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Bridging the Gaps
Reducing Barriers for Mi'kmaq Women and Families During Childbirth

Many barriers exist in health care that limit and or prevent Aboriginal women from receiving culturally competent care during childbirth. Social, political, and economic factors exclude Aboriginal women, such as Mi'kmaq women from receiving the same privileges as other women in society. Safe and effective childbirth care requires caring and competent health care providers. These providers need to understand health from the clients' perspectives. Lack of knowledge and respect on clients' views of health only perpetuates misunderstanding and creates barriers to health. Afat I. Meleis (1996) maintains that providing culturally competent care should not be viewed as a luxury but rather an essential component of health care (1). This paper is based on a recent qualitative study that was conducted in a First Nations community in Nova Scotia. The purpose of the study was to provide new knowledge and gain greater understanding about Mi'kmaq women's childbirth experiences, which occur in a large tertiary care center outside their rural Nova Scotian Community. This study explored their perceptions of culturally appropriate care during childbirth. Four themes were identified that described their experiences of giving birth in a non–Aboriginal health care setting. They included unpreparedness for childbirth, professional relations as sites for invalidation, access to health care, and support during birthing. Discussion included issues around effectiveness of care, marginalization, and the meaning of childbirth. Continued collaboration and commitment from stakeholders including governments, health professionals, administrators, academics, and communities are required to address and improve health inequalities for Mi'kmaq women and families.

Many barriers exist in health care that limit and or prevent Aboriginal women, such as Mi'kmaq women, from receiving culturally competent care during childbirth. Mi'kmaq women like many minority women want the best possible health care for themselves and their families, yet they face barriers such as ac-

cess to health care, communication and language barriers, respect from health care providers, supportive care—all of which result in feelings of isolation and disenfranchisement. According to Denise Spitzer "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" (2005: S85). Health care professionals need to understand the impact that existing social, political, and economic barriers have on health, so that they can become strong advocates for removing those barriers and creating culturally sensitive childbirth environments.

For the purposes of this paper, some frequently used terms such as culture, culturally sensitive care and culturally competent care will be defined. Suzanne 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" (26). This means that people view their world through a cultural lens that is developed and valued by their own community members. Cultural sensitivity implies that the health care provider has basic knowledge and specific attitudes toward health care beliefs and traditions (Spector 2004: 8). 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: 8). 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, Zenter, Pangman, and Pangman, 2006: 45). Culturally competent care refers to taking into consideration diversity, marginalization, and vulnerability due to culture, race, gender and sexual orientation" (Meleis, 1996: 2). Moreover, culturally competent care encompasses the total context of the individual's situation and combination of knowledge, attitudes and skills (Spector, 2004: 8). The Canadian Nurses Association (2004) maintains that culturally competent care should be a shared responsibility between individuals, professional organizations, health services, educational institutions, and government agencies (1). 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). Winnie Willis maintains that "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" (1999: 58). Although both cultural sensitivity and cultural competence have been used throughout this paper, they are not used interchangeably as the later involves a more complex process of effectively engaging in cross-cultural interaction.

Similar to other First Nations communities in Canada, Mi'kmaq women in one Nova Scotia community receive the majority of their prenatal care and postnatal follow-up care at the Health Center in their community primarily by First Nations care providers. However, during childbirth their care is provided

by non-Aboriginal health care professionals in a tertiary center located approximately 45 minutes from their community because there is no hospital located in their First Nations community. Mi'kmaq women deliver their babies in a culture different from their own, with dissimilar values, beliefs and attitudes, which may result in enhanced uncertainty and vulnerability in their transition to motherhood (Schumacher and Meleis, 1994: 123). In a society dominated by non-Aboriginal culture, minority women such as Mi'kmaq may experience childbirth that is not culturally sensitive to their needs.

