

First Nations women's experiences with perinatal care in Northern Manitoba

by

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### Abstract

**Problem:** First Nations women living in rural or remote communities in Canada are often required to leave their communities for perinatal care due to Health Canada's Evacuation Policy. Forced evacuation disrupts traditional birthing practices and knowledge transfer and has numerous adverse effects on First Nations women, children, families, and communities. In Northern Manitoba, a large proportion of First Nations women have to travel more than two hours to give birth, and many experience a lack of choice regarding their perinatal health care, while the care available is often fragmented and culturally unsafe.

**Methods:** This study was guided by a Two-Eyed Seeing framework and utilized Sharing Circles, an Indigenous practice used in research. I gathered the stories of First Nations mothers and Elders from Northern Manitoba as they shared their experiences of accessing care during the perinatal period. I also gathered their recommendations for changes to the perinatal care system in Northern Manitoba. Due to feasibility issues, most participants shared their stories in a one-on-one, conversational method.

**Results:** Two mothers and three Elders from Northern Manitoba shared their stories and experiences with perinatal care. The women who were able to utilize traditional birthing practices spoke positively of these experiences, while the experiences shared about the Western medical system were largely negative. The participants also shared teachings, recommendations, and advice for First Nations mothers and for changes that can be made to the perinatal care system in Northern Manitoba to better support First Nations women and deliver more appropriate, culturally safe care.

**Conclusions:** The perinatal care experience of many First Nations women in Northern Manitoba continues to be defined by lack of choice, communication, and support, long periods of forced travel away from community resulting in isolation and disconnection, and experiences of racism and culturally unsafe care. In order for perinatal care to be culturally safe and centred around women and

families, governments, policy-makers, and health care providers must privilege the knowledges and experiences of First Nations women and families, and work with First Nations communities in their efforts to incorporate midwifery and traditional birthing practices and return birth to communities.

## Acknowledgments

I would like to express my deepest gratitude to the women who took the time to share their stories and experiences to help future generations of women. Their time and their stories are such a gift, and I feel lucky to have worked with them all. I am forever grateful to Susan Kobliski (Grandmother Bear Woman), who has acted as a teacher, a partner in facilitating the Sharing Circles, a friend, a participant, and an honorary Kookum to my son. Susan's time, knowledge, advice, and love that she has shared is invaluable, and I'm so grateful to have her in my life. This work would not have been possible without the tremendous amount of guidance and support that she provided. I cannot thank my advisor, Dr. Nathan Nickel, enough for his unwavering support and encouragement throughout my degree, including my parental leave. He has taught me so much and has made my experience in graduate studies a very positive one. I look forward to continuing to work with and learn from him. Thank you to my committee for their time and guidance, I'm lucky to have such brilliant people supporting me and providing me with a wealth of knowledge to draw from. I would also like to express my heartfelt gratitude to the Grandmother's Circle who advised the larger project and myself, lending their important knowledge, advice, and support to ensure that we were consistently focusing on what was best for mothers and how we could conduct this work in a Good Way. I would also like to take a moment to acknowledge Esther Sanderson, who we miss greatly and whose memory lives on in all the work that she contributed to and the mothers she has and will continue to help with the knowledge that she shared. I am also grateful to scholars, particularly Indigenous scholars, who have fought against outdated and rigid institutional rules to create an academic space that is more accepting of knowledges and practices different from the Western colonial academic system. Before these challenges to the system, certain aspects of my project, such as participants being able to identify themselves by name in the study, may not have been as readily allowed. To my family, I cannot thank you all enough for your unwavering love and

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## **Dedication**

This thesis is dedicated to the First Nations women in Northern Manitoba who shared their stories, teachings, and advice in order to help future generations of First Nations families receive the type of parent- and family-centred culturally safe perinatal care that everyone deserves. Susan Kobliski (Grandmother Bear Woman), Kitana Garson, Bella Flett, Phyllis Hart, and Participant 5 – thank you.

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*“The act of Indigenous birth is, at its core, an act of radical love – an affirmation of Indigenous family resilience, of Indigenous peoples’ continued presence on these lands, and of Indigenous peoples’ strength and futurity.”<sup>1</sup>*

### **Prologue: Positionality Statement**

I am a white settler born in and living in Treaty 1 Territory and the Homeland of the Red River Métis. I am descended from settlers who came to Canada from Europe and the United Kingdom. I am a daughter, sister, cousin, niece, aunt, wife, and mother, married to a Métis man from The Pas, Manitoba, and we have a young son who is also Métis. I am currently expecting our second child, and we hope to raise our children with a strong connection to the many families and communities from which they are descended. I am influenced by the privilege that I have experienced growing up as a white settler in a society built on colonial systems. To do this work in a good way, I must constantly reflect on my experiences in these systems that cause so much harm to others, as my experiences and my white privilege influence the way that I view this work. To this end, I must also dedicate myself to listening to and learning from Indigenous individuals who must navigate the systemic injustices inherent in our current society. My experience becoming a mother and navigating pregnancy, labour, and birth as a white person in a Western medical system starkly demonstrated to me the privilege with which white bodies move through systems designed with them in mind, and the unacceptable disparities in perinatal care experiences that First Nations birthing parents in our province (and nationally) face.

My interest in working with First Nations families in Northern Manitoba began during my undergraduate degree when I conducted a literature review on Canada’s Evacuation Policy and the barriers faced by First Nations birthing parents from rural and remote communities when accessing perinatal care. My work in this area has also been influenced by the experiences that my partner has

shared with me related to growing up in Northern Manitoba, and the experiences that his family had working within the health care system in the Northern Health Region. I have been fortunate enough to be part of the *Facilitating transitions* team research project throughout my time in the Master of Science program, where I learned so much over the past five years about the unique health care experiences of Indigenous birthing parents navigating our current colonial system. I feel privileged to have worked with the Grandmothers Circle, who were integral to advising the work of the research team and to my thesis work. Their guidance, advice, and the dedication and love with which they advocate for First Nations birthing parents are invaluable. Throughout this project, I have been dedicated to conducting this work in a good way, in partnership with First Nations women, guided by their expertise and knowledge as they share their stories. I'm grateful for this learning journey, and I hope to continue contributing in any way that I can to improving health care for First Nations families in Manitoba. Throughout this written thesis, as I did throughout the research itself, I will continuously reflect on my positionality and how it affects my viewpoint and, by extension, the research presented.

## Chapter 1: Study Background

### Overview

Although the existing literature mostly uses the terms “women” and “mothers,” in order to be more inclusive, I have incorporated the term “birthing parent” throughout this thesis where appropriate, except when speaking directly about participants who identified themselves as mothers and grandmothers or reporting statistics that specifically refer to those who identify as women. In Canada, Indigenous Peoples (referred to as Aboriginal Peoples in some studies and reports) include three distinct cultural groups: First Nations, Métis, and Inuit.<sup>2</sup> The 2021 Canadian Census reported the population of Indigenous females in Canada to be 929,605, with 541,890 of those women and girls identifying as First Nations; in Manitoba, the total female Indigenous population was reported as 121,600, with 69,660 women and girls identifying as First Nations.<sup>3</sup> 26.7% of Indigenous women and girls in Canada live in areas classified as remote or very remote.<sup>4</sup> In Manitoba, a much higher percentage of First Nations women in Northern Manitoba live in rural areas compared to Southern Manitoba.<sup>4</sup> Although in terms of land mass Canada is the second largest country in the world, it has one of the lowest population densities, with the majority of the population located in the Southern part of the country; combined with financial constraints, the delivery of health care services is more centralized in locations with a higher population density, leading to health care accessibility challenges for rural and remote areas.<sup>5</sup> Birthing parents who live in rural and remote areas have higher birth rates than those living in urban areas, and many face unique barriers when trying to access health care during pregnancy.<sup>6,7</sup> Living in a rural or Northern region in Manitoba is associated with inadequate use of prenatal care due to factors such as limited access to health care services and providers and longer travel distances to access care.<sup>8</sup> In addition to these barriers, Indigenous birthing parents and babies in Canada also experience a higher number of adverse birth outcomes

compared with Canada's non-Indigenous population, including preterm births, large-for-gestational-age births, stillbirth, neonatal death, infant death, and postnatal death.<sup>9</sup> In Manitoba, the mortality rate of First Nations infants is double the mortality rate of non-First Nations infants.<sup>2</sup> Indigenous birthing parents in Canada experience higher rates of maternal mortality and clinical complications during pregnancy, and birthing parents living in rural areas experience higher rates of severe maternal morbidity (including eclampsia, obstetric embolism, uterine rupture or dehiscence, and blood transfusion) and hospital readmission.<sup>10,11</sup> In Canada, “[t]he disproportionate rates of adverse health outcomes in First Nations populations are rooted in a wide range of factors, including the legacy of colonization, fragmented health care delivery, geographical remoteness, poverty, inadequate housing, residential school experiences, behavioural risk factors, and challenges to self-governance.”<sup>12</sup>

Although First Nations birthing parents have spent nearly their entire history giving birth in their communities, Health Canada's current Evacuation Policy (common practice since the 1960s, expanded upon in the section titled *Evacuation Policy Overview*) requires many of them to leave their families and communities for labour and birth.<sup>2,13</sup> Risk factors for many adverse birth outcomes experienced by Indigenous birthing parents and babies in Canada include inadequate prenatal care, living in rural or remote communities, and stress due to evacuation for labour and birth.<sup>1,2,4-6,9,11,13-30</sup> The Evacuation Policy has been reported to have far-reaching consequences for First Nations families and communities and is associated with many negative experiences.<sup>2,31</sup> First Nations birthing parents who live in rural or remote regions of Manitoba are currently evacuated to three urban centres for labour and birth: Winnipeg, The Pas, and Thompson.<sup>2</sup> Although there are currently instruments designed to capture birthing parents' experiences with perinatal care, some specific to Canada and even to parents in rural communities in Canada, there is currently no validated instrument explicitly designed to measure Indigenous birthing parents' experiences with perinatal

health care; these experiences include many unique barriers and facilitators to accessing high-quality perinatal care.<sup>32–35</sup>

## **Problem Statement**

Throughout history, First Nations birthing parents in Canada have given birth on the land.<sup>2</sup> As far back as 1892, efforts to eradicate traditional maternal health care practices, pre-contact medicines, midwifery, and ceremonies began, with the intent to transfer labour and birth into a Western hospital setting.<sup>2</sup> Currently, across Canada, First Nations birthing parents living on rural and remote reserves are required to leave their communities during pregnancy to access health care for labour and birth in an urban centre; this is due to Health Canada’s Evacuation Policy (also referred to as the “out for confinement policy”).<sup>2,18,36,37</sup>

The Evacuation Policy was said to have arisen from concern for the health and well-being of First Nations and as a way to mitigate risks associated with birth.<sup>1,22</sup> However, the real goal of the policy was to “civilize” and assimilate First Nations women.<sup>22</sup> These forced evacuations result in the “breakup of families, the loss of community knowledge about birth, and health problems [for] women who must sit in southern cities waiting to go into labour, with strange food, little exercise, and no family support.”<sup>1</sup> There are numerous and far-reaching adverse effects on the physical, mental, emotional, social, and financial well-being of First Nations birthing parents, infants, families, and communities related to the Evacuation Policy.<sup>1,2,4–6,9,11,13–30</sup> These effects are detailed in the *Effects of Evacuation Policy* section.

My research is embedded within a team research project funded through a grant from the Canadian Institutes of Health Research (CIHR), titled *Facilitating transitions and access across the pregnancy continuum of care – A Health System Intervention for Indigenous Women Living in Northern Manitoba*. This research project is working to address the many barriers faced by Indigenous birthing parents in Northern Manitoba when trying to access health care during pregnancy, birth, and the year following

birth. Understanding birthing parents' experiences with the health care system during pregnancy, birth, and the postpartum period is critical for developing parent- and family-centred perinatal services. This study was designed in consultation with my advisor, the leadership PI team, community members collaborating on this team grant, and my committee to address this need.

In this study, I have worked to incorporate both Indigenous and Western ways of knowing using a Two-Eyed Seeing approach and Indigenous research methodology to gain a deeper understanding of the experiences of First Nations birthing parents living in Northern Manitoba with perinatal health care. Indigenous epistemologies involve ethics and spirituality connected to relationships, emphasizing relationships over one objective reality and including multiple sources and types of knowledge.<sup>38,39</sup> An Indigenous research methodology focuses on relational accountability, that is, whether the researcher is answering to *all their relations* when carrying out their research, focusing on their obligations and role in the research relationship.<sup>39</sup> These concepts and how I incorporated them into this thesis study are expanded upon in the *Indigenous Methodology* section in Chapter 2. I utilized the Indigenous method of Sharing Circles and, due to feasibility challenges, I also used a more conversational, one-on-one data collection method with First Nations mothers and Elders from Northern Manitoba. The conversational research method developed out of storytelling, and although it is found in Western research, in Indigenous research, it usually involves a decolonizing purpose, relationality, flexibility, reflexivity, and collaboration.<sup>40</sup> Research methods such as Sharing Circles or personal narratives/storytelling fit within the importance of relationships critical in Indigenous epistemologies.<sup>39</sup> Participants shared their experiences with health care during pregnancy, birth, and the year following birth and the related effects on birthing parents, children, families, and communities. The information shared during these Circles will inform changes to a patient-reported experience measures (PREMs) instrument created as part of a larger team grant (Appendix A). My study and the grant out of which it is being built are integrated with

the Northern Health Region, the Keewatin Tribal Council, Opaskwayak Health Authority, Keewatinohk Inniniw Minoyawin Inc., Wiji'idiwag Ikwewag, and First Nations communities located in Northern Manitoba as key partners (Appendix B). By documenting First Nations mothers' stories in partnership with these organizations, the stories shared in this study and the information gathered using the PREMs instruments will be returned to the health care system immediately. In this way, the results from my study and the larger grant will be able to inform positive changes in pregnancy care in a timely manner, contributing to improvements in maternal and birth outcomes, which in turn can improve the health of First Nations birthing parents, children, families, and communities in Northern Manitoba.

## **Literature Review**

### ***Life Before Colonization***

In Canada, most Indigenous cultures were traditionally matrilineal, with women having considerable influence in their communities; as life-givers, advisors, and teachers, women were highly respected and influential members of society.<sup>25,41</sup> Being “born of the land” is a meaningful part of First Nations identity, fostering a relationship and a responsibility to the land; before European contact in Canada, First Nation birthing parents gave birth in their homes or other locations in their communities.<sup>2,13,23</sup> During labour and birth, birthing parents were assisted by community members, including relatives, friends, midwives, Elders, or neighbours.<sup>17,22</sup> Midwives would use knowledge and practices rooted in culture while supporting birthing parents through pregnancy and birth.<sup>10</sup> Traditional cultural practices and ceremonies related to birth “established strong community roots for the mother, her infant, and the family,” positively influenced children’s sense of identity, and strengthened relationships among families and communities.<sup>13,17,22</sup>

Traditionally, First Nations peoples’ relationships with their families and communities were crucial

for the individual's, family's, and community's overall health, as these close relationships promoted healthy activities and behaviours.<sup>23</sup> The birth of a baby was also seen not only as an addition to the community but as a symbol of growth and the community's future, as well as a reinforcement of the essential and honoured role that First Nations women had as the "bearer[s] of life and nourisher[s] of all generations."<sup>22</sup>

### ***Historical Context of Colonialism in Canada***

The health of Canada's Indigenous Peoples, including physical and mental health outcomes as well as health care, must be discussed within an understanding of both the historical and modern contexts of colonization, including structural barriers, systemic racism, and destruction of resources; when speaking specifically about Indigenous women, this also includes gender discrimination and subordination.<sup>14,27,30</sup> Indigenous Canadians have been significantly impacted by colonial policies and actions that include The Indian Act, forced relocation of reserves to land with fewer natural resources, the "pass system" to restrict mobility, residential schools, the marginalization and criminalization of spiritual beliefs and languages, the destruction of land, and racial discrimination.<sup>14,23,25,42,43</sup>

There are many gendered impacts of colonialism that specifically affect Indigenous maternity care and mothering.<sup>14</sup> According to Brown et al. (2011), "deep-rooted practices of gender subordination combined with destruction of economic and cultural resources intersect in ways that silence and oppress Aboriginal women in all regions of Canada."<sup>14</sup> Colonialism eroded the roles and status of Indigenous women to be diminished in favour of a more patriarchal society in which men were granted sole control over community leadership and land, forced labour and birth into a medicalized field dominated by male doctors, and increased levels of sexism and violence against Indigenous women.<sup>23,25,41,44</sup> As Tabobondung (2017) describes, "[b]ased on patriarchal beliefs, the Indian Act stripped away our natural right to mother our children and transmit our culture, which

values balance and the sacredness in all Creation and life, especially female life because of our own life-giving capabilities.”<sup>44</sup> While Indigenous women’s rights were being stripped away, the colonial state gave exclusive control over leadership and lands to Indigenous men, further eroding the existing balance in communities and increasing discrimination against Indigenous women.<sup>44</sup> The depiction of Indigenous birthing parents by the colonial state as inferior or unsuitable parents also began with colonization and continues today, with child welfare agencies playing an active role in the childbirth experience for many Indigenous families.<sup>36,41</sup> This depiction acts as a justification for the state to interfere in the pregnancies and births of Indigenous birthing parents, stripping them of their autonomy and, often, the right to parents their children and pass on their culture.<sup>41,44</sup> Colonization also works to undermine and erase traditional birthing knowledges and practices, forcing Indigenous labour and birth into a colonial medicalized field.<sup>14,44</sup> Forcing birth into Western hospitals creates a significant barrier to the control that birthing parents should have over their birth experience and makes it very difficult for First Nations birthing parents to utilize traditional medicines and birthing practices.<sup>18</sup> Another barrier to the use of traditional birthing knowledges was the disruption of the transfer of these knowledges in Residential schools; the devaluation of this knowledge by the colonial state led to many young Indigenous birthing parents viewing it as “superstitious and primitive.”<sup>44</sup>

Indigenous Peoples continue to face many barriers and inequities as a direct result of colonization and its lasting impacts, including disadvantages such as poor access to health care and social services resulting from a long history of systemic racism that persists to this day.<sup>27,30</sup> There are many inequities in the provision of perinatal health care between Indigenous and non-Indigenous people in Canada, and the care that is accessible is often not consistent or culturally safe.<sup>10,15,18,29,45–47</sup> Varcoe (2013) summarizes the history of the colonization of Indigenous birth practices, describing how Indigenous Peoples were told that their traditional practices, such as midwifery, were unsafe

and that they must utilize Western medical perinatal care practices; concurrently, Indigenous Peoples “observed steady erosion in those supposed safety advances to the point where some of their communities are now left with very little of either traditional or [W]estern birthing options.”<sup>29</sup>

Historical trauma, such as the trauma that Indigenous Peoples experienced and continue to experience as a result of colonialism, has been found to have significant impacts on health and well-being, resulting in effects such as mental illness, violence, suicide, and vulnerabilities related to sex, drugs, and alcohol.<sup>25,48</sup> According to Shahram (2017), “[c]olonization practices have altered and subsumed Indigenous women’s traditional social location, which has had enduring effects on their contemporary social status and health outcomes that continue to resonate in their lives today.”<sup>41</sup> In the face of these many inequities, Indigenous women around the world continue to fight for reproductive justice and for the right to make their own decisions surrounding reproductive health, childbirth, and parenting.<sup>1</sup>

