalhousie University, School of Nursing
Telephone: 902-494-6534
Email: josephine.etowa@dal.ca

Co Supervisor: Joan Evans PhD, RN
Associate Professor Director Graduate Program
Dalhousie University, School of Nursing
Telephone: 902-494-3487
Email: joan.evans@dal.ca

Reader: Adele Vukic, MN, RN
Assistant Professor
Dalhousie University, School of Nursing
Telephone: 902-494-2207
Email: adele.vukic@dal.ca

Reader: Charlotte Loppie, PhD
Assistant Professor
Dalhousie University, Health & Human Performance
Telephone: 902-494-6620
Email: charlotte.loppie@dal.ca

Contact Person: Any questions, concerns, additional information, or clarification about the study procedure can be forwarded to Joanne Whitty-Rogers at the above address, phone number, or email address at any time. Also you may contact my co-supervisors Professor Josephine Etowa or Dr. Joan Evans at the phone numbers, addresses and email listed above.

Funding sought- Non applicable

Introduction:

I invite you to take part in a research study titled: 'Mi'kmaq Women's Childbirth Experiences' at Dalhousie University. Your participation in this study is voluntary and you may withdraw from the study at any time. The quality of your health care will not be affected by whether or not you participate. The study is described below. This description tells you about the risks, inconvenience, or discomfort, which you might experience. Participating in the study might not benefit you at the same time of your participation, but we might learn things that will benefit others. You should discuss any questions you have about the study with the person, who explains it to you.

Purpose of the Study:

The purpose of this study is to generate new knowledge about Mi'kmaq women's childbirth experiences which occur outside your rural Nova Scotian community in a health care center. The study will provide a greater understanding of Mi'kmaq women's childbirth. The knowledge learned from this study will help ensure that the care Mi'kmaq women receive is culturally appropriate.

Study Design:

Based on the findings from the one-on-one in-depth interviews, I am inviting you to participate in a focus group meeting, which will be held on a reserve in Cape Breton, Nova Scotia to examine more intensely the things I heard in the interviews. The focus group will be facilitated by myself.

Who Can Participate in the Study:

You may participate in this focus group discussion if you are a Mi'kmaq woman, nineteen years or older, living on the reserve in Cape Breton, Nova Scotia. Participants will be first time mothers having given birth within the past two years at a health care center geographically separated from the reserve and who previously participated in the interview process four to six weeks ago.

Who Will Be Conducting The Research:

The focus group will be conducted by the principal researcher, Joanne Whitty-Rogers, BScN, RN. She is a registered nurse with experience in labour/delivery, postpartum and neonatal care. She is doing this study as part of her Master of Nursing Degree at Dalhousie University.

What will you be asked to do:

You have indicated your interest in participating in a focus group on this topic. Should you participate, you will join with at least 5-8 or more Mi'kmaq women for a group discussion lasting two hours. During the focus group session, I will present the information found during the interviews and ask for discussion to determine if I have interpreted the data correctly and that it fits with your experience. Questions will be asked to clarify and validate the key points you described during the interview. You can refuse to participate in the focus group discussion, and the researcher will meet with you privately. The research study will take place over approximately one year. There is no preparation for the focus group discussion.

Possible Risks and Discomforts:

There are no anticipated risks to being a participant in this study. If participants do not feel comfortable discussing their experiences during the interview(s), they are free to refuse to answer any question or withdraw from the study anytime without being penalized. If any feelings of discomfort or issues arise or problems of physical or emotional nature occur, the researcher can provide names and contact information for counseling /support services in your area. Also, remember that although it is a requirement of participation to respect the privacy of other participants and keep confidential all group discussion, I cannot guarantee this. In other words, please keep confidential what you hear in this group; but be aware that others in the group may not keep things confidential. According to Canadian law, any information that is disclosed to the researcher that suggests the occurrence of child abuse must be reported to the appropriate authorities. Also any other information disclosed that may suggest imminent threat to individuals must also be reported.

Possible Benefits:

Your participation in this research may benefit other Mi'kmaq women, by contributing to the knowledge of childbirth issues. This study may help you gain further insight into your childbirth experience. No benefits can be guaranteed.

Confidentiality & Anonymity:

Your identity will be protected at all times. A pseudonym (made up) name will be used to conceal your identity. While reasonable precautions are being taken to ensure your anonymity and the confidentiality of your statements, you should be aware that there are particular limits to confidentiality in group interviews. While each participant may agree to keep matters discussed by the group in confidence, there is always the risk that this agreement may not be honored. For this reason, we suggest that you only talk about issues that you feel comfortable discussing in a group setting. The one file linking participant names with the focus group pseudonym (made up) name will be accessible to me. Someone will be hired to transcribe the tape of the group discussion into text. This individual will not know participant names. The transcriber will sign a confidentiality agreement. Your names will not be identified in my thesis, publications, presentations or report as a result of the study. No information that could identify you, your family, friends or the Health Center will be provided. Any information discussed with the researcher or the researcher's supervisors for the purpose of developing the thesis will not have any identifying factors. The tape of the focus group will be destroyed once it is transcribed. All transcripts will be kept in locked storage during the duration of the study and for five years into the future. After five years all transcripts will be destroyed. Individuals are free to withdraw or modify comments at any time within one month following a focus group discussion. After this time, publications based on the research will be written and the withdrawal of comments will not be possible.