Since there was minimal literature available about the experiences of Mi'kmaq women during childbirth a qualitative study entitled "Childbirth Experiences of Women from One Mi'kmaq Community in Nova Scotia" was conducted. Feminist methodology was selected to guide the study because this approach provided a means of seeing the world from the eyes of the women participants (Streubert-Speziale and Carpenter, 2003: 11). In addition, 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, 2006: 22). The purpose of the study was to provide new knowledge and a greater understanding about Mi'kmaq women's childbirth experiences, which occurred in a large tertiary care center outside their rural Nova Scotian community. Eleven Mi'kmaq women shared their experiences and perceptions of the provision of culturally appropriate care during childbirth. This data were collected in two rounds of interviews and then analyzed for emerging themes. The findings in this research suggest that Mi'kmaq women and their families encounter situations that create barriers to them receiving culturally competent health care during childbirth. Four themes were identified, which described the experiences of participants giving birth in a non-Aboriginal health care setting: unpreparedness for childbirth; professional relationships as sites for invalidation; access to health care; and, support during birthing. Three major areas for discussion evolved which include: (1) the meaning of childbirth; (2) effectiveness of care; and, (3) the marginalization and devaluation of Mi'kmaq women. It is not within the scope of this paper to discuss the entire study, but to provide a brief overview of the three major areas aforementioned. Also, this paper will address implications for education, clinical practice and future research and conclude with final remarks.

The meaning of childbirth

The meaning of childbirth varied among the Mi'kmaq participants. Some Mi'kmaq women reported their childbirth experiences as positive and memorable and commented that they received support from health care professionals, including the community health nurse working in the participants' own community. Other Mi'kmaq women did not share this sentiment and they described being disappointed, feeling disrespected and misunderstood. They experienced anxiety, lacked choice and feared labor and delivery with-

out good support from health care providers. According to Penny Simpkin "a woman in labor is highly vulnerable" (210). At this time, her body is exposed as she experiences pain, sweats, and cries out in a foreign environment. When she is not treated with respect, the woman is unable to maintain dignity and self-control, leaving a permanent negative outcome. On the other hand, if the woman is respected and cared for in a sincere and genuine manner, a positive result is permanent.

Many First Nations women view pregnancy as a natural process. Some First Nations women consider prenatal care as important, while others view this time as a normal process with no medical interventions necessary (Sokoloski, 1995: 93). Mi'kmaq women, like other women, are often influenced by Western knowledge and are convinced that following Western practices ensures a safe birth. 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, 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 the medicalized environment dominated by medical and administrative persons within which women gave birth. Participants often experienced lack of control and choice about childbirth options.

Medicalized birth practices have emerged with an increase in medical technology and medical interventions (Johanson, Newburn and Macfarlane, 2002: 892). Shirley Hiebert (2003) notes that these birth changes occurred as science and medicine began to dominate childbirth practices (47-48). The medicalization of birth practices has essentially taken birth away from women; it is no longer part of women's domain. According to Ellen Lazarus (1997) women "feel responsible for the events of birth but they in fact have only limited influence over the medical procedures" (132). People know some medical information; however, the extent of their knowledge varies as they learn through life experiences. As is seen in the doctor-patient relationship, power dominates, thus the patient becomes dependent on a physician's knowledge and decisions.

Women want to feel in control of their childbirth experience and therefore, they want the freedom to make decisions about childbirth practices. However, this was not the situation for most of the participants in this study. 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 their obstetrical care. This was contrary to their desire to be active participants in their care. Ivy Bourgeault, Cecilia Benoit and Robbie Davis-Floyd 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" (2004: 8).

Mi'kmaq women in this research described instances where they received childbirth information from the community health nurse. These participants found the information useful in preparing them for labour and delivery. They respected and valued her knowledge and did not hesitate to contact her about health related issues. Supportive care is a large part of the care that nurses give to patients (Miltner, 2002: 760).

Effectiveness of Care

Health care encounters and the politics that shape these encounters for First Nations women are important to examine as they represent and construct social, economic, political and philosophical relations (Browne and Fiske, 2001: 126). Clinical practice environments are common arenas for experiencing cultural encounters, where a dominant group provides health care to a minority population (Browne and Fiske, 2001: 126). John O'Neil (1986) points out that the relationship between Aboriginal communities and the dominant culture has evolved as a result of colonialism (120). Robert Yazzie (2000) eloquently describes colonialism as a "triangle of power in which people at the top claim they have the right to control the bottom" (43). 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 that 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: 205; Ford and Wagner, 2004: 246). They use paternalistic strategies such as persuasion or coercion as a means of influencing clients to think that the dominant society's teachings are superior. Josephine Enang (1999) claims, "there is a tendency for many professionals to assume ethno-cultural minority groups are irrational, primitive and less scientific" (131). John Macionis and Linda Geber (2002) suggest that much of the misunderstanding occurs as a result of misinterpreting Darwin's theory on evolution (112). 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 with the result that less technology based societies were viewed as being less human (112). Unfortunately, such ethnocentric thinking helped rationalize global colonialism.