### ***Evacuation Policy Overview***

The current funding and delivery of health care services for First Nations has often been described as a “patchwork,” as health care services for First Nations peoples living in remote and rural reserves are mostly delivered by the federal government and have an emphasis on primary care, while some are funded and delivered by provincial governments; some First Nations access on-reserve health care services, while others rely upon off-reserve, fee-for-services providers for primary care.<sup>2,18,49</sup> In Manitoba, prenatal services for First Nations birthing parents in rural and remote reserves are usually administered by community health nurses employed by the federal government to work at a community nursing station or health centre.<sup>5</sup> Health Canada’s current Evacuation Policy (or “out for confinement” policy) states that nurses employed by the Federal Government must “arrange for transfer to hospital for delivery at 36-38 weeks’ gestational age according to regional policy (sooner if a high-risk pregnancy).”<sup>2,18</sup> Evacuation for birth has been

common practice for First Nations birthing parents living on rural and remote reserves since the 1960s/1970s, and birthing parents evacuated to these urban centres are often separated from their families and support systems.<sup>15,23</sup> The move to medicalize labour and birth in Indigenous communities began as early as 1892 when an obstetrician was introduced into a reserve community, a practice that grew to include many reserve communities throughout the early 1900s.<sup>2</sup> The goal of this colonial practice was to “civilize and assimilate First Nations into a generic Canadian body,” and included coercing First Nations women into accepting these Western colonial medical practices by attacking the credibility of First Nations medicines, midwives, and ceremonies in a move to outlaw and destroy these traditions, instead making birthing parents give birth in hospitals.<sup>2,18,22</sup>

In 1935, Canada’s Dominion Council of Health outlined a policy recommending that all births be attended by a physician and a nurse, excluding traditional First Nations care providers, birthing practices, and birthing locations.<sup>22</sup> Until the post-WWII period, there was still a great deal of midwifery knowledge in Indigenous communities, and although knowledges, practices, and ceremonies associated with labour and birth differed across communities, “there is a general consensus of relatively safe and culturally-appropriate care.”<sup>15</sup> By the 1970s, the Evacuation Policy in place today began to take shape, with a push for hospital births and the evacuation of pregnant birthing parents from isolated northern communities in Canada to southern hospitals for labour and birth.<sup>1,18,28</sup> The evolution of the Evacuation Policy continued in the 1980s, when “the government pushed for all deliveries to occur in tertiary care centres, which were not always within the geographic area of the woman.”<sup>18,28</sup>

According to Vang et al. (2018), “routine childbirth evacuation has been criticized by Indigenous community members, activists, and some health care practitioners as a colonialist strategy that disregards and disrupts Indigenous knowledge, cultural practices, and health care approaches.” Having colonial health care services imposed upon them at the cost of a community

birth experience has resulted in a loss of self-determination and important cultural experiences for many Indigenous birthing parents in Canada.<sup>23,24</sup> Although all birthing parents who live in rural and remote communities removed from health services may have to travel for labour and birth, Indigenous birthing parents experience additional adverse effects, as leaving their communities and lands for birth conflicts with traditional practices and beliefs.<sup>18</sup> A comparison of all provinces in Canada found that in Manitoba, women in rural communities were most likely to spend more than two hours travelling to a hospital to deliver their babies, and in Manitoba's Northern Health Region, over half of women in rural communities had to travel more than two hours to deliver their babies.<sup>2</sup> Indigenous birthing parents are often not provided with sufficient information or support during their evacuation, and many have to wait alone for almost a month or more outside of their communities.<sup>2,5,21</sup>

### ***Effects of Evacuation Policy***

According to Lawford & Giles (2012b), “positive experiences with childbirth have been linked to increased competence and maternal attachment, whereas negative experiences can result in guilt, disappointment, feelings of failure, postpartum depression, and even posttraumatic stress disorder.”<sup>23</sup> There are also several positive effects associated with having a support person present throughout labour and birth, including higher satisfaction levels with the experience of birth, shorter labour times, and a decrease in the need for caesarean sections, forceps, analgesics, and oxytocin.<sup>50</sup> Despite the positive effects of having a support person present, it was only recently that the Government of Canada began providing funding for one support person, or ‘travel escort,’ to travel to urban centres and stay with expectant birthing parents.<sup>17,18</sup> However, prior studies have discussed how the “[e]rosion of local birthing capacity creates a ‘cascade of adverse consequences’ for mothers, babies, and entire communities.”<sup>29,51</sup> The Evacuation Policy, part of efforts to strip away birthing capacity from Indigenous communities, has had demonstrable adverse impacts on birthing

parents' experiences with birth, resulting in an overall negative experience for many Indigenous birthing parents in Canada.

Indigenous birthing parents often experience a lack of choice in health care, racism while accessing health care, adverse birth outcomes, and physical, emotional, social, financial, and cultural stress when evacuated for labour and birth.<sup>14,16,17,21,25</sup> Many factors created and perpetuated by colonization can have negative impacts on pregnancies and birth outcomes, including socioeconomic factors, stress, anxiety, teenage pregnancy, and high rates of sexually transmitted infections and reproductive tract infections.<sup>17,18,20,21,25,27,29,30</sup> Pregnancies among Indigenous birthing parents are often high risk with complicated deliveries, high rates of premature birth, teenage pregnancy (associated with prematurity and low birth weight) and high rates of maternal mortality.<sup>25,30</sup> Studies have shown that Indigenous women in Canada have a maternal mortality risk that is two times greater than Canada's general population.<sup>25</sup> Rural residence has been associated with higher hospital readmission rates and severe perinatal and maternal morbidity, including eclampsia, obstetric embolism, uterine rupture or dehiscence, and the need for blood transfusion.<sup>6,11</sup>

As a result of the Evacuation Policy, First Nations birthing parents who travel for birth have reported experiences of racism and discrimination, lack of choice regarding care, disconnected and poor-quality care, disruption of mother-infant bonding and family dynamics, loneliness, isolation, and loss of community knowledge and cultural practices.<sup>1,2,14,19,21,25,27,29</sup> Indigenous birthing parents experience higher rates of postpartum depression than average and report feeling loneliness, anger, guilt, fear, worry, and disconnection linked to evacuation, separation from their other children, and lack of access to family and community support.<sup>5,6,29,30</sup> The lack of availability of regular maternity care in First Nations communities often leads to discontinuity of care and has been connected to stress, anxiety, and other adverse outcomes; having to travel more than one hour for maternity care has been found to increase women's stress by a factor of seven.<sup>5,20</sup> Many Indigenous birthing parents

have spoken of poor relationships with perinatal health care providers, often reporting that they feel judged, dismissed, and discriminated against; these relationships affect birthing parents' experiences and birth outcomes.<sup>27-29,47</sup> In addition, there are many stories of Indigenous women being made to labour and birth in a hospital and then having their infant apprehended and placed into the care of child protection following birth; this is a grim reminder of another group of risk factors, “the psychological and emotional risks associated with a loss of freedom over one’s body; the risk of losing one’s child to the system; the risk of cultural erasure and identity loss for mother and child.”<sup>1</sup>

According to Smylie et al. (2010), “the health of a nation’s infants is understood to be an important upstream indicator of the health of the population more generally, as well as a reflection of underlying social determinants of health.”<sup>26</sup> Significant disparities in birth outcomes between Indigenous and non-Indigenous Peoples exist in Canada, the United States, Australia, and New Zealand.<sup>16,26</sup> First Nations infants experience high rates of many adverse health outcomes, such as a higher rate of infant mortality, stillbirth, low- and high-birthweight, prematurity, and large-for-gestational-age.<sup>5,12,25,30</sup> In Canada, First Nations peoples experience infant mortality rates between two and four times higher than that of the general Canadian population; a second study stated that this high infant mortality rate is likely connected to gaps in access to local birthing services.<sup>2,30</sup> Among birthing parents living in Canada’s rural areas, having to travel more than two hours for labour and birth has been associated with higher rates of large-for-gestational-age births and preterm births.<sup>6</sup>

The Evacuation Policy also has several adverse effects on First Nations families and communities. Many First Nations families experience financial stress and disruption of family relationships when birthing parents are evacuated for birth, and studies have found adverse effects on children who have to be separated from their parents due to evacuation.<sup>13,20,23,25,29</sup> Evacuation for birth creates costs for families, communities, and the federal government; although some of the

costs of giving birth outside of the community are covered by band councils or by the government, there are additional costs that fall to the family, including the cost of paying for childcare or a loss of income if partners take time off work to watch their other children or to travel with birthing parents for birth.<sup>13,25</sup> There are additional costs for accommodation away from home and associated fees such as food, phone calls, and internet.<sup>15,17,21</sup> Birthing parents who are evacuated for birth are often separated from their other children, which leads to stress for both the parents and children; this separation and stress can lead to higher rates of illness and anxiety among family members and associated school problems in children.<sup>21,23</sup>

Stressful birth experiences have been connected to a disruption of the mother-child relationship. Ireland et al. (2019) stated that “maternal distress is known to adversely impact the hormonal physiology of normal childbirth and early mother crafting instincts and thus contributes to poorer maternal and infant outcomes.”<sup>19</sup> For single birthing parents, there is additional stress associated with leaving children at home when being evacuated for birth, and there have been cases of parents having to temporarily sign their children into care when they are evacuated because they have no one else who can stay with their children.<sup>17</sup> The removal of birthing services to urban centres impacts First Nations communities due to the resulting loss of cultural practices, teachings, knowledge transmission, ceremonies, and celebrations, and putting financial strain on many communities in supporting birthing parents who are evacuated for birth.<sup>2,13,17,29</sup> Celebrating the joy of childbirth is important to First Nations families and communities, and the disruption of this due to evacuation for birth “has left a significant cultural gap.”<sup>2,25</sup>

### ***Gaps in the Literature***

During my literature review, I discovered several gaps in the literature that my study, in partnership with the larger team project, will begin to address. The first gap relates to the small number of studies in the area of perinatal care for First Nations birthing parents that utilize

Indigenous research methods. There is also a gap in current instruments designed to capture perinatal care quality or experiences and the lack of items addressing the unique challenges faced by First Nations birthing parents in Canada when accessing perinatal care.

Several studies on the birth experience of Indigenous birthing parents living in rural and remote areas have been conducted, utilizing various research methods, including surveys, interviews, focus groups, and participant observation.<sup>2,5,14,21,24,28,29,31,47,52</sup> Cidro et al. (2021) used a ‘conversational’ interview method when speaking to members of Indigenous doula collectives from across Canada, Wiscombe (2020) conducted a case study of culturally safe prenatal care in the inner city of Winnipeg and used Indigenous research paradigms, and Leason (2021) conducted research on the maternity narratives of Indigenous mothers in British Columbia that focused on wholistic perinatal wellness, strengths, and epistemologies of mothering, and utilized semistructured, one-on-one interviews.<sup>53–55</sup> However, I could not find any studies that specifically utilized Sharing Circles or Indigenous research methods with First Nations birthing parents in Northern Manitoba, which leaves a gap in this area of research. These existing studies also overwhelmingly utilized data analysis methods such as thematic analysis, presenting findings as themes with supporting quotes from interviews or focus groups while leaving out a complete picture of each participant’s story, which does not always capture experiences holistically. I am designing my research to include Indigenous research methods and a data analysis plan that will move away from fragmenting and decontextualizing stories, which is expanded upon in the *Methods* section of this proposal.<sup>56–58</sup>

The Quality of Prenatal Care Questionnaire (QPCQ) is a Canadian instrument developed and tested by Heaman et al. in 2014, designed to be completed by women and to measure prenatal care quality.<sup>32</sup> While the item reduction, validity and reliability, and temporal testing phases of the instrument development included some Indigenous participants and took place across several study sites that “provided a broad cross-section of the childbearing population in Canada and its

multicultural uniqueness,” the instrument does not address the unique challenges that First Nations birthing parents in Canada face in accessing perinatal care.<sup>32</sup> The Rural Pregnancy Experience Scale is an instrument designed to assess worry and concerns related to the anxiety and stress surrounding pregnancy and birth experienced by pregnant women living in rural areas.<sup>33</sup> Although this instrument does capture some of the same dimensions as the PREMs instrument from the team project that this study will inform, and the development and testing of the instrument did include a few Indigenous participants, it does not include many of the unique barriers and stressors experienced by First Nations birthing parents, such as experiences of racism and lack of access to traditional birthing practices.<sup>33</sup> The Birth Place Lab, in the Division of Midwifery at the University of British Columbia, has developed several tools such as the Mothers Autonomy in Decision Making scale (MADM), the Mothers on Respect Index (MOR), The Mistreatment Index (MIST), The Birth Place Research Quality Index (ResQu Index), and Provider Attitudes to Planned Home Birth (PAPHB) Scale to measure different constructs associated with the birthing experience.<sup>59</sup> These tools were developed in either British Columbia, Canada or the United States, and each measures a specific aspect of the perinatal care experience for either mothers or healthcare providers.<sup>59–63</sup> There are several other instruments, such as the multidimensional measure of Prenatal Interpersonal Processes of Care (PIPC) and the Patient Expectations and Satisfaction with Prenatal Care (PESPC) instruments that also focus on patient experiences with prenatal care, but the studies conducted in the development of these instruments took place in the United States with a different health care system and with populations characteristically different than populations in Canada, with no Indigenous representation.<sup>34,35</sup> These instruments are challenging to use in a Canadian context, particularly with Indigenous birthing parents, due to the perinatal health disparities that First Nations birthing parents living in rural and remote areas of Canada face. These disparities are influenced by the Evacuation Policy and a distinct set of barriers, which must be understood and

addressed to improve the health of First Nations women and children in Canada. A study conducted in Winnipeg did utilize several of these instruments, including PESPC and PIPC, but was conducted in an urban centre and did not focus on Indigenous women specifically, with only 20% of participants identifying as Indigenous.<sup>64</sup> The PREMs instrument these Sharing Circles will inform was created in partnership with First Nations communities, an advisory Grandmother's Circle, health care providers from the Northern Health Region, the Keewatin Tribal Council, and the Opaskwayak Health Authority. The instrument is designed to capture Indigenous birthing parents' experiences with health care during pregnancy, birth, and the year following birth. Because the instrument was created in partnership, it begins to address the gap mentioned above, ensuring a focus on the unique challenges faced by First Nations birthing parents in Canada when accessing prenatal care. This instrument also examines many aspects of the perinatal care experience, providing a broad picture of the current perinatal care environment for Indigenous birthing parents in Northern Manitoba. Heaman et al. (2014) recommend that future research examine other outcomes such as postpartum behaviours, the uptake and continuance of healthy behaviours, and the utilization of health care by mothers and babies, all of which are captured in the PREMs instrument created as part of the team study.<sup>32</sup> The Prenatal and Birth PREMs instruments are the first being implemented in the team study, and the current version of each can be found in Appendices D and E.

### **Research Goals and Objectives**

The main research goal for my study was to better understand the experiences of First Nations birthing parents living in Northern Manitoba with health care during pregnancy and in the year following birth. This main research goal was achieved by meeting the following objective:

1. To use Indigenous methodologies to document and understand the experiences of First Nations birthing parents living in Northern Manitoba with the health care system during the prenatal, birth, and postnatal periods.

To achieve this research goal, I have utilized a Two-Eyed Seeing approach, incorporating the strengths of both Indigenous and Western ways of knowing. For the past five years, our team in the *Facilitating Transitions* project has partnered with First Nations communities in Northern Manitoba, Indigenous health organizations, and health care providers and administrators working in the North. Our team and partners will disseminate the results from this research to improve the health care provided to First Nations birthing parents living in rural and remote northern communities. In addition, the results of this thesis study will inform changes to the PREMs instruments created as part of the larger team project.

## Chapter 2: Study Design, Methods, and Analysis

### Two-Eyed Seeing

Throughout this project, I worked to apply a Two-Eyed Seeing approach, “seeing with one eye with the *strengths* of Indigenous knowledges and ways of knowing, and from the other eye with the *strengths* of Western knowledges and ways of knowing, and using both eyes together for the benefit of all.”<sup>65</sup> Two-Eyed Seeing acknowledges that different understandings of the world exist and that recognizing and reflexively considering these differing perspectives can help create an understanding of health conducive to addressing complex health concerns.<sup>66</sup> Two-Eyed Seeing highlights ‘weaving’ different perspectives together, acknowledging that each is of equal importance, and realizing that one view may better lend itself to increasing our understanding of something in certain situations.<sup>67</sup> Charles Labrador, a chief from Acadia First Nation in Nova Scotia, stated that Two-Eyed Seeing could be thought of as “the roots of trees in a forest intertwining to hold hands.”<sup>68</sup> Two-Eyed Seeing is important in research because, overwhelmingly, our health and academic systems are guided by Western views and approaches, often excluding alternate perspectives and ways of knowing that may further our knowledge of health and well-being.<sup>66</sup> In addition to the general exclusion of differing perspectives, there has been colonization of Indigenous ways of knowing and several examples where Indigenous knowledge has been appropriated by the Western scientific system and used within a positivist approach, separating this knowledge from its origins and cultural and social contexts.<sup>66</sup>

Two-Eyed Seeing “encourages fluidity, multiple perspectives, and the use of self-reflection to pose questions and critically consider the partiality of one’s perspective.”<sup>66</sup> As an individual and a white settler, I acknowledge that I alone cannot hold the dual perspective required in Two-Eyed Seeing and that balance is critical to this framework. Ermine, Sinclair, and Jeffery (2004) discuss the

idea of “ethical space,” which denotes an abstract space where two individuals or groups can interact even with differing intentions and perspectives, and this can be thought of in a Two-Eyed Seeing framework as “the space for meaningful dialogue between Indigenous and Western worlds.”<sup>66,69</sup> The creation and maintenance of this “ethical space” can help to enhance and strengthen the entirety of the research process.<sup>69,70</sup> With this in mind, throughout this work, I consulted Cree Elders and Knowledge Keepers, as well as Cree and Anishinaabe scholars, and incorporated their perspectives and guidance. I would also like to acknowledge that the concept of Two-Eyed Seeing originated on the East Coast with the Mi’kmaw People and that its use in the context of First Nations groups in Northern Manitoba could be considered inappropriate.<sup>65</sup> This study has been guided by the knowledge and teachings of Indigenous Elders, Knowledge Keepers, scholars, and health care providers, as well as by the voices and stories of First Nations mothers and grandmothers from Northern Manitoba. Through this guidance and knowledge, I have tried to allow Two-Eyed Seeing to guide the entire research process, including the choice of methodology, data analysis, and, moving forward, knowledge mobilization. The ways in which Indigenous knowledges and voices influenced these decisions are explained further in the sections on research methods, analysis, and knowledge mobilization. This study utilized Indigenous research methods and knowledge from First Nations Elders, mothers, health care practitioners, and researchers while being influenced by Western methods and perspectives due to my positionality as a Western researcher. Through this work, I aim to privilege the perinatal care experiences of First Nations mothers and Elders from Northern Manitoba, sharing their personal stories, knowledge, experiences, and advice for the future of perinatal care for Northern First Nations birthing parents.

### **Indigenous Methodology**

Several principles are generally used to guide Indigenous research, including collaboration, interconnectedness, relationships, respect for different life experiences and ways of knowing, and

connection to community.<sup>71</sup> Indigenous research and ways of knowing emphasize the importance of relationships and interconnectedness and of undertaking research that is culturally respectful and safe.<sup>66,72</sup> In Shawn Wilson's (2001) discussion on what Indigenous methodology means to him, he speaks about relational accountability; rather than focusing on validity or reliability or an abstract pursuit of knowledge, the researcher focuses on "fulfilling your relationships with the world around you."<sup>39</sup> Indigenous methodology also goes beyond the production of new knowledge in that research carried out in partnership with Indigenous Peoples can also decolonize, build capacity, rebalance power, and contribute to healing.<sup>40</sup> My focus when conducting this study was not to judge the stories shared by participants or to determine whether the information in these stories fit within my particular worldview. My goal was to amplify First Nations women's voices, learn about their perinatal care experiences in Northern Manitoba, and share these stories with the hope that the knowledge and experiences of the women involved will help improve care for future generations. Throughout the research, I have reflected upon my positionality as a settler working within a Western academic institution and how this affects my worldview, my view of how knowledge is created and what knowledge itself is, and my approach to this research. I have endeavoured to gain knowledge "not just... in some abstract pursuit... [but] in order to fulfill my end of the research relationship," which in this study I view as amplifying the voices of First Nations women and contributing to positive changes in the perinatal health care system in Northern Manitoba.<sup>39</sup>

This study was undertaken with a focus on decolonizing research, acknowledging and respecting different ways of knowing and diverse lived experiences.<sup>66</sup> Throughout this work, I have reflected on how Indigenous knowledges and the sharing of those knowledges have been influenced by colonization and how this affects every stage of research, from what research questions are asked and why, to the research methods used, to the manner in which knowledge is disseminated.<sup>66</sup> The pluralization of the word 'knowledge' is used throughout this thesis to recognize the various

knowledge systems of Indigenous Peoples in Canada and throughout the world.<sup>73</sup> This research focuses on the concerns of the First Nations birthing parents and communities involved. The research aims to share mothers' and Elders' stories to increase awareness and understanding of the current state of perinatal care for First Nations birthing parents in Northern Manitoba, as well as to inform an instrument designed to influence positive changes in perinatal health care and, by extension, to contribute to health improvements for First Nations birthing parents and children.