Questions:

If you have any questions, concerns, additional information, or clarification about the study you can contact Joanne Whitty-Rogers at 902-867-3629 work or 902-863-6797

home at any time or my Co-supervisors Professor Josephine Etowa at 902-494-6534 or Dr. Joan Evans at 902-494-2391.

Problems or Concerns

“In the event that you have any difficulties with, or wish to voice concern about, any aspect of your participation in this study, you may contact Patricia Lindley, Director of Dalhousie University’s Office of Human Research Ethics/ Administration, for assistance: (902) 494-1462, patricia.lindley@dal.ca”.

Signature:

“I have read the explanation about this study. I have been given the opportunity to discuss it and my questions have been answered to my satisfaction. I hereby consent to take part in this study. However I realize that my participation is voluntary and that I am free to withdraw from the study at any time.” I agree that the focus group may be audio-taped, and recognize that I may ask to have the audio-tape turned off at any point if I wish. I agree to keep what is said in the group confidential but I cannot be assured that others in the group will hold what I say in confidence. My participation is voluntary and I realize that I am free to withdraw from the study at any time. I have been given a copy of this consent form for my records.

Study Title: Mi’kmaq Women’s Childbirth Experiences

Participant (Print name) _____

Participant (signature) _____

Date _____

Focus Group Facilitator (print name) _____

Focus Group Facilitator (signature) _____

Date _____

Appendix G

INTERVIEW GUIDE

Introduction

Before the interview begins, I would like to take this time to thank you for agreeing to participate in this study. Your perceptions about childbirth experiences are valuable for learning because this knowledge will help to ensure that culturally appropriate care is available to the Mi'kmaq population. Here are a few questions that may help to guide the interview for our discussion. Also you may have questions and or comments during the interview that you wish to address. During this discussion, more questions may actually arise. I hope that you will find this research experience interesting and rewarding. You are free to refuse to answer any questions or withdraw from the study at any time.

Questions

1. Could you please describe your view of health?
 Probes:
 What do you see as your greatest strength to maintaining good health?
 How would you describe your overall health status?
 How did you acquire information about health related issues?
 Are there any cultural influences on your views of good health?
2. Please tell me how you acquired your knowledge about childbirth?
 Probes:
 What did your mother/grandmother, aunts, sisters and friends talk about prior to the birth? Did your family or friends describe their own birth experiences to you?
 Describe what information they shared with you.
 What was most helpful about receiving this information?
3. Describe what it was like when you left your home to go to the health care facility to deliver your baby?
 Probes:
 What were you thinking about as you drove to the hospital?
 Were you in labour at the time. Describe.
4. What do you see as the ideal place to deliver your baby?
 Probes:
 Describe the birth setting.
 Who would you like to have present?
5. Describe the admission procedure to the maternity unit health care facility.

Probes:

Is this what you expected to receive?

What birth options did you anticipate you would have? Which did you get?

Do you think having birth options is important at this time?

6. During your childbirth experience, please tell me what you considered important?

Probes:

What or who was most helpful to you during this time. In what way?

What did you expect when you began labour?

What was it like when the baby was delivered? Tell me what you experienced.

Who were your main support persons during labour and birth?

After the baby was born what happened next?

Describe what childbirth experience means to you.

If you were able to change anything about this experience, what would you change?

7. Please tell me what cultural traditions, beliefs and values you view as important during the childbirth experience?

Probes:

What are your cultural beliefs and how did you communicate them with your care providers?

How did you communicate your cultural preferences during childbirth?

What suggestions do you have for health care providers to improve the care?

8. Could you please summarize your childbirth experience and describe what meaning this has for you?

Probes:

Is there anything that we discussed that you would like to change?

Is there any information that you would like to add to this discussion?

Appendix H

CONFIDENTIALITY AGREEMENT FOR TRANSCRIBER

Thesis Title: Mi'kmaq Women's Childbirth Experiences

Researcher: Joanne Whitty-Rogers

I, _____ have agreed to keep the information contained within the tapes for the above research strictly confidential. I will not relate any segment of this information to another person, nor will I discuss the contents with anyone other than the researcher, for purposes of clarification in transcription.

Transcriber (print name) _____

Transcriber (signature) _____

Date _____

Researcher (print name) _____

Researcher (signature) _____

Date _____

Appendix I

CONTACT INFORMATION FOR COUNSELING

Mental Health, Sr. Franklin Ferguson's Office

Cape Breton, Nova Scotia

Phone number to call- 379-2910

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