Neocolonalism, meaning "new forms of colonial ideology," are deeply rooted in health care practices such as racism in health care facilities, thus limiting opportunities for access to heath care, education and economics prospects (Browne and Fiske, 2001: 126; Browne and Smye, 2002: 30). Although neocolonism may not be as overtly evident as older colonial practices, these racial practices still exist in health care institutions. Culturally 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.

Birthing a baby in a health care facility where women and their families do not feel supported and cared for is contrary to the philosophy of family-centered care adopted by many health care facilities. Willis remarks, "family-centered care can only be provided within the client's cultural system of values, beliefs and life ways" (1999: 56). The family-centered maternity care approach acknowledges the importance of family beliefs and values and a primary concern is the participation of parents and families in planning care in a manner that is empowering (Zwelling and Phillips, 2001: 5). Although some Mi'kmaq participants described their labour and delivery care as supportive, others felt isolated and alone, and relied on family during hospitalization. In this research, it is evident that they value family support and view it as an integral part of the childbirth experience. However, participants' lack of control regarding the presence and involvement of family members was often lacking for Mi'kmaq women delivering in a non-Aboriginal health care setting.

Although there were instances when participants described not feeling supported and respected during childbirth, eight Mi'kmaq women participants responded that the hospital was the ideal place to deliver their baby. Some Mi'kmaq women described that many of the nurses genuinely cared about them and their babies. One participant, who was admitted to hospital in the last month of pregnancy for gestational diabetes and hypertension, spoke about a maternity nurse who brought her ten videotapes from home to view. This nurse was concerned about the participant 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."

Language barriers between health care providers and clients can also affect care, even when the client and health care provider speak the same language (Andrews and Boyle, 1995: 70). It may be that both have different and unexplored understandings. Mi'kmaq women identified language as a barrier to communicating with health care professionals and some described the challenges posed by not being able to speak English fluently.

Being aware of the power relations and social positions between care providers and clients is essential (Grant, Giddings, and Beale, 2005: 500). Clients are considered vulnerable in health care institutions and this vulnerability affects their hospital experience. Barbara Grant, Lynne Giddings, and Jenny Beale comment that the "social justice discourse of nursing care" that is part of nursing education in Aotearoa, New Zealand includes cultural safety (2005: 500). According to Joan Anderson, Joanne Perry, Connie Blue, et al. (2003: 197) and Vicki Smye and Annette Browne (2002: 46), cultural safety is a concept that originated from Indigenous Maori nurse leaders in New Zealand. It was conceptualized 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 of New Zealand and White settlers" (Anderson et al., 2003: 197). Cultural safety enables clients to identify the care they prefer to receive and it includes many social aspects including gender, socioeconomic status, age, religion, ethnicity, and others (Grant, Giddings, and Beale 500). A similar education system ensuring cultural safety is a consideration for the Canadian health care system that would be particularly beneficial for Mi'kmaq women during childbirth.

Marginalization of Mi'kmaq women

Social, political, and economic factors create barriers for Aboriginal women from receiving the same health care privileges as other women in Canadian society. Aboriginal peoples have suffered stress for many years as a result of the social, cultural, political and economic strain of colonization (Bartlett, 2003: 166). Bartlett claims that Aboriginal peoples "are products of forced acculturation." Understanding the stresses that they have endured may assist with developing more appropriate cultural models, rather than forcing Western programs that have not been historically useful for them (Bartlett, 2003: 166). Along with the burden of colonization, Mi'kmaq women, like all women, experience marginalization within the context of patriarchal society.

Joanne Hall, Patricia Stevens, and Afat Meleis define marginalization "as the process where persons are peripheralized on the basis of their identities, associations, experiences, and environments" (1994: 25). Having no voice is one of the main properties of marginalization. Evidence of marginalization was observed in this research as many of the Mi'kmaq women participants did not feel their voices were heard during their childbirth experience. Hall, Stevens, and Meleis explain 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 (31). 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.