### ***Non-Indigenous Researcher***

There is a long history of research conducted by non-Indigenous researchers involving Indigenous communities that has not benefitted and has often harmed Indigenous communities in Canada.<sup>71</sup> Researchers have frequently approached research with Indigenous Peoples in an exploitative way, viewing Indigenous Peoples only as research subjects and utilizing research methods that do not include Indigenous values or knowledge, and the result has been a vast body of research focused on problems and deficits.<sup>40</sup> The Truth and Reconciliation Commission of Canada (TRC) states that reconciliation must include recognizing and acknowledging past harms, atoning for the causes of those harms, and undertaking actions that work to change behaviour.<sup>43,74</sup> In order for research to support reconciliation, "it should respond to the Truth and Reconciliation Commission's Calls to Action, in particular item 19, which calls on us to close the gaps in Indigenous health outcomes."<sup>74</sup> This research responds to item 19 in its focus on the gap in health outcomes experienced by First Nations birthing parents, infants, families, and communities in the area of perinatal health care. Other items in the Calls to Action relate to Indigenous healing practices and cultural competency training for professionals in the health care field. Both the experiences of Indigenous healing practices and cultural safety were discussed in the Sharing Circles and are intended to be captured in the PREMs instrument being informed by this study.

Research supporting reconciliation should also be guided by the United Nations Declaration on the Rights of Indigenous Peoples, which states that Indigenous Peoples have the right to the improvement of social and economic conditions in the area of health and that particular attention should be paid to the needs and rights of Indigenous women and children.<sup>75</sup> Both of these statements guided this work because of its focus on improving the perinatal health care experiences of First Nations birthing parents and its continuous collaboration with and guidance from First Nations women. This work also followed the themes and core principles identified by Kilian et al. (2019) regarding the approaches of non-Indigenous researchers to Indigenous research; these focus on trust, accountability, humility, acknowledgement of privilege and allyship, focus on reconciliation, privileging Indigenous knowledge and knowledge frameworks, knowledge of institutional facilitators and barriers, and respectful, reciprocal relationships.<sup>71</sup> In the interest of trust and accountability, I invited each participant to review their story and quotes as presented in the *Results* section of this thesis and incorporated their feedback and advice. I will also work in partnership with participants and Indigenous health organizations on an integrated knowledge mobilization plan to disseminate the results of this thesis in ways most beneficial to First Nations families in Northern Manitoba. Throughout the research and the writing of this thesis, I have continuously reflected on my positionality, the limits that my Western worldview and research experience impose on this work, and the privilege with which I, as a white woman, move through the Western perinatal care system. I have endeavoured to privilege the words, knowledge, and experiences of the First Nations women who gifted their stories to this work and have tried to navigate the tension between the existing Western institutional traditions and rules and what is best for the women involved in this study. In the interest of respectful, reciprocal relationships, I acknowledged the gift of each woman's time and knowledge and provided honoraria for sharing their stories and participating in data analysis. Lavallée (2009) advised that "reciprocity also includes the advancement of Indigenous ways of

knowing,” and I hope that this work has been able to play some part in that through sharing the stories and teachings of First Nations mothers and Elders.<sup>73</sup>

## **Methods**

### ***OCAP®***

This study follows the First Nations principles of ownership, control, access, and possession, collectively referred to as OCAP®. These principles are in place to support data sovereignty by assuring that First Nations control how data is collected, own that data, and have control over how the data can be used.<sup>76</sup> Several “champions” were instrumental in the team project and in moving this work forward, including the Grandmothers Circle and Indigenous scholars and health care providers from Northern Manitoba. In this project, I did not work directly with communities; instead, I worked with individual women from different First Nations communities in Northern Manitoba, with recruitment carried out in Thompson. Decisions regarding data storage and confidentiality were discussed with each participant as part of the informed consent process. Methods and data analysis were influenced by OCAP® and are explained in more detail in the *Indigenous Methodology* section below. At the end of this study, participants will each receive a copy of the study and any related publications. I will approach the participants to inquire if they would like to co-author these publications. Each participant will also be given copies of their recordings and transcripts and will control access to these records. I will discuss with the participants whether they want me to destroy my copies of these records after completion of the study so that they possess the sole copies or whether they will allow me to keep copies.

### ***The Four R's***

My study was also guided by the Four R's of Indigenous Research – Respect, Relevance, Reciprocity, and Responsibility.<sup>77</sup> Relevance to First Nations communities in Northern Manitoba

was at the forefront of creating the PREMs instruments in partnership with First Nations women from Northern Manitoba, including the Grandmother's Circle. Decisions regarding data access and storage and data analysis following Sharing Circles, as well as respect for protocols regarding offerings and honoraria for participants, were guided by respect and relevance. There is also respect for different ways of knowing, as my study involves Indigenous and Western ways of knowing, as well as respect for guidance from the Grandmothers Circle and community members involved in the larger team project. Throughout this study, I endeavoured to honour my responsibility as a researcher to the women with whom I was working by continuously reflecting on my positionality and always acknowledging and privileging the lived expertise of these women. I will also collaborate with the participants and Indigenous organizations connected to this work to discuss knowledge mobilization and ensure that the forms of output generated from this study include those that will most benefit First Nations families in Northern Manitoba, which will be guided by reciprocity.

### ***Recruitment***

Initially, this project was designed with a plan to conduct Sharing Circles with three groups from Northern Manitoba: First Nations mothers, First Nations Elders, and perinatal health care practitioners. With the help of the Northern Health Region and the Thompson Plaza Mall, recruitment posters were displayed in the Thompson Clinic, where many birthing parents receive prenatal care, and in the mall. I also conducted snowball sampling by reaching out to First Nations Elders and women from Northern Manitoba with whom I have worked and to contacts given to me by my committee members.

The inclusion criteria for First Nations mothers from Northern Manitoba were: at least 36 weeks gestation OR at least one child; 18 years of age or older; has had to leave their home community for prenatal care, birth, or postnatal care; could understand and speak English. The exclusion criteria for mothers were: had a planned birth in Winnipeg; had a known severe

psychiatric/developmental disorder that precluded participation in the Sharing Circles. The inclusion criteria for First Nations Elders from Northern Manitoba were that they could understand and speak English. The exclusion criteria for Elders were if they had a known severe psychiatric/developmental disorder that precluded participation in the Sharing Circle.

Recruitment challenges arose during the study, as many interested potential participants lead busy lives balancing work and family responsibilities and logistical challenges with travel to Thompson from the surrounding communities. I discuss some of these challenges further in the *Sharing Circles* section of this chapter. By the end of my data collection, I was able to speak to two First Nations mothers and three First Nations Elders from Northern Manitoba, all of whom are mothers and grandmothers.

### ***Sharing Circles and Interviews***

#### *Sharing Circles*

Indigenous research methods incorporate experiential learning and focus on fully engaging each participant, privileging Indigenous knowledge and incorporating Indigenous protocols, values, and beliefs.<sup>73</sup> As a research method, Sharing Circles are most analogous to focus groups but have different foundational principles.<sup>56–58</sup> Sharing Circles are “meant to provide space, time, and an environment for participants to share their story in a manner that they can direct.”<sup>56</sup> During Sharing Circles, it is essential that the participants and facilitators are seen as equal and that among them is a sharing of emotion, spirituality, and information.<sup>58,73</sup> In addition, emphasis is put on respect, listening to and supporting one another, and the opportunity for each participant to experience growth and transformation through the discussion.<sup>58,73</sup> Sharing Circles emphasize sharing all aspects of each participant, their spirit, mind, heart, and body.<sup>73</sup> Indigenous research methods should be culturally relevant and serve functions beyond just data collection, such as supporting autonomy and cultivating relationships.<sup>40</sup> Sharing Circles and storytelling/personal narrative research methods

support this focus on relationships as the person telling the story and the person listening to the story form a strong relationship through this process.<sup>39</sup> Dyll-Myklebust (2014) discussed how historically, “[t]he domain of research and science was mobilized to suit the imperialist agenda,” and Drawson et al. (2017) built off this idea by suggesting that researchers with formal training can utilize Indigenous research methods with meaningful participation and collaboration from individuals and groups who have been marginalized, and can do so in a way that builds capacity and lends itself to a culturally safe research environment.<sup>40,78</sup> Other researchers have discussed Indigenous research methods as being reciprocal, with an equitable sharing of knowledge and power between researcher and participants, and transformative, shifting qualitative research from the oft-seen deficit-based perspective to a perspective rooted instead in resilience.<sup>40,79,80</sup> One of the goals of using Sharing Circles was to hear women’s stories in their own words, guided not by a strict interview guide but by what they chose to share. This led to rich descriptions of both positive and negative experiences intertwined with traditional teachings and advice for mothers and the perinatal health care system in Northern Manitoba.

I attended training to become a Sharing Circle facilitator through an organization called Circles for Reconciliation. At the end of the training, I was gifted a beautiful talking stick, which was used during the in-person Sharing Circle to indicate a participant’s turn to speak.<sup>73</sup> Before beginning recruitment, I approached Susan Kobliski (Grandmother Bear Woman), a member of the Grandmothers Circle working with the larger project. We discussed my thesis project, and I offered her tobacco and asked if she would be interested in co-facilitating the Circles with me. She agreed to co-facilitate and has provided guidance throughout the many stages of my research. I created a general guide for the Sharing Circles, located in Appendix C, based on work done as part of the larger project and conversations I had with First Nations women, Elders, and health care

practitioners from Northern Manitoba. The intention of this guide was to provide prompts to participants if requested, not to be strictly adhered to as with an interview guide.

In October 2023, I travelled to Thompson intending to conduct at least two Sharing Circles, one with mothers and one with Elders. Several potential participants from each group were interested in being part of the Sharing Circles. With Susan's help, a date was chosen, and a location was booked with the assistance of one of the partners of the larger project from the Northern Health Region. Unfortunately, on the morning that the Circles were to be held, a snowstorm rendered travel to Thompson from the surrounding communities unsafe, and only one participant (a mother) could attend. Susan and I conducted the Circle with this participant; Susan began the Circle in ceremony, we used the talking stick that I was gifted, and we shared food and stories among the three of us.<sup>73</sup>

### *Conversational Interviews*

Following discussions with Susan, my advisor Dr. Nickel, my committee members, and potential participants, a decision was made to offer a virtual meeting option to those interested in participating in the study. This was done to provide more flexibility to participants and mitigate the risks involved with travel in Northern Manitoba during the winter. This necessitated changes to the research method, which pivoted from a more formal Sharing Circle to a more conversational interview method of data collection. During the second meeting I conducted (the first virtual meeting) in November 2023, I spoke to two Elders individually, with Susan also present. The third meeting was also virtual and was held in January 2024 with a mother. Susan was unable to be present. The fourth meeting was a one-on-one virtual meeting held in March 2024, and Susan was the participant. Before these meetings, I discussed the change in method with each participant, and they all provided their informed consent to participate in the study, even with the change in the data collection method. I referred to the Sharing Circle guides when participants requested topics or

prompts for areas they could discuss. However, I ensured the process was still flexible and participant-driven, as the Sharing Circles were meant to be.

## **Analysis**

Transcripts of the Sharing Circle and the conversational interviews were initially analyzed using NVivo to identify themes woven throughout the stories shared. I completed three rounds of coding using NVivo before writing up my results, utilizing a blended coding approach. Before I began coding, I sorted each transcript into one of two case categories: *mothers* and *Elders*. My first round of coding was approached inductively, using descriptive coding, and as I progressed, I sorted codes into broader, top-level themes drawn from the literature and my previous work on the larger project.<sup>81</sup> Starting inductively prior to incorporating theory from other sources helps ‘give voice’ to the data.<sup>81</sup> As I finished the first round of coding, I realized that it would be helpful for further analysis to sort participants’ experiences into ‘positive’ and ‘negative’ experiences to compare and contrast any themes that were more commonly discussed positively or negatively. This approach, which can be referred to as ‘pattern coding,’ constituted my second round of coding, in which I did not code each section of text as I did in the first round but instead focused on experiences shared by participants that I could confidently sort into a positive or negative theme.<sup>81</sup> My third round of coding consisted of adding two final codes, which became clear to me throughout my first two rounds of coding but which I had not yet included. Following my third and final round of coding, I ran three coding matrix queries to examine patterns in the themes found throughout the transcripts. The first query looked for patterns in how often each top-level code was also coded to either ‘positive experiences’ or ‘negative experiences.’ The second query examined how often each of the 29 total codes was coded to either ‘positive experiences’ or ‘negative experiences,’ and the third query looked at how frequently each code was discussed by mothers as compared to Elders. The results of these queries can be found in the *Results* section.

The *Results* section begins with a presentation of each participant's story, utilizing many direct quotes from the participants. The stories for each participant were presented first in order to privilege the experiences shared, to allow the impactful stories to stand on their own, and to avoid fragmentation or decontextualization of the experiences shared.<sup>56-58</sup> The second results section includes a discussion of the themes woven throughout the stories as a collective, illustrating common threads between negative and positive experiences that participants shared. This section contains the results and analyses of the matrix coding queries discussed above. The third results section highlights each participant's teachings, advice, and recommendations. These include recommendations to improve the current system, as well as teachings and advice for other mothers as they navigate the perinatal health care system in the North. When utilizing Sharing Circles as a research methodology, Indigenous persons must be involved in data analysis and interpretation; this leads to greater documentation of the social reality lived by community members, captures a range of perspectives, and is a more culturally sensitive method of attaining data.<sup>58</sup> I reached out to each participant after the presentation of their stories was drafted to ask if they wanted to look over their story, providing feedback and opinions to ensure their story was presented in a way they were happy and comfortable with. Four out of the five participants chose this option, providing me with feedback to incorporate into the presentation of their story. The same four participants also agreed to look over sections of the *Themes* and *Participant Teachings, Advice, and Recommendations* sections of the results, which included [Figure 1](#), summarizing the themes, and any sections that included information or direct quotes from that participant. The participants also provided feedback on these sections, and each was given an honorarium for the time they spent participating in data analysis.

### **Ethical Considerations**

Ethics approval for this work was obtained from the University of Manitoba Health Research Ethics Board (H2022:105 HS25421), the Health Information Research Governance

Committee of the First Nations Health and Social Secretariat of Manitoba (FNHSSM), and the Northern Health Region.

For the in-person Sharing Circle, participants were provided a physical copy of the consent form, and I read through the entire form with them, giving them time to ask any questions or raise concerns they may have. Virtual participants were sent a copy of the consent form via email prior to our meetings so they could read over the form on their own time. At the start of each virtual interview, I asked each participant's permission to audio record the meeting. I then read through the entire form with them, and we discussed any questions or concerns they may have. Following a verbal and written description of the project, participants were given the option to provide either written or oral consent (all virtual participants gave oral consent, which was audio recorded) if they wanted to participate in the Sharing Circle or conversational interviews and for the Circles/interviews to be audio recorded and transcribed. Sharing Circle and conversational interview participants were also given the option to provide written or oral consent if they wished to be identified by name in the study, on recommendation from the advisory Grandmothers Circle. This was recommended to ensure that women were able to claim their voices and their stories and that, if they chose, their communities would know that they provided their time and knowledge to help improve care for others. For those participants who did not wish to be identified, safeguards were followed throughout this work to ensure confidentiality and anonymity using unique identifiers for each participant, password-protected servers and files, and de-identification of information when possible.

Decisions about data storage and access were made while trying to incorporate OCAP<sup>®</sup> principles. During the study, audio recordings, transcripts, participant information, and any other data collected were stored in a password-protected file on a secure, password-protected server. Physical copies of forms were kept either in a locked filing cabinet to which only I had access or in a

locked carry-on during travel, to which only I had the combination. The transfer of data between the transcriptionist and myself occurred via the physical hand-off of a USB drive. Following the completion of the study, copies of all data collected, as well as the final thesis and publications, will be given to the respective participants, and it will be the decision of the participants whether my copies of the data are destroyed so that they have the sole copies, or whether I can retain my copies. Potential benefits to participants include the chance to share their stories and experiences with audiences that could consist of academics, policy-makers, Indigenous health organizations, and the Northern Health Region, and contribute to improvements to perinatal healthcare in Northern Manitoba. Potential risks to participants included emotional or psychological risks if traumatic experiences were discussed during the Sharing Circles or conversational interviews. To address this risk, Susan and I were available to participants following the Circles or interviews if a participant wanted to discuss any conversations that occurred during the Circles or interviews, or any adverse psychological or emotional effects experienced as a result. If any participants were to experience adverse effects, Susan and I would have ensured they were connected to an appropriate Elder, counsellor, or therapist to discuss and monitor these effects.

### Chapter 3: Results

By the end of the data collection stage, I had spoken to five participants, gathering 3 hours, 4 minutes, and 48 seconds of audio recordings. These recordings were then transcribed into 57 pages and analyzed using NVivo, as described in the methods section above. The first section, *Stories*, summarizes the story that each participant shared to illustrate the continuing challenges and harms that the colonial health care system causes for First Nations women in Northern Manitoba. The second section, *Themes*, presents the results of the three rounds of NVivo coding of the transcripts, exploring repeating themes and connections among the stories shared. The impact of each story and direct quotes from the women involved, along with the broader picture presented through the qualitative analysis, weave together to demonstrate just how far we still must go to improve culturally safe women- and family-centred perinatal care for First Nations women in Northern Manitoba.

#### Stories

##### *Participant 1 – Susan Kobliski (Grandmother Bear Woman)*

Susan Kobliski (Grandmother Bear Woman) is an Elder from Nisichawayasihk Cree Nation (Nelson House) in Northern Manitoba, who not only shared her story as part of this project but has advised me throughout my degree and helped to co-facilitate my discussions with several other participants. Susan shared personal experiences of giving birth as well as attending the births of family members, which she describes as “embedded in my memory, um because it was both a very joyful experience but there was a twist of um memorable sadness because of what I had experienced.” When Susan was pregnant with her first child, she was sent to a home for unwed mothers in Winnipeg; this home was set up with the intention of women giving their children up for adoption when they were born. Susan shared that she felt pressured to give her child up for

adoption, as well as pressure against breastfeeding, which at the time was “looked upon as taboo.” She resisted these pressures and insisted on taking her child home with her. At the time that Susan went into labour, she had not been given any information about what to expect regarding labour and birth, and along with this lack of communication, she was met with a lack of support as well:

“And um so on the night that I went into labour I remember I was across the room from Sister [A] and I, I woke up in the middle of the night, no idea what happened and here my water had broke, and I’m like freaking out and I went to knock on the nun’s door, I told her. And I, I recall she just said, okay now you have to get dressed and you have to walk to the Misericordia Hospital. This is wintertime. I had no idea what to do, nothing. I got dressed and I, I made my way to the front entrance, explained to them what had happened and I remember being told to sit, and then they came and escorted me to some kind of, and I went into labour for 36 hours. I had a really hard time.”

When Susan was admitted to the hospital, she described the room she was taken into for labour and birth as “cold” and “dark,” and she reflected on the lack of support offered by the health care providers attending her birth:

“I was in so much pain and I remember trying to grab this woman’s hand, this nurse, and she, I wanted help and support and she pushed my hand away. She said, you’re on your own, I’m not here to hold your hand. It was very, that was the one experience in my first child bearing, there wasn’t, it was just, just nothing, I just had to go by what the doctors instructed me to do as my child was coming into this world and that was really, really difficult.”

Susan also discovered that her son was being treated for jaundice when she saw him in the hospital nursery “covered in wires and um band-aid,” but the hospital staff had not informed her of the jaundice diagnosis or treatment. When Susan returned to Thompson with her baby, she experienced minimal health services, unsanitary accommodations, and a lack of support and spirit,

sharing that “the whole experience was cold and unwelcoming for myself as a mother and also for my child.” Susan gave birth to her second and third children in Prince Rupert, sharing that these were better experiences because “I had already gotten used to living out of the community, but I had also, I also knew how to fend for myself somehow, speak for myself.”

Susan also shared her experiences attending the labours and births of several family members, including her niece and daughter-in-law. Susan’s niece gave birth at the Thompson General Hospital, and Susan describes the doctor attending the birth as

“a horrible doctor who sedated women after women after women in labour, sedated them so heavily and it was consistently one caesarean after the other, ‘cause I’m from the north and there are many women that would ask me to be there for their childbirth to support them, to help them, and this continuous what I saw.”

When Susan’s daughter-in-law gave birth to Susan’s first grandchild, she noted that she was also heavily sedated and that she “was shocked at the health care system and how, how unattached, how detached the nurse was to the mother bringing this child into the world, it was so callous.” Despite these challenges, Susan brought her drum and traditional songs into the nursery to play for her grandchild, following the teachings of her people. The final experience that Susan shared was when she encountered racism from the same doctor that Susan was concerned sedated too many women during labour while she tried to support her niece who was giving birth:

“And then my niece, the one niece was pregnant and again I was asked to come in, she was having a hard time, so I placed my hand on her and started to pray. And the same doctor came in and deliberately interrupted so abruptly and said... get your hands off of her, you’re causing stress for her, she’s in labour, don’t do that. Like really just, it, it, it really, again put you in a state of shock and of course I can’t, I can’t be assertive in saying you know like you

know don't be so rude, and this is very racist, but um no this is part of our culture. But you couldn't do that because she was in labour and my niece I didn't want to stress her."

***Participant 2 – Kitana Garson***

Kitana is a mother from Tataskwayak Cree Nation (Split Lake) in Northern Manitoba and shared some of her experiences of receiving perinatal care and giving birth both in Thompson and in Winnipeg. She shared that, even when having to travel out of her community for medical appointments, she was sometimes only given one day's notice of her appointment. She also described the challenges of having to travel alone for care, especially with multiple children, as her partner often had to stay home with their children.

"And most of the time you're going out alone because um because like most, most mothers already at their second kids or fourth, so most of the time it the father saying home and the mother going out alone. And I'm pretty sure that mothers are just like want to go there and back right away so there is rushing there and rushing back, trying to jump on the medical van right away. And it's more like a nuisance of coming, going in and out of the community and like especially hard when, if there's an emergency and you're alone and like it takes quite a while for support to come in because it's, it's like an hour and a half drive, if the roads aren't good it's like, is like an hour and if it's they're bad it's two hours twenty minutes. And especially if you get sent out to Winnipeg, it's, it's more harder, you're more alone, more, you're probably alone for a good two or three days."

Kitana shared how depressing it can feel to be alone for weeks when sent out of the community for care without support and described how some mothers try to return to their communities rather than wait in urban centres, leading to "probably a few births on the highway in, in our community because of that because the wait, the wait here is too, we just want to go home."

Kitana also discussed the lack of choice that First Nations women are offered regarding their perinatal health care providers. She shared that in her community, care is provided by whoever is available, usually a nurse or a paramedic. Once women are sent out to an urban centre for care, they are often not informed of their provider (usually a doctor) until they arrive at their appointment: “Sometimes they tell you like oh you’re going to Dr., this doctor or that doctor beforehand but most of the time it’s just you’re, you’re coming here blindsided.” In addition to a lack of provider choice, Kitana shared that her prenatal appointments felt very rushed, with each doctor having a large number of patients to see. Kitana was also not given the option to incorporate traditional cultural practices into her perinatal care in Thompson or Winnipeg. The only time that she experienced any kind of traditional care being offered was when her grandmother was able to come and bless her twins when they were in the NICU. Still, she thinks that “It would be great to be offered um traditional ways because um it just seems like... we see other communities having, having this and that for their, for their thing once they get home and some other communities don’t.”

Kitana reflected on the differences in care between Winnipeg and Thompson, experiencing a greater amount of support in Thompson. One example she gave was the process for getting Treaty numbers for her children – she was unable to obtain Treaty numbers for her children who were born in Winnipeg because rather than supporting her through the process, she was just handed a large stack of papers and forms to sign without any guidance. In contrast to this experience, her children born in Thompson all have their Treaty numbers because the staff there supported her through the process.

### ***Participant 3 – Bella Flett***

Bella Flett is an Elder who has lived in Nisichawayasihk Cree Nation for the past 55 years. Bella described the experience of being sent to The Pas when she was pregnant with her first child, having to stay far away from home for more than four months during the first year of her marriage.

She shared about the lack of support that she experienced while giving birth, being left alone throughout her labour except for nuns coming into her room, which she was uncomfortable with. She experienced a severe medical problem during delivery but felt unable to speak up for herself. Bella discusses her fear about this type of experience and the lack of support continuing for First Nations women:

“So I would not want that for the young people, especially the teen mothers now, they are so young when they go to wait for their child to be born hey. And they’re, sometimes these young teen mothers come from home where nobody cares, nobody advised them, nobody tells them anything, nobody tells them what to expect, and it’s such a scary feeling not to know what you’re, you know what to expect or what’s going to happen to you during the whole time of labour. And you go through so much pain and you’re all by yourself and there’s nobody there to reassure you that everything’s going to be okay that uh or even to tell you that you know things are going to be okay. But we do not know that, even us we do not know that, we do not know if we are going to be okay.”

The trauma that Bella went through during her first childbirth caused her to be “very afraid to have another child after that,” especially because she was far away from her family and her husband was unable to travel with her. When Bella found out that she was pregnant with her second child, she shared that it brought her to tears because “I was convinced that I would die this time.” Bella was sent to Thompson to give birth to her second child, and again, she was sent out much sooner than expected. During her time in Thompson, she experienced a lack of support at the receiving home, sharing that “nobody checked on you, even during the night to ask you if you’re hungry, do you need to drink something or are you comfortable, are you cold... They didn’t really care for your well-being.” These issues persist today, with Bella sharing that the receiving home is infested with bedbugs and roaches, that they do not provide nutritious meals to the women staying there, and that

no emotional support is offered to the women. Bella reflected on the loneliness she felt having to wait for her children to be born while she was alone in The Pas or Thompson, and shared how difficult it was “going out to wait for this child to be born and then delivering my baby all by myself without anybody to reassure me that I’d be okay... nobody was there to wipe my sweat or my tears. I was all alone.” Even once her babies were born, Bella had no one around to visit her. She shared her sadness at not having anyone with her to welcome her babies to the world and to share in her happiness once they were born. Her youngest child was born just before Christmas, leaving Bella and her baby alone throughout the holidays while she was worrying about her other two children waiting for her at home.

“So basically I was all by myself during all the deliveries of my children and waiting for my children to be born. And it was horrible, like I, I went through so much, I cried so many tears all by myself. And you know I did not know what was going to happen, what I was I going to endure, like you know I would have loved to have somebody with me, somebody to hold my hand and tell me that I would be okay. But no there was nobody. And that’s what I don’t want for the young generation, the young girls especially...”

Other issues that Bella discussed included the lack of choice women are offered, being assigned a doctor rather than getting to choose their care provider, as well as the lack of privacy in the hospital after women have given birth. “... there’s about six other beds in the same unit where you’re going to be laying, and often... somebody will pull your curtains when you’re trying to sleep, and they’ll be talking loud and laughing... what about the ones that want to sleep because they’re tired.” Bella lamented that a lot of people are not allowed a choice in where to give birth or who can attend the birth to support them, even today. She shared her experiences of seeing nurses being “so rude” to women during labour, telling one woman “be quiet, what’s all the fuss about.” Bella discussed not

being offered anything to help with her pain during labour, but still being expected to suppress her cries of pain, and that this experience was not unique to her, but something that many women faced.

Bella also discussed the racism that Indigenous women experience, remembering how stressful it was when she was sent to urban centres to wait to give birth and was shuffled from one place to another while dealing with “many rude comments, negative comments because of who we were, who we are as Native women.” She reflects on trying to be positive during her pregnancy but remembers how much harm hearing negative comments and constantly being put down did to her. “I was even afraid to be around people for the longest time in my life after that because I was afraid to be put down... The things they said were so harmful and so hurtful that I carried them for a long time.”

Bella reflected on memories of women having their babies at home in their communities. She shared the story of her brother being born at home and her aunt, a midwife, assisting her mother during labour and birth.

“She said the, the mouse is going to bring your little sister or your little brother, cover your heads, if you look they won’t come, so we covered our heads, and the thing that amazed me was we never heard my mom cry out or you know to scream and stuff like that. The only thing we heard was you know the, my auntie talking to my mom, coaching her along. And the next thing we heard was the baby crying, and we were right in the room when our brother was born.”

Bella discussed how the midwife stayed with her mom after the birth to support her and how amazed she was by the experience: “I always remember that, I always reminisce hey, I sit and I look back, beautiful memories, you know things that uh I would want the young mothers to know, to feel the love.”

***Participant 4 – Phyllis Hart***

Phyllis is an Elder and an elementary school teacher in Nisichawayasihk Cree Nation who shared her experiences as a young mother, being cared for by the women in her family. She discussed her belief that birth “is a sacred journey... with yourself and a newborn, a child growing within you... I find it to be very sacred, a sacred time.” Phyllis remembers feeling that a lot of information about what to expect during pregnancy and birth wasn’t made clear to her, and the information provided by the health system was not reassuring to a new mother. She reflected on previous generations of her family having more knowledge from the midwives in her family:

“I had, I had um how do you say lack of experience, knowledge and even, even how to say things like iterate some things that are, that were deep in my mind like privacy issues and you know about the overall female, female system, the reproductive system and the, the actual you know before and after prep for, for pregnancy although our parents did because we had midwives in our, in our, in our families that they helped a little bit, what to do before and after...”

Phyllis shared that she feels traditional practices, such as midwives and mothers taking care of other new mothers, and other traditions, such as naming ceremonies, have been “put aside.” She discussed her fears about the medicalization of birth, using her daughter-in-law’s current situation as an example:

“...my daughter-in-law is going through, I’ll be having a grandchild soon any day and I was telling, she was telling me that they were trying to um induce her. I feel, I feel it’s not, it’s not part of that, that birthing system of traditional people, traditional practices and things like that to take babies out at a time when they’re not you know a time when they’re not ready to be, ’cause everything has time right, everything is, there’s a time for everything and a time to be born. And I feel that there’s an interruption, a lot of interruptions there during birth that

could affect the baby, you know the, the life of the child I feel strongly about that, I'm against that, allowing, and it's not only my daughter-in-law it's a lot of young women I hear are getting induced and I think that's scary to get you know. So my fears, my you know my worries about not completing that, that journey, that, that timeframe set for babies to, to arrive in this, in this world, date and time whenever that was meant to, to be the original plan for that child right. So I don't know how many, how many parents are aware, or mothers are aware of that, of these things that are happening to the, to the children being, being abruptly you know their, their journey being abruptly stopped. So I, I have a lot of concerns about that..."

Phyllis contrasted this with her own pregnancy and birth experiences, in which she received guidance and care from family members, including midwives, who took care of herself and her baby, shared knowledge of how to take care of her body, and shared traditional practices involving the placenta and the belly button. Phyllis reflected on how new mothers often miss out on this support and guidance, which can especially be true in small communities that lack resources. Phyllis discussed the endurance of the support she received from her family, including help to care for her children while she finished university, and her parents teaching her about responsibility and accountability, lessons which she has carried throughout her life. She also discussed how her family shared in the responsibility of raising children, with grandparents, aunts, and uncles all involved: "...so that's the, the family that we shared our children with their, with their future in mind and their care and you know all these things that, that happen through child-rearing." She reflected on the adjustment period that happens in early parenthood and how guidance and support helped her cope with challenges:

"...we were guided to these situations too by our, by our grandparents or parents and everybody else in the community looked after people, so that was, that was really helpful.

Like my children were looked after by different people in our family to help and assist you know... they were always there, people were always present with them to hold the children and you know they wanted to hold the children, so they'd watch over them too. So there was that bond, that bond, family building and making bonds with the Elders and all the people involved in your family, so it's kind of a family thing right."

Phyllis remembers family members visiting new parents and working "together to, to ensure that the baby was brought safely into this world." As children, she shared that they weren't allowed in the room at the time of the birth, but they could be involved after the baby was born. Phyllis discussed the contrast between these experiences of traditional practices and family support and the lack of support that many mothers today experience, having to grapple with their fears about motherhood alone. Phyllis remembers some of her own fears about motherhood, including when she experienced a miscarriage where she was sedated, did not get to see her unborn child, and was thrown out of the hospital the following day, left with many unanswered questions about her experience. Phyllis shared that she thinks many young mothers feel alone and afraid to express their fears, worried about the attitudes or responses of other people.

### ***Participant 5***

Participant 5 is a First Nations mother from Northern Manitoba who shared her experiences of being sent out of her community to give birth. She discussed being sent to a boarding home for two weeks before giving birth and having to stay for another week or two after giving birth. She was not provided with support for her partner to travel with her; he would have had to pay for his own room and board, so she was alone for those weeks in the urban centre. She shared that,

"...most people yeah would like their partners to be with them right and they can't though because it's going to cost them room and board for them to be there when they're not covered by medical to be there with their partners during pregnancy and confinement."

She remembers the time away from her family and community as feeling lonely but was happy with the room and the food provided. Overall, she shares that “I didn’t have many problems with my pregnancies, they went, they went well, my caregivers were okay, they were, they were on top of things.” The birth of her last child was a more challenging experience:

“Um the last experience I had was with my son was I don’t know they put me in a separate room from all the birthing mothers saying I was contagious or something like they, I don’t know they isolated me in a room alone with my child ‘cause I was positive for something that they swabbed my nose with. They swabbed my nose and said I was positive for something, I’m not too sure but yeah that was, I don’t know it kind of made me feel like um I don’t know so isolated after giving birth and not able to see family and friends and not able to have visitors and like you know after giving birth it was, it was awful, that’s the worse, that’s the worse experience I had during one of my pregnancies.”

She shared that she wished there was a way that her care providers wouldn’t have made her feel so contagious during her time at the hospital.

Participant 5 attended the clinic in her community for care but had to travel to an urban centre for specific appointments, such as ultrasounds. She reflects that it was hard to travel for appointments while pregnant, wishing instead that care could be provided to women in their home communities. Another challenge she experienced when having to travel for care was related to transportation, “...sometimes they wouldn’t even have us on the list for, for rides and we would miss our appointments.” She discussed having the option of asking for a home birth but deciding against it, and she was never given the option to incorporate traditional practices into her perinatal care. Speaking about the care she did receive, she shared that,

“I felt like I was being taken care of like they kept with my appointments and they kept with my dates and yeah. Um I went to my appointments all the time and they were okay with me.

Um my two, my first two were with uh one doctor and then I switched the doctor with my third child with [different doctor] And they were both great.’

## **Themes**

By the end of three rounds of coding, I had identified nine top-level themes and 29 themes total, illustrated below in [Figure 1](#).

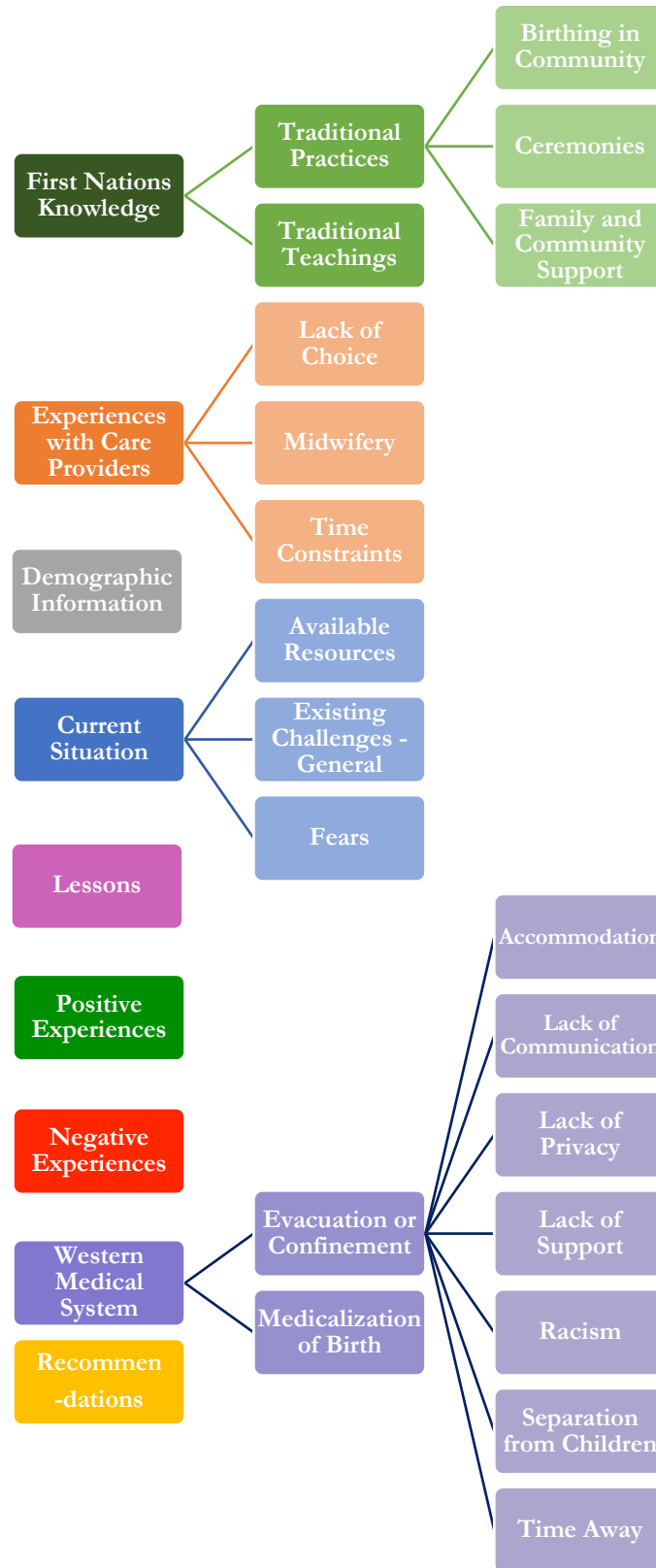


Figure 1. Themes from Participants' Stories

Two top-level themes classify experiences shared by participants as ‘positive’ or ‘negative,’ and coding matrices demonstrated certain patterns in themes more commonly discussed as part of positive experiences or as part of negative experiences. [Table 1](#) shows the number of top-level themes that fell under positive experiences or negative experiences, and [Table 2](#) shows all themes and how many times each theme fell under positive or negative experiences. I coded sections of the transcripts to positive or negative experiences based on how the women shared each experience with me, the words used to describe the experiences and their feelings stemming from the experiences, and their demeanours as they shared the experiences. If experiences were shared that I felt I could not fully categorize as positive or negative, I did not code it to either.

**Table 1. Top-Level Themes Coded to Negative or Positive Experiences**

	Negative Experiences	Positive Experiences
Experiences with Care Providers	4	4
Current Situation	1	0
Demographic Information	1	0
First Nations Knowledges	3	5
Lessons	0	0
Recommendations	6	1
Western Medical System	56	0

For the top-level themes, *Experiences with Care Providers* were evenly split between positive and negative, *First Nations Knowledges* were primarily connected with positive experiences, and the *Western Medical System* was overwhelmingly discussed as part of negative experiences that participants shared. The *First Nations Knowledges* codes that fell under negative experiences were related to not having access to traditional practices and knowledges around pregnancy and birth, and having to advocate against a Western medical practice that was in direct contravention to a traditional Indigenous teaching during birth. The following two quotes illustrate these experiences:

“...if they want a home birth, that’s their choice. If they want to have their baby in the hospital that’s their choice again. If they want their husband or their children... present during childbirth, that’s their choice, they should be allowed you know but so sad to say it does not happen, they don’t allow them. A lot of people are not allowed these things, even today.”