To gain a more in-depth understanding of marginalization, bell hooks, an African American feminist writer, teacher, and scholar offers insights about racism, sexism, and classism. hooks describes her own personal encounters of being ignored, misunderstood, treated with disrespect, silenced, and dehumanized (1989: 30-31). Although hook's research originates from her own lived experience and those of other Black women, there are some similarities with the experiences of racism, sexism and classism experienced by the Mi'kmaq women in this research. For example, one participant had difficulty convincing the nurses in the hospital that she was in labor. Despite being in early labour, her efforts were unsuccessful and she was sent home. She felt misunderstood and frustrated that she was forced to endure a 45-minute drive back to her community before returning to the hospital again. Another participant reported

that the nurses would not say hi to her in the hospital. She felt ignored, disrespected, and devalued. Another participant recalled the doctor "telling her off." She felt powerless and disrespected. Many who are affected by domination experience these encounters and feelings.

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, Stevens, and Meleis claim that marginalized environments may lack access to appropriate health care resources (1994: 34). 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: 4.5-4.6).

Some Mi'kmaq women felt uncomfortable asking the nurses questions because they were perceived to be too busy. Other participants reported that nurses and physicians did not listen to them and sometimes even ignored them. As a result, some participants chose to limit their communication with health care providers. Such behaviour illustrates a problem that oppressed people encounter situations where options are often reduced to a small choice with consequences (Frye, 1983: 2-3). Joanne Hall, Patricia E. Stevens, and Afat I. Meleis (1994) note that marginalized people are often silenced in the dominant society (31). bell hooks provides additional insight about silence from a feminist perspective and points out that "within feminist circles, silence is often seen as the sexist 'right speech' of womanhood - the sign of woman's submission to patriarchal authority" (1989: 6). That nursing is primarily a woman's occupation raises a challenge for nurses if they are to provide sensitive care to marginalized patient populations such as Mi'kmaq women.

hooks (1989) points out that people of colour around the world, including Black women in the United States and South Africa, experience the "pain of white supremacy, oppression and exploitation that comes from resistance and struggles" (112). The introduction of social policies, which were thought to end racism, ironically has served to perpetuate white supremacy. Racism is often further complicated by its intersection with gender issues (Spitzer, 2005: S80). In addition to the discrimination caused by gender, some women belong to a minority race, which causes them further discrimination. For instance, racism often results in denying minority women such as Black and Aboriginal women equal access to health care and health education. Although the resulting health disparities vary and are complex, racism plays a significant role and must be considered a feasible determinant of health in the lives of minority women (WHIWH, 2003: 4). Although racism was not explicitly named by the women who participated in this study, our analysis of these women's stories suggest that racism, especially at the systemic level, may be responsible for some of the barriers faced by these women. For example, comments from the participants suggest that racism and classism may have created obstacles to their receiving respectful, high-quality care and adequate education about childbirth.

While listening to the birthing stories of participants, the researcher realized that women were not simply recalling their experiences, but reliving them. Some women were teary-eyed and others looked sad. These findings in this research are congruent with those of (Simpkin, 1991: 209) who described how first-time mothers relived their birth stories. Simpkin concluded that the manner in which women are cared for during childbirth by health care providers may stay with them forever (210). The importance of providing culturally respectful and loving care cannot be underestimated.

Marcia Hills and Jennifer 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 (85). Some Mi'kmaq women in this research suggested improvements in policies and procedures to promote equal access to health care, culturally competent care, engaging the women in the dialogue around childbirth practices and involving them in future research projects are some ways to help address the findings from the study. Although the words policy and procedure were not spoken, recommendations for change were implicit in their stories as they spoke about the need for better access to health care in their own community and for more information about labour and delivery and medical conditions such as gestational diabetes and hypertension. The women also recognized that change was needed if they were to receive culturally sensitive and respectful care. Such findings regarding needed improvements in policies and procedures are similar to those reported by Enang in a study of the childbirth experiences of Nova Scotia African women.