-Bella Flett

“And when I went into... the operating room I guess it was so cold, everything was steel and it was dark and they took this huge mirror and they were placing it in front of me, and I’m like no, I don’t want to, I’m not supposed to look, ‘cause in our culture we don’t, we concentrate on the passage of the child coming, we’re not allowed to look at something so sacred. That was for the midwives, it was for the women... I said no, you have to take that mirror away, and I was in so much pain...”

-Susan Kobliski (Grandmother Bear Woman)

The breakdown of all coding levels, presented in [Table 2](#) below, illustrates which sub-themes from each top-level category fell under negative and positive experiences, and how many times each theme was discussed positively or negatively.

**Table 2. All Themes Coded to Negative or Positive Experiences**

			Negative Experiences	Positive Experiences
Experiences with Care Providers	Lack of Choice		2	0
	Midwifery		0	3
	Time Constraints		1	0
Current Situation	Available Resources		0	0
	Existing Challenges – General		0	0
	Fears		1	0
Demographic Information			1	0
First Nations Knowledges	Traditional Practices	Birthing in Community	1	2
		Ceremonies	0	0
		Family and Community Support	0	2
	Traditional Teachings		0	1
Lessons			0	0
Recommendations			6	1
Western Medical System	Medicalization of Birth		7	0
	Evacuation or Confinement	Accommodation	4	0
		Lack of Communication	14	0
		Lack of Privacy	2	0
		Lack of Support	29	0
		Racism	2	0
		Separation from Children	2	0
Time Away	9	0		

***Experiences with Care Providers***

When discussing experiences with care providers, participants' negative experiences primarily focused on the lack of choice that women are given regarding who is providing their perinatal health care, and time constraints, with appointments often feeling rushed.

“Sometimes they’ll tell you like oh you’re going to... this doctor or that doctor beforehand, but most of the time it’s just you’re, you’re coming here blindsided...”

-Kitana Garson

“...you don’t get to pick a doctor to look after you while you, you’re at the receiving home expecting to have this child, you don’t get to pick your doctor, they pick your doctor for you.”

-Bella Flett

When participants shared positive experiences with care providers, it was often during discussions of the traditional practice of midwifery in participants’ home communities. However, Participant 5 shared that the two doctors who cared for her during her pregnancies “were both great.”

“...I believe a lot of the mothers were... they were very well taken care of by, by, by the other mothers and midwives.”

-Phyllis Hart

### *First Nations Knowledges*

Participants shared many positive experiences with First Nations Knowledges, including traditional practices and birthing in community. One traditional practice that several participants spoke positively of was the support provided by family and community during pregnancy, birth, and raising children.

“So we... were guided to these situations to by our, by our grandparents or parents and everybody else in the community looked after people, so that was, that was really helpful. Like my children were looked after by different people in our family to help and assist you know.”

-Phyllis Hart

Bella and Phyllis shared other positive experiences of family and community support as well, which can be found in the *Stories* section of the results.

### ***Western Medical System***

When speaking about the Western medical system, participants' experiences were overwhelmingly negative, and many of the experiences shared were related to aspects of the evacuation or confinement experience. Participants often spoke about experiencing a lack of communication, support, and privacy while in urban centres waiting to give birth, during labour and birth, or during the postpartum period. Participants discussed many communication breakdowns in the current Western medical system related to appointments, transportation, care providers, and what to expect during the perinatal period.

“...when traveling out of the community for appointments, for ultrasounds, they're kind of like um sometimes they're a weeks notice, sometimes they're like a, a days notice.”

-Kitana Garson

“...they didn't explain possibilities as to what might happen after a child is born, what to expect.”

-Susan Kobliski (Grandmother Bear Woman)

Participants often experienced a lack of support when evacuated during the perinatal period, both due to having to travel alone and a lack of support from the medical staff who were supposed to be providing them care.

“...pretty much just for my two last one I was here alone for two weeks. I pretty much just stayed in our room with nothing to do, just sitting there, kind of gets depressing when it’s just you got a little TV in the room when you’re sitting there.”

-Kitana Garson

“...we were left all alone from the time our labour began right to the end to delivery we, we were all alone, like I was all alone, I didn’t have anybody with me at all.”

-Bella Flett

“...you go through so much pain and you’re all by yourself and there’s nobody there to reassure you that everything’s going to be okay... or even to tell you that you know things are going to be okay. But we do not know that, even us we do not know... if we are going to be okay.”

-Bella Flett

“How the support, there was no spirit at all, the only spirit that there was, was the bond between the mother and the child and it shouldn’t be like that, it’s very, I remember especially that operating room was not, there was no kindness, it was just a matter of the medical team bringing a physical child into this world and that was it, period full stop, there was no celebrating and excited about the child coming.”

-Susan Kobliski (Grandmother Bear Woman)

Other adverse experiences that participants had with the Western medical system centred around being separated from their children and having to spend long periods of time away from their families and communities.

“...you worry so much about the children when you have to leave them to go out and have your other child in, in the city or wherever eh. You worry about their well-being...”

-Bella Flett

“...we had to leave our families, we had to go to the, well we had to travel to The Pas to have our children. And when I left home, I left home in um I left home earlier than the time I was supposed to. My due date was in August, I left home in the beginning of June and uh that was the first year of our marriage and I was in The Pas for, from June to September, and that’s a long time to be away from home.”

-Bella Flett

“...leaving home for confinement was lonely because you were away from your family for two weeks and then another week or two for like when you’re giving, giving birth right.”

-Participant 5

Participants also shared experiences of racism and negative feelings towards the continuing medicalization of birth by the Western medical system. Participants voiced their worries about doctors pressuring women to have inductions and caesareans, over-utilizing sedation on women, and pushing colonial practices that were in contravention of traditional First Nations practices and beliefs. In addition, Western care providers often disallowed, discouraged, or interrupted traditional practices and ceremonies. Many of these experiences are shared in the *Stories* section of the results.

“And then there’s that um, and then there’s uh racism. There’s so much of that, it is so sad to say, but yes being Native women we do go through a lot of that.”

-Bella Flett

Unfortunately, participants shared more negative than positive experiences of perinatal care, often linked to their evacuation from their communities into urban hospitals in a colonial medical system. The three Elders who participated in the study shared the majority of experiences with First Nations Knowledges and traditional practices, such as birthing in community, experiences of family and community support, and ceremonies. The two younger mothers who shared their stories did not have as many experiences with these practices; instead, they received care through the Western medical system. However, the Elders also shared their experiences navigating the colonial medical system while receiving perinatal care. A summary of how many times each theme was discussed by Elders compared to Mothers can be found in [Table 3](#).

**Table 3. Summary of Themes Discussed by Elders Compared to Mothers**

	Elders	Mothers
<b>Experiences with Care Providers</b>	11	7
Lack of Choice	4	1
Midwifery	7	0
Time Constraints	0	1
<b>Current Situation</b>	8	2
Available Resources	0	2
Existing Challenges – General	5	0
Fears	3	0
Demographic Information	3	2
<b>First Nations Knowledges</b>	30	4
Traditional Practices	25	4
Birthing in Community	6	0
Ceremonies	6	0
Family and Community Support	8	0
Traditional Teachings	10	0
Lessons	2	0
<b>Negative Experiences</b>	24	19
<b>Positive Experiences</b>	8	5
<b>Recommendations</b>	28	3
<b>Western Medical System</b>	42	28
Evacuation or Confinement	35	28
Accommodation	4	4
Lack of Communication	7	12
Lack of Privacy	1	0
Lack of Support	19	11
Racism	2	0
Separation from Children	1	1
Time Away	3	7
Medicalization of Birth	12	0

This table lists all of the themes from this study and the number of times each theme was discussed by Elders and by mothers. The participants of the study included three Elders and two mothers.

### ***Current Situation***

When discussing the current situation regarding perinatal care for First Nations women in Northern Manitoba, participants brought up resources presently available, existing challenges, and fears. Kitana shared about a tea and bannock meeting held for pregnant women and new moms in Thompson, which is a resource where women can access support. Phyllis shared her fears about the

current practice of inducing mothers, seeing it as an interruption of a baby's journey, and she also discussed how many young people are afraid to express their fears and get support.

“...I find a lot of people are, are afraid to express their fears, their concerns or you know, just ‘cause people, it’s the way some people are I guess, you know and they keep it to themselves and it builds and sometimes they feel alone... and that what they have to say might be they think, they’ve already preconceived um you know responses or attitudes of people you know. So a lot of, I find a lot of um young people, even talking to young men and things about issues like that, they’re very clamped about even saying things you know.”

-Phyllis Hart

Phyllis also discussed some challenges that currently exist for young First Nations parents, including housing issues, a lack of support and teachings, and adjusting to new family situations. She shares that housing issues and living with many other people can cause a lot of tension and require everyone to adapt to others in the household. She also worries for young parents who lack support and may not have a plan in place when starting a family:

“...there’s a lot of things that are not being taught to, to young people and they have to learn on their own, no help to do this, no help to do that and much less have a family you know... a lot of these parents I find are really young. It’s concerning...”

-Phyllis Hart

### **Participant Teachings, Advice, and Recommendations**

In addition to sharing their personal stories and experiences, each participant also shared knowledge, teachings, and advice for First Nations mothers navigating the perinatal care system in Northern Manitoba and for changes that should be made to the current system.

### *Mothers*

The young mothers who shared their stories, Kitana and Participant 5, provided advice both for mothers and for the current perinatal care system. Kitana recommended that traditional practices be offered to First Nations women during their perinatal care, sharing that it would have been particularly helpful when she was alone in Thompson or Winnipeg. She also discussed not knowing what supports are available and wanting that to be made clearer to women. Participant 5 shared a recommendation for mothers to try to remain as positive as they can when carrying their children:

“...when carrying their child always keep your emotions happy ‘cause what we carry, our child carries with us as well... what we take in, they take, they get...”

-Participant 5

### *Elders*

The Elders who participated in the study shared advice for young mothers, recommendations for changes to the current perinatal care system, and traditional teachings surrounding pregnancy and birth. Susan recommended that in the hospital, new mothers should be given “a specific and detailed explanatory form of information” to help prepare them for their journey as a new parent, reflecting on her experience of not being informed when her first son was being treated for jaundice in the hospital. Speaking directly to young First Nations mothers navigating the perinatal healthcare system in Northern Manitoba, Susan shared the following teachings and advice:

“...you’re carrying a beautiful life that’s gifted to us from our Kisimanitou. And we do carry our children with the teachings of the women of our communities of our Kokums or our, our um Aunties and there’s traditions that are still very much alive in their community, to pay very close attention to those teachings when you’re with child, and to ensure that you embrace those teachings and take them with you during your nine months of, of pregnancy and not to ever let them go and not to ever be ashamed of how those teachings are that we’re taught when we carry, when we carry life in our bodies, it’s a very sacred ceremonial time during those nine months and you have every right to carry out those teachings that we were taught by who we are as First Nations women that are becoming mothers. Not to be ashamed to use your language when you speak to your newborn child or even to sing the humming songs while you carry your child and to do the prayers and to always pay attention to what our Kokum’s tell us what we’re not supposed to do and what we’re supposed to do. And make sure that when you speak up don’t be afraid to speak up when you come into the care system, when you leave your communities because you have rights, you have rights to use your voice and you have rights to be assertive and speak against anything that you feel is racist towards you. There’s advocates in our hospitals now that can help you. Um be careful not to be um dismissed, don’t feel dismissed, you’re just as important as any other pregnant woman that comes into any hospital. Use your voice if you have to and not to be ashamed of it. And if you’re not comfortable with something, ask for an explanation, ask why you can’t have a natural childbirth, ask to see the x-rays... make them show you so that you’re comfortable. There’s nothing wrong with having...

...caesareans at all, it's still a child coming into this world. But the experience of having natural childbirth is one of the ways of our people are very accustomed to and there's nothing wrong with it, but make sure that you're absolutely involved and make sure you're informed to the point where you thoroughly understand... That's what I want to tell the women, the young mothers... I want to encourage them to do their best to breastfeed, do your wrapping, use your tikinagan if you have to, bundle them in your, in your moss bags and you sing them songs and you, you ask your Kokum to be there, your Aunties or somebody who's there to support you, to make you drink those medicines after you give childbirth and to eat those kind of foods that we were raised to eat after baby, to keep baby's belly button to, to make sure that you, you, you have every right to carry out the cultural and our First Nation ways of life through the Dene customs, through the Inuit customs, through the Cree customs, through the Anishinaabe, the Métis customs, whatever you're taught during prenatal, during child carrying, you're carrying a life and it's so beautiful. And to make sure that you're taken care of, speak and use your voice, look for people can help you, yeah."

-Susan Kobliski (Grandmother Bear Woman)

Bella expressed her concern about teenage mothers and the lack of support that many of them face when navigating pregnancy, birth, and the postpartum period, as the current accommodations can cause stress to women. She shared that these young mothers should have someone with them who is familiar with childbirth, "somebody that's been there to reassure them and to guide them along, so they do not feel alone." She strongly recommended that mothers who are going to give birth have somebody with them who will care for them all the way through the

birth of their babies, and who will be there to celebrate the birth after the pain that they have endured. Bella also recommended that a receiving home specifically for expectant mothers be set up in Thompson, “where they could share, talk amongst themselves, where they won’t feel alone, you know they would have somebody to talk to.” She expressed a desire for a receiving home of this nature to be a place where women can ask for support and stay somewhere that feels more “comfortable” and “homey” while they have to be away from their homes and families. Bella also discussed the possibility of allowing family members, especially children, to be able to stay in this home with the mother:

“And then it’s close enough for the, for the... family members to be allowed to go with the mother, especially the children... And also for the children to know that they’re going to have a brother or sister and they’ll be anxious to wait for the baby too and they’ll be the first ones to see the baby, that would be awesome.”

-Bella Flett

Bella also recommended that, if a receiving home like this were to be created, Elders should be invited to mentor and support young mothers. She also advocated for First Nations women in Northern Manitoba to be given more choice in their birthing experience, whether they choose to have a home birth or a hospital birth or decide to have family members present with them during the birth. Bella’s recommendations encompass both allowing home birth as well as improving the current situation and the experience of women who may choose to have a hospital birth, as she advocates for choice in every aspect of the birth experience. She reflected on how sad it is that so many First Nations people currently experience so little choice in decisions about their birth experience.

Another recommendation that Bella made was for a panel of Elders to be available to hold Sharing Circles and speak to young mothers, sharing their own experiences with childbirth and encouraging young parents. She also shared that she would like to see a designated space where people can donate supplies like diapers, baby clothes, blankets, and even furniture such as bassinets and cribs so that young parents who don't have access to supplies and resources can be more prepared to bring their babies home.

Bella also shared traditional teachings around birth, speaking of how beautiful the experience of holding your baby is and discussing the importance of young First Nations women being taught that the Creator loans our children to us:

“...the joy of seeing your child even after all these hours of being in so much pain like you know, it's so beautiful holding your baby, you forget about all the pain that you go through and everything that you go through... when you're holding your child hey. And then of course you thank Kisimanitou for bringing you through and for the beautiful gift he loaned you, because they're loaned to us hey, they're not given to us... they're not ours to say, well I want to keep him forever, no it does not happen that way. And even that, there's so many young women that do not understand that. And you know if they had the knowledge that their child is only loaned to them for so long, as long as Kisimanitou wants them to have that child for them to love and nurture... maybe it would be a little easier if they come across difficulties or even losing the child hey, they would be able to, to focus on themselves, their feelings like they've heard it from somebody, somebody cared enough to talk about that to them ...”

-Bella Flett

Bella finished her story by expressing her wish for people to show care for young First Nations mothers:

“...that’s what I want is for them to know that there is somebody out there that cares... I did not have that and I wouldn’t want the young mothers or the mothers expecting to experience the, the things that I experienced eh, I would want somebody there with them for them... But even in this day and age where people don’t seem to care for one another eh, being there for somebody is so important... Loving, loving you know people you don’t even know like you know to share the love that you have in your heart with them, that is such a good thing.”

-Bella Flett

Phyllis recommended that women be given more support during delivery, having someone with them, whether a birth helper, family member, or other support person who can help them with different birthing techniques and help coach them through birth. She also recommended that babies be allowed to stay with their mothers longer directly after birth, lamenting that they are often “whisked away immediately, they need to bring back that connection.” Phyllis also discussed the possibility of having Elders in each community assist in supporting young parents through any issues they may face:

“...I don’t know much about support systems they might have or even setting up programs for, to help mothers with, even with loss, you know they, they don’t know how to deal with loss and what should be done, especially the Elders of the community could assist in that, in that process with the loss and what’s usually done with things like that, they could be...

...I'm pretty sure they, they would assist these young people, young parents that are having, or any other kind of problem I feel with Elders being present and taking care of the you know bereaved or even in the celebrations you know, whichever way it goes. So that would be, that would be really good too, I believe, and just to, just to guide them into that, that, that um, guide them into that direction of um being into independence and taking care of the baby by themselves..."

-Phyllis Hart

Another idea Phyllis proposed was creating a support group for young mothers, where they could share with each other, learn how to take care of themselves following birth, get support with issues such as body image during pregnancy and postpartum, and receive teachings and traditions about the process of birth. She believes this would also be an outlet for young people to discuss their fears and concerns and learn about their options as young parents, including lessons about family planning and financial management.

"...hopefully they can, they can you know, people that are working on these things can find ways to, to help them cope with and adapt to the changes that are there you know with themselves, with a child and with their families, there's always hope, there's always a helping hand..."

-Phyllis Hart

Phyllis also shared traditional teachings about the significance of naming children in First Nations families, and the importance of names that come from your family and your root systems. She discussed how a lot of traditional teachings, such as naming ceremonies, are not carried out by young families and shares the importance of these ceremonies:

“...the naming ceremonies, what should be done with children before they have that, that natural uh with the earth meeting of the earth and how they, how they’re connected to the earth ‘cause we’ve been told we’re part of the earth, we’re born to the earth and we’ll, we’ll go back to the earth eventually and that, that sacredness between the earth and the sacredness and the spiritual part of people right, I think a lot of that has um, a lot of that has somehow been put aside...”

-Phyllis Hart

## Chapter 4: Discussion

This thesis study was developed out of a larger CIHR-funded team project in which I have been involved for the past five years, titled *Facilitating transitions across the pregnancy continuum of care – A Health System Intervention for Indigenous Women Living in Northern Manitoba*. This team project represents a partnership between the Northern Health Region, the Keewatin Tribal Council, Opaskwayak Health Authority, Keewatinohk Inniniw Minoayawin Inc., Wüjji'idiwag Ikwewag, First Nations communities located in Northern Manitoba, and researchers at the University of Manitoba (Appendix B). The three branches of the team project are: (1) implementing maternal care guides in Northern Manitoba to help Indigenous women and families navigate the complex perinatal health care system; (2) anti-racism training for health care providers, which will also be made available to Indigenous birthing parents to help empower them to know what their rights are when accessing perinatal care; and (3) designing and implementing Patient-Reported Experiences Measures (PREMs) instruments to capture the current perinatal care experiences of a large number of birthing parents, the results of which will continually be fed back to the health care system to guide improvements to perinatal care. My work on this team project has heavily influenced my thesis work, designed in consultation with my advisor, the leadership PI team on the larger project, community members collaborating on the team project, and my thesis committee. The Sharing Circle guides that I used in this study were influenced by conversations with mothers, Elders, and health care providers involved in the team project, and the results of my thesis study will inform changes to the PREMs instruments being implemented by the team project.

### Summary of Findings

This study aimed to better understand the experiences of First Nations birthing parents living in Northern Manitoba with health care during pregnancy, birth, and the year following birth.

My research objective was to use Indigenous methodologies to document and understand the experiences of First Nations birthing parents living in Northern Manitoba with the health care system during the prenatal, birth, and postnatal periods. I chose to share the women's stories first in my results, with long quotes in their own words. In speaking to a smaller number of women in a format that allowed them more freedom to share their stories and experiences as they chose, my focus was on the depth and richness of their stories, as the PREMs in the larger project will allow a large number of birthing parents to share a broad range of experiences in a briefer format. In this way, the two branches of the study can complement each other, the PREMs gathering experiences on a larger scale and the stories providing a deeper insight into the birthing parents and families behind these experiences and their effects on parents, infants, families, and communities.

Each participant shared their unique story, teachings, and recommendations, but several common themes were woven throughout the stories when examined as a whole. Each woman shared negative experiences with the current Western perinatal care system, most in Northern Manitoba and two in Winnipeg. Although not every experience with the Western system was negative, the majority were, with women discussing a lack of support, communication, privacy, and choice in their perinatal care, isolation and racism when evacuated from their communities, pressure from health care practitioners to accept certain medical interventions, and lack of access to traditional practices. In the Western system, women are often assigned a care provider rather than allowed to choose who is caring for themselves and their babies, and women frequently felt rushed when they did get to see these providers. In contrast to these experiences, the Elders shared many positive experiences with First Nations Knowledges and practices surrounding prenatal care, birth, and postpartum care. Each Elder remembered experiences of either birthing in community with a midwife or attending a birth in community, and spoke of the teachings and support provided by generations of family and community members. Recommendations from the participants included

returning birth to community, continuing to fight for the right to incorporate traditional teachings and practices into perinatal care, and ideas of how to make the current system more supportive for women, including increasing communication, improving accommodations, and allowing women more support during evacuation and birth.

## **Interpretation of Findings**

### *Experiences with Care Providers*

My study uncovered three primary themes about participants' experiences with care providers: lack of choice, time constraints, and midwifery, which are supported by the literature. Participants felt negatively about the lack of choice that they were given regarding who would be providing their health care during the perinatal period, sometimes not even being told who their provider would be prior to showing up for their appointment. They also voiced concerns about appointments with their care providers in the Western medical system often feeling rushed. This contrasted with the participants' positive experiences about receiving perinatal care from midwives. Previous literature has indicated that Indigenous birthing parents often experience poor relationships with prenatal health care providers, describing experiences of dismissive and impersonal medical appointments, judgment, discrimination, systemic racism, poor communication, uncoordinated care services, lack of access to culturally appropriate care, and feelings of powerlessness stemming from a lack of choice and control over care decisions.<sup>5,21,27-29,47</sup> Traditionally, Indigenous midwives provided comprehensive perinatal care grounded in cultural practices and knowledge for birthing parents in their home communities, and there is a general agreement that the care provided was culturally appropriate and safe.<sup>10,15</sup> In more recent years, midwifery care in Manitoba has resulted in positive effects on the outcomes of birthing parents and infants and is a cost-effective method of perinatal care.<sup>5,82</sup> The intention of legislating midwifery in Manitoba was to

serve the Indigenous population, and Indigenous midwifery is crucial to the reproductive justice movement for Indigenous women.<sup>1,5</sup> The findings of this study support the existing literature documenting the negative experiences of Indigenous birthing parents with health care providers in the Western medical system and positive experiences with Indigenous midwifery care, supporting a move towards increasing First Nations birthing parents' access to midwifery care as discussed in the *Recommendations* section of this chapter.

### ***First Nations Knowledges***

Participants discussed many positive experiences with First Nations knowledges relating to pregnancy, birth, and postpartum, including ceremonies, birthing in community, and traditional practices such as having family and community support throughout the perinatal period, similar to other studies.<sup>2,13,14,25</sup> Prior to colonization, First Nations birthing parents gave birth in their communities, with support from family, community members, Elders, and midwives.<sup>22</sup> The birth of babies in the community was a celebrated occasion, providing an important sense of identity and strong community roots and positively affecting babies, parents, families, and communities.<sup>2,13,14,17,23</sup> The support provided by families and communities during birth had positive effects not just on the health of the individual but on the health of the community, strengthening “what has been labelled as “social embeddedness” or “interconnectedness,” which serve to reinforce health-promoting behaviours and activities in the community, family, and the individual.”<sup>23</sup> Consistent with other studies, this study also found that this network of support, along with ceremonies connected to traditional birthing, strengthen connection to family and the land, and contribute to strength and resiliency.<sup>18,23</sup> More recently, research has supported allowing birthing parents with low-risk pregnancies to give birth in community, citing these meaningful connections and the benefits of family and community support, the stress caused by evacuation that could be avoided, as well as examples of birthing parents safely birthing in community and the resulting positive effects.<sup>2,13,14,20</sup>

The findings of this thesis study provide further insight into the many benefits that First Nations birthing parents experience when utilizing traditional birth practices and receiving family and community support, and their desire for this to be made more accessible to First Nations birthing parents in Northern Manitoba.

### *Western Medical System*

The stories that participants shared about their experiences with the Western medical system were overwhelmingly negative, with discussions focused on the medicalization of birth and the many challenges faced during evacuation, such as lack of communication, support, and privacy, time away from their children and communities, experiences of racism, and issues with the accommodations provided as found in previous studies.<sup>1,2,5,10,14,19,21,24,25,27,29,53,83</sup> The systematic medicalization of Indigenous birthing and its resulting adverse effects on Indigenous families and communities has been discussed by many researchers; Indigenous practices have been framed as unsafe compared to Western practices, and Indigenous birthing traditions “are only recognized insofar as they do not disturb medicalized standards for proper birth practices as per the dominant Canadian nation state’s macrosystem.”<sup>1,29</sup> The push to medicalize Indigenous birth into the Western medical system has happened alongside an erosion of accessible Western medical services in many Indigenous communities, leaving these communities without adequate access to Western or Indigenous perinatal care and, therefore, the requirement to travel for birth.<sup>29</sup> It has been well-documented that First Nations birthing parents and infants living in rural and remote areas already face poorer health outcomes due to the intersection of colonization and lack of access to local health care, and the Evacuation Policy has been shown to have many detrimental effects on First Nations infants, birthing parents, families, and communities in my study as well as others.<sup>2,4–6,9–13,15–18,20,23,25,26,29,30,46,84</sup> Many of these effects are reflected in the stories shared by participants of the current study, such as isolation, lack of communication, cultural losses, lack of choice, worry caused by separation from

their other children, lack of breastfeeding support, and lack of pain medication.<sup>1,2,14,18,21,23,24,28</sup> The experiences of racism shared by the participants are, unfortunately, a common health care experience for Indigenous people in Canada, have been shown to have direct adverse effects on health, and can even have fatal consequences.<sup>45,53,83</sup> The many negative consequences of the evacuation policy for First Nations birthing parents, babies, families, and communities, especially when contrasted with participants' positive experiences with traditional birthing practices, provide support for the growing movement of birth sovereignty for Indigenous birthing parents, expanded upon in the *Recommendations* section of this chapter.

### **Filling the Literature Gap**

This study and the larger team project begin to address two main gaps in the existing literature. The first, which this thesis study focuses on, is the paucity of studies on perinatal care for First Nations birthing parents that utilize Indigenous research methods. Although there are studies in this area that utilize Indigenous research methods, I could not find any studies in the area of perinatal care experiences that utilized Sharing Circles or explicitly focused on First Nations birthing parents in Northern Manitoba.<sup>53-55</sup> This study begins to address this gap by privileging the stories of First Nations women when speaking about their unique experiences with the perinatal care system in Northern Manitoba.

The larger team project, and specifically the PREMs instrument that the results of this thesis study will impact, will begin to address the gap in instruments designed to capture perinatal care experiences or quality, as the existing instruments lack items that address the unique challenges faced by First Nations birthing parents in Northern Manitoba as they navigate the perinatal care system. The PREMs instruments created by the team study have been designed in consultation with Indigenous women, Elders, and health care providers from Northern Manitoba, and changes will be made to the instruments based on the stories shared by the participants of this thesis study, ensuring

that the instruments capture these unique experiences and challenges. Development and testing of the PREMs instruments are beyond the scope of my study, but are being carried out as part of the larger group project.

## **Recommendations**

The stories shared in this study, particularly concerning the many negative experiences shared as part of Western perinatal care practices, such as the evacuation policy, demonstrate the ongoing, pressing need for improved perinatal health care for First Nations birthing parents in Northern Manitoba. As Lawford et al. (2019) stated, the culmination of gaps in care faced by First Nations birthing parents “reveals a system of health services that urgently requires attention and commitments from multiple levels of government to improve maternity care for First Nations women.”<sup>5</sup> The results of my thesis support improvements to perinatal care for First Nations birthing parents in the areas of communication and accountability, traditional birthing practices including returning birth to community, culturally safe care, and shared decision-making.

### ***Traditional Practices***

Participants in this study who had experiences of birthing in their home communities, attending births in their communities, and utilizing traditional care practices spoke very positively of their experiences, which starkly contrasted many of the stories shared about experiences with the current Western perinatal care system. A previous study conducted with four Indigenous communities in British Columbia found that “[i]n all communities, there was expressed a hope to reclaim traditional birthing practices; reclaiming birthing and strengthening culture were seen as inseparable and necessary for enhancing the health of mothers, babies, families, and communities.”<sup>14</sup> This desire is echoed by many of the participants who shared their stories with me, expressing their desire to see traditional birthing practices offered to women more regularly and advising future

generations of women to reclaim these practices and to be unapologetic in advocating for their right to utilize traditional perinatal care practices. Experiences of midwifery shared by participants included the ongoing support provided by midwives, the intergenerational knowledge transfer about perinatal care practices carried out by midwives, and sadness that midwifery does not currently seem as readily available to First Nations women in Northern Manitoba as it once was. Midwifery care has been shown to positively affect the outcomes of birthing parents and infants, such as lowering the odds of medical interventions during labour and birth, lowering perinatal mortality rates, and increasing rates of breastfeeding, and it is a cost-effective method of care.<sup>5,82</sup> The stories shared in this study support increased training opportunities for Indigenous midwives and increased availability of midwifery services in Northern Manitoba.

Indigenous Birth Helpers (or Doulas), such as those who are part of Wiji'idiwag Ikwewag in Manitoba, help to “encourage traditional approaches to healthy pregnancies, healthy sexuality, culturally-appropriate childbirth education, and breastfeeding and parenting support through community-based programming.”<sup>2</sup> The Indigenous Birth Helpers of Wiji'idiwag Ikwewag provide support to birthing parents grounded in traditional Indigenous teachings about childbirth and parenting and support families throughout their pregnancy, birth, and postpartum journey.<sup>85</sup> Indigenous Birth Helpers or Doulas offer a unique resource to First Nations birthing parents because their work is rooted in cultural knowledges and practices, promotes returning birth to communities, and supports midwifery as a care alternative to evacuation.<sup>18,19</sup> The experiences of the participants in this thesis study provide many examples of instances in which a Birth Helper or Doula could have supported or advocated for them. Increasing support for organizations such as Wiji'idiwag Ikwewag, and therefore increasing the availability of Indigenous Birth Helpers to First Nations women in Northern Manitoba, would help provide women more opportunities to utilize

traditional care practices, more culturally safe support, and someone to help advocate for them and help them navigate the perinatal care system.

The participants in this study also emphasized positive experiences related to other traditional practices surrounding pregnancy, birth, and raising a family, such as support from family and community, ceremonies, and birthing in one's own community. The participants made several recommendations in this area, including allowing women to have more family and community support during birth, encouraging young people to incorporate ceremony into their lives and those of their children, and creating support groups for young mothers consisting of Elders or other mothers. Traditional practices and support can help mitigate the adverse effects of evacuation and support resilience and connection, and knowledge surrounding traditional practices can increase the likelihood of health care offering services more focused on local First Nations communities.<sup>18,21,23</sup>

There is a growing body of research advocating for the return of birth to Indigenous communities, and the experiences shared by participants in this study provide another source of support for this movement. A study titled *Canada's evacuation policy for pregnant First Nations women: Resignation, resilience, and resistance* was conducted in Norway House, a First Nations community in Northern Manitoba, and reported that 74% of community members who participated in the study supported community birthing.<sup>2</sup> The same study envisioned a future of “[w]omen caring for women in their own communities, offering choice of birth place and caregiver, and bringing birth back home...”<sup>22</sup> There are examples of rural and remote communities that have established birthing centres or developed local, multidisciplinary, collaborative perinatal care services, and birthing in community has been associated with more positive experiences than being evacuated to an urban centre for birth.<sup>6,25</sup> Birthing in community can contribute to greater family involvement and patient satisfaction, better relationships with local health care providers, more opportunities for celebrations of birth, and is an important part of First Nations community and identity.<sup>25</sup> As Phillips-Beck

reminds us, being able “to choose where, how and by whom our babies are born... and to have our families and friends there to share and bond in this experience” is a choice that many Canadians take for granted and a choice that should be available to every Canadian citizen.<sup>37</sup> A study conducted in Australia provided a strong argument for birthing in community (termed “Birthing on Country” in Australia), which is a birth option that privileges Indigenous knowledges and governance, provides continuity of care from midwives, and prioritizes cultural competency in staff, strength-based approaches, and a focus on the well-being of families.<sup>86</sup> Birthing parents receiving Birthing on Country services were less likely to give birth preterm, more likely to attend a higher number of prenatal care visits, and more likely to exclusively breastfeed when leaving the hospital.<sup>86</sup> In the current study, participants’ negative experiences that occurred during evacuation, when compared to positive experiences shared about birthing in community with midwives, provide a great deal of insight into the effects that different care options can have on birthing parents, infants, and families, and support a return to community birthing as an option for First Nations birthing parents in Northern Manitoba.

### ***Culturally Safe Care***

Participants’ experiences with racism and pressure to accept certain medical procedures illustrate the ongoing need for increased cultural safety in perinatal care for First Nations birthing parents. The need for perinatal care providers to provide care that is culturally safe, incorporates input from Indigenous communities, and is tailored to a community’s specific needs has been suggested by many studies, as culturally safe care increases trusting relationships, satisfaction with care, and the effectiveness of care.<sup>14,19,25,30,47</sup> One of the three main focus areas of the larger team study, out of which this thesis work developed, is the creation of cultural safety training tools for perinatal health care providers working with First Nations birthing parents in Manitoba. The stories shared by participants in this study clearly demonstrate the pressing need for cultural safety training

to be required for everyone providing perinatal care to First Nations birthing parents to improve their perinatal experiences and ensure their safety and that of their babies.

### ***Communication***

One of the gaps faced by First Nations birthing parents related to the evacuation policy, demonstrated in the stories shared by participants, is the lack of communication that many birthing parents experience. One of the recommendations from Susan Kobliski (Grandmother Bear Woman) was that after giving birth, women should be given “a specific and detailed explanatory form of information” designed to help them plan their journey into parenthood. Previous studies have recommended that First Nations birthing parents and families experiencing evacuation should be provided with detailed, written guidelines outlining the maternity care services offered in their home community, that information sharing and care coordination between clinics and hospitals providing perinatal care to First Nations birthing parents needs to be improved, and that healthcare providers should be accountable to those receiving care.<sup>5,46,47</sup> The combined implementation of these recommendations would help inform First Nations birthing parents and families of different options for care, give them the information required to advocate for themselves and their babies, and provide a less fragmented experience when navigating the complicated perinatal care system.

### ***Shared Decision-Making***

Another common theme discussed by participants in this study was the lack of choice they were given in their perinatal care. Prior studies have recommended that health care services should be owned and managed by, or at the very least tailored to, Indigenous communities and that Indigenous voices should be privileged in health workforce planning, health research, and policy development.<sup>2,22,25,45</sup> Previous research has also advocated for greater “equality and shared power in the patient-provider relationships to avoid fear-inducing, paternalistic, and ineffective healthcare.”<sup>47</sup>

The stories and recommendations of the participants in this study support the need for increased shared decision-making at the policy and health care planning levels and at the level of individual patient-provider relationships. The voices of First Nations birthing parents must be prioritized when working toward much-needed changes to the delivery of perinatal care for First Nations families in Northern Manitoba, and perinatal care providers need to ensure that patients are informed of the different care choices available to them and that their choices are respected and implemented.

### **Knowledge Added**

This study adds to the literature surrounding First Nations birthing parents' experiences with perinatal care access and the multitude of barriers they face when accessing care. The stories shared by the participants help provide a richer understanding of the real lived experiences of First Nations women in Northern Manitoba with the current perinatal health care system. The stories, experiences, and teachings shared will also inform changes to the PREMs instrument created as part of the larger study. The PREMs instrument is unique due to its focus on the birth experiences of First Nations birthing parents and its creation in partnership with First Nations communities and organizations. In order to respond to TRC Call to Action item 19 and close the gap in perinatal health care currently experienced by First Nations birthing parents, infants, families, and communities, the experiences of Indigenous birthing parents with health care during birth must be understood to help improve those experiences for families; the results of this study will increase that understanding. Through the larger grant and the partnerships with the Northern Health Region, the Keewatin Tribal Council, Opaskwayak Health Authority, Keewatinohk Inniniw Minoayawin Inc., and Wiji'idiwag Ikwewag, results from this study and the PREMs administered as part of the grant will be immediately fed back to the health care system to inform positive changes in perinatal care, develop perinatal care centred on birthing parents and families, and improve health outcomes.

## Knowledge Mobilization

Knowledge mobilization of the results of this study will be approached in two ways, with two different groups: (1) First Nations women and Elders involved in the work; (2) organizational partners of the larger grant – the Northern Health Region, the Keewatin Tribal Council, Opaskwayak Health Authority, Keewatinohk Inniniw Minoayawin Inc., and Wiji'idiwag Ikwewag. In Canada, it has been recommended that appropriate knowledge mobilization for research involving Indigenous Peoples should focus on “sharing knowledge in ways that are ‘locally developed and contextualized.’”<sup>87</sup> To ensure that knowledge co-created with First Nations participants in this work is shared in ways beneficial to First Nations families in Northern Manitoba, an integrated knowledge mobilization plan will be developed in consultation with the participants; this will ensure that the knowledge is shared in a way that is led by First Nations women in Northern Manitoba and is relevant to the particular context, priorities, and ways of knowing of First Nations in Northern Manitoba.<sup>87-90</sup> Results from this work will also be shared with the *Facilitating Transitions* team and our organizational partners. The team and partners will disseminate this information, with each partner tailoring dissemination to their organization, allowing it to be fed directly back into the perinatal health care system to inform positive changes in health care for First Nations birthing parents and families living in Northern Manitoba. Results will also inform modifications to the PREMs instruments created as part of the team project. Publication of results in academic or scientific journals and presentations at professional conferences may also be pursued. In this case, the participants will be invited to be co-authors or co-presenters of this work, as their stories and knowledge will impact perinatal health care in Northern Manitoba.

## Study Strengths

The main strength of this study comes from the First Nations mothers, Elders, Knowledge Keepers, scholars, and health care providers who have gifted their voices, knowledges, and guidance to this study throughout the entire research process. As a white settler who has completed my entire formal education in Western colonial institutions, my worldview and knowledge are limited, and alone would not have been adequate to conduct this study in a Good Way. The knowledges of the many First Nations women involved in this study with me have enabled me to work towards incorporating a Two-Eyed Seeing framework through which to examine the current perinatal care system for First Nations birthing parents in Northern Manitoba and how we can move forward with a focus on creating more culturally-safe perinatal care centred on birthing parents and families.

The data collection methods of Sharing Circles and one-on-one conversational interviews are another strength of this study. Due to their lack of time constraints and more unstructured nature than many interviews or focus groups, these methods allowed women the space and time to share their stories in their own words, guide the conversation themselves, and speak about experiences that were particularly important to them. It also allowed these experiences to be contextualized within the larger narratives that women shared, including background information about their home communities and families, lessons they have learned throughout their lives, and their future visions for the perinatal health care system in Northern Manitoba.