Hall, Stevens, and Meleis (1994) propose that since marginalized persons have been silenced by mainstream society, nurses need to identify other ways of capturing their expressions (35). Gaining knowledge through feelings instead of words, verbal actions rather than textbooks, and caring, rather than seeking solutions to questions, may be effective strategies. Because marginalized people often use narratives to tell their stories, Hall, Steven and Meleis suggest that dialogue is a much more effective way of learning about a person's culture as compared to structured questionnaires (38). The following sections on education, clinical practice and research highlight ways to address many of the concerns identified by the Mi'kmaq women in this study.

Implications for education

Since Canada represents a multicultural society (Potter et al., 2006: 128), educational standards need to include cultural diversity and culturally competent care. Several implications for education arise from this research: (1) Emphasis needs to be placed on increasing minority students in educational programs, particularly in the health professions. (2) Childbirth education should be designed to reflect the unique needs of Mi'kmaq women and their families. (3) Prenatal educational materials need to be available in the Mi'kmaq language and contain images of Aboriginal women. (4) More education in

the area of gender/women's studies and social justice would assist nurses to develop a critical social practice. (5) A greater emphasis on cultural diversity and knowledge and skill development is needed to enable nurses and other health care professionals to work with diverse patient populations in ways that are respectful, comfortable, and culturally safe.

Implications for clinical tractice

Implications for clinical practice include the importance of providing culturally competent care. Changes in current health policies and procedures in health care settings are needed to delivery culturally competent health care to Mi'kmaq women and their families. A cultural assessment, which is a means of assessing and examining oneself, another individual, family or community, is essential. Health care providers need to understand their own cultural lens in order to understand how other view the world. In addition, recognizing the effectiveness of listening and demonstrating genuine care can make a significant difference in the level of trust and collaboration in the nurse/client relationship. The findings of this study highlight the importance of nurses' providing supportive care during the birthing experience. Family, friends and health care providers play a significant role during childbirth. Some participants recommended that interpreters be present during the birthing experience so that someone familiar with Mi'kmaq culture could provide more in-depth explanations about medical procedures and nursing care.

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 help-ful to include women from other Mi'kmaq communities in Nova Scotia to gain a broader perspective. They need to be active participants in their care. Although some participants stated they would prefer to deliver in a hospital to ensure the physical safety of their babies 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 their community, attended by competent nurses, physicians and/or midwives. Also, additional research is required to determine whether Mi'kmaq women prefer informal or formal prenatal classes since there were differing views on this point.

Another recommendation for further research would be to explore with health care professionals their perspective of culturally competent care. Increasing one's consciousness of cultural diversity increases the chances that health care providers will provide culturally competent care (Purnell, 2005: 7).

Conclusion

There are a number of challenges associated with multiculturalism in health care. One challenge that has been identified by Smith (1998: 61) 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 the manner in which they think and react to situations. The challenge is to learn to interact in an effective manner that demonstrates cultural competence to people of diverse cultures.

Health care providers must understand health from the perspective of clients (Spector, 2004: 53). Being insensitive to clients' views on health only perpetuates misunderstanding and creates barriers to health (Spector, 2004: 53). 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: 317; Baker and Daigle, 2000: 22).

In this research, Mi'kmaq women did not consistently receive culturally sensitive care during childbirth. This is a significant barrier to health care. As first time mothers, participants often did not know what to expect during childbirth. Having said this, they did expect healthcare professionals to be caring and respectful of them. Comforting and supporting interventions would have made a difference between a satisfying birth experience as opposed to one that was frightening and disappointing as voiced by some of the participants. As pointed out by Patricia Hawley "Nurses are supposed to alleviate discomfort, not inflict it" (2000: 20).

All health care professionals are trained to provide the best possible medical care based on current research evidence. However, many are less proficient in understanding societal issues that create barriers to women receiving appropriate childbirth care. Judith Wuest (1993) suggests, "women's health can only be understood within the context of their lived experience of social inequity, medicalization, and family caregiving" (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, 1993: 407). Health policy changes will only be effective and meaningful if Mi'kmaq people have an active role to play in the research process and share in the work of identifying and developing strategies to eliminate barriers to health and health care. Improved access to health care can be achieved by working together collaboratively with communities to address cultural issues (Spector, 2004: 7).

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