Another strength is that the participants' voices are heard in every aspect of the study. The four out of five participants who also assisted in data analysis, reviewing their stories and the themes and recommendations sections of the results and providing feedback and more information strengthened the study results. This process helped ensure that each woman's voice was shared in a way that she was comfortable with and accurately captured her experiences and teachings. In addition, each participant had a choice of whether or not to share their name as part of the study,

which was recommended by the Grandmothers Circle advising the larger team project and allows women to claim ownership over their stories and to share that they have gifted their time and knowledge to help improve perinatal care for birthing parents in their communities.

Finally, the large number of partners connected to this study through the larger team project is a strength of this study. Being able to share these results directly with the Northern Health Region, Keewatinohk Inniniw Minoayawin Inc., Wiji'idiwag Ikwewag, and other organizations connected to perinatal health care in Northern Manitoba will help to ensure that the findings of this study can reach a larger audience that includes policymakers, health care administrators, health care providers, and First Nations communities. This will allow the findings of this study to contribute to positive changes in perinatal health care in Northern Manitoba.

### **Study Limitations**

The application of a Two-Eyed Seeing framework by a non-Indigenous researcher is a potential limitation of this study, as by definition, Two-Eyed Seeing requires a balanced perspective between the Western and Indigenous worlds and knowledge systems, and I cannot hold both perspectives. I hope that my dedication to privileging the words and knowledge of the First Nations mothers and Elders who shared their stories and incorporating the advice and knowledge given to me by the First Nations Grandmothers and scholars connected to my project and the larger team project has helped to address this limitation.

The shift from in-person Sharing Circles to virtual meetings also presents a possible limitation, as some of the benefits of Sharing Circles include the sharing of emotion, spirituality, and information and the opportunity for those in the Circle to listen to and support one another, experiencing growth and transformation throughout the discussion.<sup>58,73</sup> Conducting most data collection through virtual, individual conversational interviews with participants required forgoing some potential benefits of Sharing Circles. The individual discussions did, however, allow each

participant more flexibility in setting a time to meet and alleviated the time constraints that can occur as part of Sharing Circles, in which discussions can continue for hours depending on the number of participants. As all of the participants lead busy lives balancing many responsibilities, this allowed for participation from people who may otherwise not have been able to share their stories.

The COVID-19 pandemic also presented several feasibility challenges for this study, including delays to this work and the larger team project. Throughout much of the pandemic, travel to Northern Manitoba was put on hold in the interest of public health and the safety of Northern Communities. The inability to meet in person created both practical delays and a barrier to building and nurturing the relationships that are so important in this research. Being able to gather, share meals, and provide offerings in-person helps to strengthen relationships, while strictly scheduled virtual meetings do not lend themselves to this type of connection. The delays and challenges with maintaining relationships throughout the pandemic contributed to recruitment challenges during this study. To help address these challenges, I turned to discussions carried out throughout the pandemic regarding how researchers and Indigenous communities continued to work together throughout periods of public health restrictions and had planned to offer an option for virtual Sharing Circles if restrictions required this. Although virtual Sharing Circles were not conducted, my discussions on this topic with my advisor, committee, and others influenced my decision to shift to virtual discussions with participants when in-person Sharing Circles were not feasible for the participants.

The final two limitations of this study stem from recruitment challenges. The first is a smaller sample size than anticipated. Initially, I had hoped for at least four participants from each group with whom I planned to conduct Sharing Circles (First Nations mothers, First Nations Elders, and perinatal health care practitioners in Northern Manitoba). The final sample size of two mothers and three Elders was fewer than planned. Still, the rich stories they shared and their wide range of experiences, both with traditional First Nations birthing practices and the Western medical

system, provided content saturation and a wealth of information for data analysis. The lack of health care practitioner perspective can also be viewed as a limitation, but as there are many health care providers from Northern Manitoba partnered with the larger team project, I believe that their knowledge and perspectives will still provide an important influence over changes to perinatal care in Northern Manitoba as recommended by the larger project.

## **Reflections**

### ***Theoretical Framework***

Two-Eyed Seeing was the theoretical framework that guided my thesis research. My thesis study design was influenced by the work on the larger team project with Indigenous community members and organizations, conversations with Elders and Indigenous scholars, and the voices of First Nations mothers and Elders. Throughout this work, I sought to balance the Western perspective and knowledge that I, as a white settler researcher, bring to the study with the knowledges, perspectives, and guidance of the participants, Cree Elders and Knowledge Keepers, and Cree and Anishinaabe scholars and health care providers. The lived expertise of the women who shared their stories with me during this study and the experiences and guidance that they shared are the focus of this thesis. I am sure their expertise and recommendations will help guide positive changes to the perinatal health care system in Northern Manitoba and will help to empower other birthing parents as they navigate the Northern health care system.

In carrying out this study, I experienced moments of tension between the Western university system and the advice I received from partners on the team project, the Grandmothers Circle, and Indigenous organizations. When competing interests or requirements arose, I worked to navigate them with the guidance of my advisor, my committee, and others who have advised me throughout this project, such as the Grandmothers Circle. As a Western settler researcher working within the

constraints of the Western educational system, I tried to continuously acknowledge my limited viewpoint, as well as the way that a thesis project within a Western institution is carried out and presented, and how this affected work focused on First Nations birthing parents, children, families, and communities. By putting the participants' stories at the forefront of the study, often in their own words, and by working closely throughout this project with Indigenous Elders, Knowledge Keepers, scholars, and healthcare providers, almost all women, I have tried to address this as much as possible, seeking the balance between Western and Indigenous knowledges encouraged by a Two-Eyed Seeing approach. I think that this study, with its mixture of Western and Indigenous voices, accomplishes "seeing with one eye with the *strengths* of Indigenous knowledges and ways of knowing, and from the other eye with the *strengths* of Western knowledges and ways of knowing, and using both eyes together for the benefit of all."<sup>65</sup>

### ***Findings in the Context of Two-Eyed Seeing***

Although Two-Eyed Seeing emphasizes weaving together two perspectives, each given equal importance, Bartlett et al. (2012) acknowledged "that in some instances, one perspective may further our understanding of a specific concept or situation more than the other."<sup>65</sup> Colonial society has made decisions about areas such as health care and research without incorporating the knowledges and perspectives of the Indigenous Peoples affected, only accounting for the dominant Western viewpoint. This research, although weaving together both Western and Indigenous knowledges and perspectives, privileges the stories and lived expertise of First Nations women, acknowledging that their firsthand experience with perinatal care in Northern Manitoba provides a crucial view of the effects that the current system of perinatal health care delivery has on First Nations birthing parents, children, families, and communities. While Western ontologies and epistemologies focus on the external, Indigenous ontologies and epistemologies focus on the relational, on our relationships to reality and the world around us.<sup>67</sup> The findings of this study focus on the relationships of five First

Nations women to the reality and the world through which they journey, examining the effects that different methods of perinatal care (whether Western practices or Indigenous practices) have not only on the women themselves but on those connected to them through family and community.

### *Personal Reflections*

Throughout my journey completing this thesis, I have undergone many changes in the academic, professional, and personal areas of my life. When I was first accepted to the MSc program in early 2019, I had limited experience working with or learning from Indigenous individuals, I had never been involved in a large team research project, and I had never travelled to Northern Manitoba. During my first trip to Thompson in July 2019, I felt nervous about my lack of knowledge of the challenges that Indigenous Peoples in Canada face when navigating the health care system, worried that I would say or do the ‘wrong thing’, but also excited to see some of Northern Manitoba and to meet and learn from so many different people. Everyone was so welcoming, warm, and friendly, as has been the case every time I have been able to travel to Thompson as part of the larger project or my thesis work. I also learned that the discomfort and nervousness I felt during that first trip to Thompson, and that I continue to feel about my lack of knowledge and the ease through which I, as a white settler, am able to navigate Canadian society while so many others face challenges, is a discomfort that I should acknowledge, sit with, and use to fuel my desire to learn more and to dedicate my professional and academic work to change. Over the past five years, I have been fortunate to learn from many Indigenous Elders, Knowledge Keepers, mothers, researchers, and health care providers; our large team meetings where we share meals and stories hold a special place in my heart. One of my favourite memories from my time in the MSc program was when I was sitting with Susan, Doris, and Esther, the Grandmothers Circle who were advising the large team project, as they told stories and jokes, some in English and some in Cree, and sharing in their laughter and friendship. I will forever be grateful to everyone that I have been able to work with and

learn from throughout this academic journey, and I'm constantly in awe of the many accomplished and hard-working people that I get to call colleagues and friends. Susan Kobliski (Grandmother Bear Woman) has made me, my husband, and our son feel like family, gifting us with love, knowledge, teachings, and special items that we will always treasure. Her guidance throughout this study, her support and confidence in myself and this project, and the stories and teachings she shared as a research participant have been integral to this work.

During my time in the MSc program, I also became a mother. Motherhood has been, by far, my favourite journey on which I have embarked. Navigating pregnancy as a white woman in a Western medical system is something that, prior to working on my thesis and the larger project, I would have taken for granted. Instead, I have reflected many times throughout pregnancy, labour, birth, the postpartum period, and now another pregnancy about the many stories that I have heard from First Nations women having to navigate a fragmented, complicated, and racist Western medical system during the perinatal period and the many challenges that they face in seeking safe care. The experience of becoming a mother while working on these projects has increased my passion for improving perinatal health care for First Nations birthing parents and children, work that I hope to continue beyond my thesis.

I know that I will spend my life learning from the experiences of people in Canada that differ from my own experiences and unlearning the many lessons ingrained in me from living in a Western colonial society. I want to end my discussion section by reflecting on how much I've learned over the past five years from so many different people, and by sharing my hope that this work will, in some way, help improve perinatal care for First Nations birthing parents, children, families, and communities in Manitoba.

## Chapter 5: Conclusion

The stories shared by participants in this study illustrate the harm that the Western medical system often causes to First Nations babies, birthing parents, families, and communities in a continuation of the many colonial harms that Indigenous Peoples around the world face. The stories also provide a look back at the many positive experiences that First Nations birthing parents have had with traditional birthing practices and, at the same time, a look into a future where these practices are made increasingly available to birthing parents and families in order to improve perinatal care experiences and outcomes for First Nations birthing parents and infants in Northern Manitoba. These stories exemplify how, despite well-documented evidence of the adverse effects that the medicalization of birth and the Evacuation Policy have on First Nations birthing parents, the perinatal care experience of many First Nations birthing parents in Northern Manitoba continues to be defined by lack of choice, communication, and support, long periods of forced travel away from community resulting in isolation and disconnection, and experiences of racist, dismissive, and culturally unsafe care. The teachings and recommendations provided by participants in this study demonstrate that many aspects of the current system can be improved upon to better support First Nations birthing parents while at the same time highlighting the importance of reproductive justice and the need for a system that supports First Nations birthing parents in having autonomy over their own perinatal care experience. There is a pressing need for improvements to perinatal care for First Nations birthing parents in the domains of traditional birthing practices and Indigenous birth sovereignty, culturally safe care, communication, accountability, and shared decision-making.

Utilizing a Two-Eyed Seeing approach in the design and implementation of perinatal care for First Nations in Northern Manitoba and privileging the knowledges, expertise, and birthing practices of First Nations while working towards a Western medical system that incorporates and promotes

these practices will lead to perinatal care that is culturally safe and centred on the best interests of First Nations infants, birthing parents, families, and communities. This effort must include governments, policymakers, health care administrators, and health care providers working with communities in the fight for reproductive justice and returning birth to communities, providing women with a choice in where and how they give birth.

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## Appendix A – Grant Summary

Gregory, Patricia

Appl. # / Numéro de la demande :

Team Grant: Transitions in Care/Subvention d'équipe : Transitions dans les soins Application/Demande 2019-01-24

Summary of Research Proposal/Résumé de la proposition de recherche

**Rationale:** The pregnancy period (defined here as the time between conception and a child's first year of life) is one of the most critical time periods to promote health across the lifespan. Indigenous women living in rural areas experience several transitions in care during this time, between care providers and health jurisdictions. Lack of continuity in these transitions can lead to poor prenatal, postpartum and infant care, resulting in significant morbidity in mothers and children, perpetuating inequities in health. Wholistic, culturally safe interventions are needed to support continuity of care during the pregnancy period to reduce these inequities and promote lifelong well-being among Indigenous women and their children.

**Aims and Hypothesis:** We assembled a multi-disciplinary team of scientists, policy makers, health providers and Indigenous women to develop and evaluate an intervention to improve continuity of care for Indigenous women during the pregnancy period. Using a population-based quasi-experimental controlled design we will **test the primary hypothesis** a Northern prenatal care network, led by an Indigenous patient navigator, will improve rates of prenatal and post partum care as well as neonatal outcomes among Indigenous women and their children in Northern Manitoba.

**Design:** To test the primary hypothesis and research questions we will rely on an interrupted time-series analysis of prenatal care and maternal-child health outcomes in the 10 years (2009-2019; 40 time points) before and 4 years (2019-2024; 16 time points) following the implementation of the pregnancy care network.

**Population:** We will rely on population-level administrative data for all Indigenous women who delivered a children in Manitoba between 2009 and 2024. We will exclude data from women that delivered in the city of Winnipeg and those who delivered in their community, due to differences in the health systems.

**Intervention:** Over a period of 2 years, we conducted a mixed methods formative study to assess barriers and facilitators to prenatal care, then used that information to co-design an intervention with health care providers and Indigenous community leaders. We came to a consensus that a pregnancy care collective impact network, consisting of an Indigenous patient navigator, combined with training in cultural safety and shared decision making would be the appropriate intervention to improve maternal child health outcomes for Indigenous women in the region.

**Control condition:** The control population will consist of Indigenous women delivering a child in all other rural health regions in Manitoba, excluding those that delivered at the two major hospitals in Winnipeg.

**Outcomes:** *The co-primary outcome measures* will be a (1) adequate prenatal care, *and* (2) a composite measure of infant outcomes; preterm birth defined as a birth occurring before 37 weeks gestation and small for gestational age. *The secondary outcome measure* rates of 6 week post-partum care, infant breastfeeding initiation, 2 month vaccination rates and rates of infant apprehension in the first 7 days of life. We will also examine family experiences within the health systems at different time points of the perinatal period.

**Qualitative Studies:** In addition to these quantitative outcomes, we will work with local Elders and knowledge keepers to create narratives to describe the "women's journey" during the pregnancy period. We will rely on local women to gather the narratives of women throughout their journey to describe the contextual factors associated with the intervention. **Finally, we will also examine** the cost effectiveness of the intervention based on changes in the hard end-points described above.

**Importance:** This will be the first health systems intervention to improve transitions in care during the pregnancy period for Indigenous women living in northern regions in Canada. It will serve a model for improving health care and jurisdictional transitions among Indigenous women during the pregnancy period.



Appl. #	0
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### Lay Title and Lay Abstract

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**Lay Title:**

Facilitating pregnancy care for Indigenous women in northern Manitoba

**Lay Abstract:**

Pregnancy is a time of transition. Women and families transition from pregnancy, to birth, to post pregnancy care. Each transition requires a connection to various health care providers, from a nurse, physician or midwife, sometimes to a specialist, and from care in an office setting, to hospital care for birth, and back home. In northern Manitoba one of every three pregnant women does not receive adequate care in pregnancy. Indigenous women and children experience the greatest health inequities in this region and in Canada more broadly. These inequities are compounded by transitions between health care systems. The federal government provides health care in First Nations communities, however, for specialized services and birth, women need to transition to the provincial health care system. Many barriers including, travel, transportation issues, financial constraints, poor communication, different providers, and weak referral links are encountered through those transitions. For many, relocating for care and birth away from home is characterized by insecurity, strange surroundings, and isolation from family.

A pregnancy collective impact network of service providers, families and community members led by a patient navigator is proposed to assist with access to care, navigation of complex system transitions, and to improve linkages between the services and across systems. Culturally safe care and promotion of shared-decision making between patients and providers are foundational and will be supported through training. It is not enough to facilitate access and navigation, services need to be inclusive and respectful of Indigenous beliefs and issues faced by Indigenous peoples. Shared-decision making promotes effective participation in care. These strategies are expected to increase use of care, decrease low birth weight and premature birth, increase breastfeeding, increase use of well-child care and vaccination rates, and improve patient experiences.

## Appendix B – Research Team

### Core Research Team

<b>Team Member</b>	<b>Affiliation</b>	<b>Position/Title</b>
<b>Principal Investigator (Scientific Lead)</b>		
Jon McGavock	University of Manitoba	CIHR Applied Public Health Chair
<b>Former Principal Investigator</b>		
Patricia A. Gregory	Red River College, University of Manitoba	Research Coordinator, Assistant Professor
<b>Core Research Team Members</b>		
Nathan Nickel	Manitoba Centre for Health Policy, University of Manitoba	Director, Assistant Professor
Nancy Vystrcil	Northern Health Region, Keewatinohk Inniniw Minoayawin Inc.	Public Health Nurse, Client Advocate
Susan Kobliski	Nisichawayasihk Cree Nation	Elder
Tamara Beardy	University of Manitoba	Research Coordinator
Emily Brownell	University of Manitoba, Manitoba Centre for Health Policy	MSc Student, Student Research Assistant

### Grandmother's Circle – Past and Present Members

Susan Kobliski

Doris Young

Esther Sanderson

Amelia Moose

### Organizational Partners

University of Manitoba

Red River College

Northern Health Region

Keewatinohk Inniniw Minoayawin Inc.

Wiji'idiwag Ikwewag

First Nations Health and Social Secretariat of Manitoba

Opaskwayak Health Authority

Keewatin Tribal Council

## Appendix C – Sharing Circle Guides

For Mothers and Elders:

We would like to hear about your experience receiving health care during your pregnancy, labour and birth, and in the year following pregnancy. Please feel free to only share what you are comfortable with, there is no wrong or right response, we just want to hear your story and your experiences. If you would like some prompts to help you think of areas to talk about, we would be happy to give you some.

Probing questions:

- Did you have to travel outside of your community for care? If so, can you share a bit more about that experience? Were there good things or bad things about that experience?
- Who did you receive care from, and did you have a choice in your provider? Please share a bit more about that.
- How were you treated by the people who provided care for you and your baby?
- Were you given the option to incorporate traditional practices into your care experience?
- How did you feel about the care that you received?
  - Positive experiences?
  - Negative experiences?
- *If appropriate* – what would you have preferred to have happened?
- *If appropriate* – can ask participants how an experience made them feel or made their family feel.

- How were you treated by the people who provided care for you and your baby?
- Were you given the option to incorporate traditional practices into your care experience?
- How did you feel about the care that you received?
  - Positive experiences?
  - Negative experiences?
    - *If appropriate* – what would you have preferred to have happened?
- *If appropriate* – can ask participants how an experience made them feel or made their family feel.
- For Elders:
  - Is there anything that you would like to share with young women who will be coming into contact with the perinatal health care system in Northern Manitoba?

For Healthcare Providers:

We would like to hear about your experience providing health care to First Nations women during their pregnancy, labour and birth, and in the year following pregnancy. Please feel free to only share what you are comfortable with, there is no wrong or right response, we just want to hear your story and your experiences. If you would like some prompts to help you think of areas to talk about, we would be happy to give you some.

Probing questions:

- Have you cared for women who have had to travel outside of their communities for care? If so, can you share a bit more about that experience?

- Have you worked with patients who have wanted to incorporate traditional practices into their care experience?
  - *If appropriate* – what kind of experiences did you observe in this context (e.g., positive or negative)?
- How do you feel about the current perinatal health care system in Northern Manitoba?
  - *If appropriate* – is there anything that you would like to see change?

**Note:** This is not a true guide. Sharing Circles are an open-ended forum for participants to share their stories, and they are intended to be an uninterrupted narrative of their experiences. These probing questions exist for use only if the participant requests further guidance regarding topics that they can discuss if they choose.

## Appendix D – Prenatal PREMs Instrument

### Prenatal PREMS - Survey A

Page 1

Facilitating Transitions and Access across the Pregnancy Continuum of Care: A Health System Intervention for Women Living in Northern Manitoba

Women's and Families' Experience of Pregnancy Care

Survey A (36 weeks of pregnancy/after birth)

Your experiences are important, and we hope you take the time to answer our questions!

If you are at least 36 weeks pregnant, this Prenatal Survey about the care you received during pregnancy is for you. Please answer the questions below thinking about all the pregnancy care you received.

Completing the survey

Thinking about this pregnancy and the care you got from doctors, nurses, midwives, or other prenatal care providers, please fill out the questions, by selecting your answer. For some questions you may be asked to select more than one answer.

Not all questions may fit with your experience, and you do not have to answer those ones. If you don't want to answer the questions or get tired of answering the questions, go to the last page and click submit.

Questions or help?

If you have any questions, about this survey, ask the research assistant

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#### Women's and Families' Experience of Pregnancy Care

1. When is your baby's due date?

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2. How many times have you been pregnant including this pregnancy?

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3. How many children do you have?

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4. When did you find out for sure you were pregnant? (For example, you had a pregnancy test, or a doctor or nurse said you were pregnant.)

- 5 or less weeks
- 6-7 weeks
- 8 - 10 weeks
- 11 - 13 weeks
- 14 - 18 weeks
- 19 - 22 weeks
- 23 - 27 weeks
- 28 - 32 weeks
- 33 - 36 weeks
- 37 - 42 weeks
- Don't know/Cannot remember

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5. Thinking back to just before you got pregnant, how did you feel about becoming pregnant?

- I wanted to be pregnant sooner
- I wanted to be pregnant later
- I wanted to be pregnant then
- I didn't want to be pregnant at any time now or in the future
- I had not been thinking about becoming pregnant

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6. A prenatal care visit is a visit to a doctor, midwife, nurse practitioner, or nurse for medical care for your pregnancy and to learn about your baby and get information about a healthy pregnancy. This can include things like physical examinations, ultrasounds, urine and blood tests, or someone talking to you to provide education about your pregnancy. Did you get prenatal care during this pregnancy?

- Yes
- No (If 'no', go to Q.58)
- Don't Know (If 'don't know' , go to end of survey and submit)

---

7. How many weeks or months pregnant were you when you first saw a doctor, nurse, or a midwife for a pregnancy check-up? (Do not count a visit that was only for a pregnancy test)

- Weeks pregnant
- Months pregnant
- Don't know

---

How many weeks?

---

---

How many months?

---

---

8. Was it hard for you to get your first prenatal care visit?

- Yes
- No
- Don't know/cannot remember

9. From which of the following types of care providers did you receive prenatal care? Select all that apply and identify number of visits as closely as possible.

- Nurse/Nurse Practitioner
- Doctor
- Specialist (Obstetrician)
- Midwife
- Traditional healer
- Other (Specify) \_\_\_\_\_
- Don't know/Cannot remember

Number of nurse/nurse practitioner visits

\_\_\_\_\_

Number of doctor visits

\_\_\_\_\_

Number of specialist (Obstetrician) visits

\_\_\_\_\_

Number of midwife visits

\_\_\_\_\_

Number of traditional healer visits

\_\_\_\_\_

Number of other care provider visits

\_\_\_\_\_

10. Where do you go for most of your prenatal care?

- Private Doctor's Office
- Northern Health Region Consultation Clinic
- Thompson/The Pas Clinic
- Nursing Station
- Health Centre
- Other (Specify) \_\_\_\_\_
- Don't know/Cannot remember

11. Where will you be having your baby?

- Thompson General Hospital
- St. Anthony's General Hospital (the Pas)
- At home
- Winnipeg
- Other (specify) \_\_\_\_\_

12. Did you see the same prenatal care provider every time?

- Yes  
 Yes, but would have preferred not to  
 No, but I wanted to  
 No, but I did not mind  
 Don't know/Cannot remember

13. Did you have a doula or traditional/cultural birth helper support you during your pregnancy?

- Yes  
 Yes, but would have preferred not to  
 No, but I wanted to, none were available  
 No, but I did not want to

14. Have you taken part in any kind of pregnancy or mom/baby program since you found out you were pregnant?  
(Check all that apply)

- Healthy Baby/Healthy Start Program/CPNP  
 Families First/Strengthening Families Program (Maternal Child Health)  
 STAR/Insight Program  
 Prenatal Classes  
 Other (Please specify) \_\_\_\_\_  
 None of the above

**The following questions ask about your experience with the prenatal care you received from a physician, midwife, or other health care providers during this pregnancy. The questions are about support and how safe you felt where you got most of your prenatal care. Please read each statement carefully and choose the answer that feels right to you. If no answer feels right to you, choose 'Not Applicable' .**

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Not Applicable
15. I have supports in my community who understand and support me to help me have a healthy and safe pregnancy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. I have the support and guidance I need to make healthy choices	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. The place where I got my prenatal care feels like a safe environment to get my care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. The place where I received my prenatal care was warm, friendly, and caring	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

- 19. At the place where I received my prenatal care, I saw staff with similar cultural backgrounds or identities to mine
- 20. My prenatal appointments were at days and times that were easy for me
- 21. I was able to find a way to get to my prenatal visits
- 22. If needed, I had enough money to get to my prenatal visits
- 23. I was able to help choose who my prenatal care provider was
- 24. My prenatal care providers asked me how involved in decision making I wanted to be
- 25. I was able to choose what I thought were the best care options
- 26. My prenatal care provider respected my choices
- 27. I was asked about cultural practices I would like during my pregnancy
- 28. My prenatal care provider helped me understand all the information
- 29. My prenatal care providers asked me questions and spoke to me in a caring, supportive manner and did not judge me
- 30. I felt I could trust my prenatal care providers
- 31. I felt safe asking my prenatal care providers questions
- 32. I felt safe answering questions my prenatal care provider asked me
- 33. My prenatal care providers asked me what I was worried about and tried to understand my worries

34. I felt safe talking with my prenatal care provider about my behaviors that might be harmful to me and baby
35. My prenatal care providers helped me solve problems in a respectful way
36. At my prenatal visits, my prenatal care providers asked me how I was feeling emotionally
37. My prenatal care providers considered my personal life situation when they were giving me advice
38. My prenatal care providers helped me deal with difficult emotions
39. My prenatal care providers spoke to me in a way I could understand
40. My family was encouraged to be a part of my prenatal care
41. I was told about the prenatal benefit program
42. I was given the Manitoba prenatal benefit form
43. I felt that my cultural identity and practices were respected during my pregnancy
44. I felt judged, hassled, or made to feel lesser when I tried to get medical care for this pregnancy
45. I have experienced racism while receiving prenatal care

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46. Did you have to leave your community while you were pregnant to receive medical care/services related to your pregnancy?

- Yes  
 No (If no, go to Q. 58)

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47. Where did you have to go for these medical care/services related to your pregnancy? Select all options that apply

- Thompson  
 The Pas  
 Winnipeg  
 Other (Specify) \_\_\_\_\_

48. How far did you have to travel outside of your community to receive these medical care/services related to your pregnancy?

- 0 - 100 kms  
 101 - 200 kms  
 201 - 300 kms  
 301 - 400 kms  
 More than 400kms

49. How did you get to these care visits related to your pregnancy outside of your community?

- Walk  
 Bus  
 My own vehicle  
 Friend or family member's vehicle  
 Taxi  
 Shuttle/medical transportation van  
 Airplane  
 Not Applicable

50. I was able to bring someone with me to support me during these medical appointments/services related to my pregnancy.

- Yes  
 No  
 Not Applicable

51. Did you have to stay overnight outside of your community to get medical care related to your pregnancy?

- Yes  
 No

52. My support person was able to stay with me outside of my community

- Yes  
 No  
 Not applicable

**The following questions ask about the prenatal care you received from a physician, midwife, or other health care providers during this pregnancy and your experiences having to leave your community for prenatal care. Please read each statement carefully and choose the answer that feels right to you. If no answer feels right to you, choose 'Not Applicable'.**

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Not Applicable
53. I was able to help plan my prenatal visits outside of my community	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
54. I got enough information for what to expect at my prenatal visits outside of my community	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

55. I had enough money to meet my needs while I was outside of the community (food etc...)
56. I had supports for childcare at home while I was away from my community for prenatal visits
57. I had the support I needed while I was outside of my community for prenatal care
58. I had a place to stay overnight for medical care outside of my community

---

**Please answer a few questions about you!**

59. What is your date of birth?

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60. What is your highest completed level of schooling? (Please select the highest level)

- No schooling  
 Elementary School (K to 5)  
 Middle School (6 to 8)  
 High School (9 to 12)  
 Non-University (Vocational/Technical/Community College)  
 University

---

61. Do you, or did you have a paid job of any kind during this pregnancy?

- Yes  
 No

---

62. What is your marital status? Are you...

- Married  
 Living common-law  
 Single - never married  
 Divorced  
 Separated  
 Widowed  
 Don't Know

---

63. To which racial group(s) do you most identify?

- First Nations
- Metis
- Inuit
- Indigenous-Other (Specify) \_\_\_\_\_
- Caucasian/White
- South Asian
- West Asian
- East Asian
- Black
- Other (Specify) \_\_\_\_\_
- Unknown

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64. What language do you speak most often at home? (Select all that apply if languages are spoken equally)

- English
- French
- Dene
- Cree
- Ojibway
- Other (Specify) \_\_\_\_\_

---

65. Were you born in Canada?

- Yes
- No

---

66. For the previous year ending December 31, please think of your total household income from all sources, before deductions. We are asking for the total sum of all the money you and the other earners in your household made in the past year. Please include income from social assistance, child tax benefits, disability benefits, workers' compensation, maintenance enforcement payments

Which income range does it fall into?

- No income
- \$1-\$39,999
- \$40,000-59,999
- \$60,000-89,999
- \$90,000-125,000
- \$>125,000
- Don't know
- Prefer not to answer

---

67. Have you applied for the Manitoba Prenatal Benefit in this pregnancy?

- Yes
- No

---

68. What is the name of the community you live in?

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69. Including yourself, how many ADULTS live with you in your home?

(Please include anyone who has been living with you in the last month)

---

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70. How many CHILDREN live with you in your home?

(Please include anyone who has been living with you in the last month)

---

71. Is there any further information you want to share?

## Appendix E – Birth PREMs Instrument

### Birth PREMs Survey B

Page 1

#### Birth PREMs Survey

Facilitating Transitions and Access across the Pregnancy Continuum of Care: A Health System Intervention for Women Living in Northern Manitoba

Women's and Families' Experience of Care received during Birth  
(after birth of baby)

Your experiences are important, and we hope you take the time to answer the questions!

This survey about the care received during and after birth.

Please answer the questions below thinking about this birth and all the care you received from doctors, nurses, or midwives during your labor and birth.

#### Completing the survey

Thinking about your labour and birth with this pregnancy and the care you got from doctors, nurses, or midwives at that time, please answer the questions, by selecting your answer. For some questions you may be asked to select more than one answer.

Not all questions may fit with your experience, and you do not have to answer those ones.

If you don't want to answer the questions or get tired of answering the questions, go to the last page and select submit.

Questions or help?

If you have any questions, about this survey, ask the Research Assistant.

---

1. How many times have you been pregnant including this pregnancy?

- Yes  
 No

---

2. How many children do you have?

- Yes  
 No

---

3. A prenatal care visit is a visit to your doctor, midwife, nurse practitioner, or nurse for medical care for your pregnancy and to learn about your baby and get information about a healthy pregnancy. This can include things like physical examinations, ultrasounds, urine and blood tests, or someone talking to you to provide education about your pregnancy. Did you get prenatal care during this pregnancy?

- Yes  
 No (If no go to question 9)  
 Don't Know

---

4. How many weeks or months pregnant were you when you first saw a doctor, nurse, or a midwife for a pregnancy check-up? (Do not count a visit that was only for a pregnancy test)

- Weeks pregnant  
 Months pregnant

---

How many weeks?

---

---

How many months?

---

---

5. Did you have to leave your community for pregnancy related care ?

- Yes for pregnancy related care before birth  
 Yes for birth  
 No I did not have to leave my community for pregnancy related care  
 No I did not have to leave my community for birth

---

6. When was this baby's due date?

---

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7. What date was your baby born on ?

---

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8. Where did you give birth?

- Thompson General Hospital  
 St. Anthony's General Hospital (The Pas)  
 At Home  
 Winnipeg  
 Other (please specify) \_\_\_\_\_

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9. My baby was born by?

- Vaginal delivery  
 Planned Cesarean delivery  
 Emergency Cesarean delivery

---

10. I received care from the following care providers during my labour and birth. (Please select all that apply)

- Nurse/Nurse Practitioner  
 Family doctor  
 Specialist/Obstetrician  
 Midwife  
 Doula/Birth helper  
 Other (specify) \_\_\_\_\_  
 Don't know/Cannot remember

11. Did any of the health care providers who cared for you during your birth also take part in your prenatal care?

- Yes  
 Yes, but I did not want this  
 No, but I wanted this  
 No, but I did not mind  
 Don't know/Cannot remember

12. Did the staff who cared for you introduce themselves?

- Yes, all staff introduced themselves  
 Some of the staff introduced themselves  
 Very few or none of the staff introduced themselves  
 Don't know/Cannot remember

13. Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after birth?

- Yes  
 No, this was not possible for medical reasons  
 No, it was not offered to me  
 No, I did not want this

14. Did you use any traditional/cultural health practices during your labour and birth?

- Yes, I did use traditional health practices  
 No, but I would have liked to know more about traditional health practices  
 No, but I would have liked to use traditional health practices  
 No, I did not want to use traditional health practices  
 No, traditional health practices were not relevant to me

**The following questions ask about your experience with the care you received during birth. Please read each statement carefully and choose the answer that feels right to you. If no answer feels right to you, choose 'Not Applicable' .**

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree	Not Applicable
15. My care providers asked me how much I wanted to help make decisions during labour and birth	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. I had confidence and trust in the providers caring for me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. My care providers told me about different options for my care during labour and birth	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. My care providers told me about the risks and benefits of different care options	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

- |  |                       |                       |                       |                       |                       |                       |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 19. I was able to choose what I thought were the best care options provided to me                                  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 20. My care providers respected my choices   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 21. While I was in labour, I was able to move around and choose the position that made me the most comfortable     | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 22. When I raised a concern during labour and birth, it was taken seriously  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 23. My concerns about pain were heard and addressed  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 24. My partner or main support person(s) were able to be a part of my care as much as they wanted                  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 25. My family and support person(s) were encouraged to be involved in my care during labour and birth              | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 26. I was treated with respect and dignity during my labour and birth  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 27. I was spoken to in a way that I could understand   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 28. My care providers helped me understand all the information   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 29. My care provider(s) asked me questions and spoke to me in a caring, supportive way and did not judge me        | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 30. My care provider(s) treated me as a whole person (emotional, mental, physical, and spiritual parts of my life) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 31. The place where I gave birth was a safe place to have my baby  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 32. I felt safe asking my care providers questions   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

- |   |                       |                       |                       |                       |                       |                       |
|---|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 33. I felt safe answering questions my care provider asked me   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 34. I was able to connect to my support person/family who were not able to be with me using a phone or other device | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 35. I saw similar cultural backgrounds or identities to mine in the staff at the place where I gave birth           | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 36. I was asked about cultural practices I would like considered during my labour and birth                         | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 37. I felt that my cultural identity and practices were respected during my labour and birth                        | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 38. I felt judged, hassled, or made to feel lesser during my labor and birth  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 39. I have experienced racism while receiving care where I gave birth   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

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40. Did you have to leave your community to give birth?

- Yes  
 No (If 'no' go to question 52)

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41. At what point in your pregnancy did you have to leave your community for birth?

- Before 36 weeks or 8 months  
 Between 36 and 38 weeks  
 After 38 weeks  
 I left when I had signs of labour

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42. How long did you have to be away from your community before your birth?

- More than 1 month  
 3 to 4 weeks  
 1 to 2 weeks  
 Less than 7 days  
 I was able to travel from my community when labour started

43. Were you able to bring a support person with you when you had to leave your community for birth?

- Yes  
 No, my support person had responsibilities at home  
 No, there was no accommodation for my support person  
 No, I did not need or want to  
 No, I did not have a support person  
 No, other reason

44. I was connected to a public health nurse outside of my community where I gave birth

- Yes  
 Yes, but I did not want to be connected  
 No, but I wanted to be connected  
 No, I did not want to be connected

**The following questions ask about your experiences when having to travel outside of your community for birth. Please read each of the following statements carefully and indicate how much you agree or disagree with it by selecting the appropriate box. If the item does not apply to you select 'not applicable'**

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Not Applicable
45. I was part of the planning of my birth outside of my community.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
46. I was given enough information to know what to expect at my birth outside of my community.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
47. I had support for childcare at home when I was away from the community for birth	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
48. I was asked by staff if I had enough money to meet my needs outside of my community where I gave birth	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
49. I had enough money to meet my needs outside of my community where I gave birth	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
50. I had someone who could give me support while I was away from my community	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
51. I had enough access to personal and professional mental health support	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

52(a). In the first few days after birth how was your baby fed?

- Breastfed  
 Bottle fed with formula  
 A combination of breast milk and formula

52(b). Did you receive any education on breastfeeding?

- Yes  
 No  
 Don't Know/Not Sure

53. Were you told about the Application for Registration on the Indian Register to fill out before going home?

- Yes  
 No  
 Not Applicable  
 Don't know/Cannot remember

**The following questions ask about your care experiences just after the birth of your baby before you leave hospital. Please read each of the following statements carefully and indicate how much you agree or disagree with it by selecting the appropriate box. If the item does not apply to you select 'not applicable'**

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Not Applicable
54. After the birth of my baby, I was given the information and explanations I needed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
55. My decisions about how I wanted to feed my baby were respected by health care providers and staff	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
56. The care providers gave me consistent advice about feeding my baby	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
57. I was worried that my baby was going to be taken away from me in hospital by Child and Family Services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
58. The length of my hospital stay was just right	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
59. I feel/felt ready to go home	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**Please answer a few questions about you!**

60. What is your date of birth

---

61. What is your highest completed level of schooling? (Please select the highest level)

- No schooling
- Elementary School (K to 5)
- Middle School (6 to 8)
- High School (9 to 12)
- Non-University (Vocational/Technical/Community College)
- University

62. Do you, or did you have a paid job of any kind during this pregnancy?

- Yes
- No

63. What is your marital status? Are you...

- Married
- Living common-law
- Single - never married
- Divorced
- Separated
- Widowed
- Don't Know

64. To which racial group(s) do you most identify?

- First Nations
- Metis
- Inuit
- Indigenous-Other (Specify) \_\_\_\_\_
- Caucasian/White
- South Asian
- West Asian
- East Asian
- Black
- Other (Specify) \_\_\_\_\_
- Unknown

65. What language(s) do you speak most often at home (Select all that apply if languages are spoken equally)

- English
- French
- Dene
- Cree
- Ojibway
- Other (Specify) \_\_\_\_\_

66. Were you born in Canada?

- Yes
- No

---

67. For the previous year ending December 31, please think of your total household income from all sources, before deductions. We are asking for the total sum of all the money you and the other earners in your household made in the past year. Please include income from social assistance, child tax benefits, disability benefits, workers' compensation, maintenance enforcement payments

Which income range does it fall into?

- No income
- \$1-\$39,999
- \$40,000-59,999
- \$60,000-89,999
- \$90,000-125,000
- \$>125,000
- Don't know
- Prefer not to answer

---

68. Have you applied for the Manitoba Prenatal Benefit in this pregnancy?

- Yes
- No

---

69. What is the name of the community you live in?

---

\_\_\_\_\_

---

\_\_\_\_\_

---

70. What type of community do you live in?

- Urban (city)
- Rural town or municipality
- First Nations Community
- Metis Settlement

---

71. Including yourself, how many ADULTS live with you in your home?

(Please include anyone who has been living with you in the last month)

---

\_\_\_\_\_

---

72. How many CHILDREN live with you in your home?

(Please include anyone who has been living with you in the last month)

---

\_\_\_\_\_