Kadiminekak Kiwabigonem: Barriers and Facilitators to Fostering Community Involvement in a Prenatal Program in an Algonquin Community[1]

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Abstract

Background: Inequities in maternal child health exist for Aboriginal populations in Canada. Community involvement in health services programming can reduce health inequities, but barriers and facilitators to community involvement have been understudied. The primary aim of this study was to answer the question: What are the barriers and facilitators to fostering com-

1. **Acknowledgements:** The authors would like to acknowledge the Rapid Lake community and all of the participants of this study for sharing their stories and experiences; Health Canada, for funding the costs of this project; the staff at the Nursing Station for their unwavering support; and Dr. Anita Gagnon for sharing her invaluable research expertise throughout the project.

munity involvement in the development and implementation of a prenatal program in the Rapid Lake Algonquin community? To this end, this study also examined the questions: a) What are the health-related needs of pre- and postnatal women in Rapid Lake?, and b) How could these needs best be met in light of the community's current context and available resources?
Methods: A focused ethnography was conducted over 3 months, with 21 participants. Data collection included semistructured interviews, pilot programs, participant observation, and fieldnotes, and was followed by thematic analysis.
Results: Barriers to community involvement included political tensions, historical relationships with government institutions, cultural knowledge, language and literacy, and lack of health promotion events in the setting. Facilitators included incentives, trusted group leaders, social capital, regularity of activities, and a sense of community. Four needs were identified including effects of alcohol and drug use during pregnancy, nutrition, exercise, and social support. Three themes for how to best meet these needs in a community program emerged: sharing the knowledge and experiences of community members, involving families, and integrating traditional teachings into programs. Results can be used to support efforts toward community involvement in prenatal health services in other rural Aboriginal communities.
Keywords: participation, community programs, prenatal, Aboriginal, cultural knowledge

Introduction

Inequities in health for Aboriginal populations in Canada have been documented, including discrepancies in maternal child health. Aboriginal women in Canada and elsewhere are often late or low participators in prenatal care and experience poor outcomes of care relative to the general population. Increasingly, in Canada and abroad, Aboriginal communities are taking control of their own health services and health promotion efforts. It is recognized that Aboriginal participation in developing health programs can promote community capacity and reduce disparities in health. Studies have shown that community involvement in prenatal care program design and implementation improved participant satisfaction, early access and participation in care, as well as enhanced women's health behaviours.

In this study, such a participatory pre- and postnatal program was undertaken in the Rapid Lake Algonquin community under the funding

and partial direction of the Canadian Prenatal Nutrition Program. This community has experienced prolonged internal conflict which has limited its means to provide community-controlled services. The purpose of this project was to: a) examine the barriers and facilitators to fostering community involvement in prenatal health services in the Algonquin community of Rapid Lake, Quebec; and b) develop and implement a culturally relevant, community-based program to meet the health needs of pre- and postnatal women in this First Nations community. To accomplish this, it was first necessary to identify the health-related needs of pre- and postnatal women in Rapid Lake.

Background

Inequities in First Nations Maternal/Child Health

Health indicators for Aboriginal populations in Canada are frequently described as inadequate and incomplete. According to the Health Council of Canada (2005) "due to the varied ways that information is collected or not collected in some instances, an accurate assessment of the health status of Aboriginal peoples remains beyond reach at the present time." Although few health statistics are routinely collected for the Rapid Lake community, important health inequities have been documented between Aboriginal and non-Aboriginal populations including disparities in maternal child health. While significant progress in this area has been made, in 2000 the infant mortality rate for First Nations was 6.4 deaths per 1000 live births — 16% higher than the Canadian rate of 5.5 (Health Canada, 2005). Sudden Infant Death Syndrome (SIDS) has been reported as the leading cause of infant death (Health Council of Canada, 2005). While SIDS rates have fallen for infants in the general population, rates remain high in Aboriginal populations (Health Canada, 2005). Rates of death due to injury for Aboriginal infants are four times higher than in the general Canadian population (Canadian Council on Social Development, 2002).

Teenaged mothers accounting for 20% of First Nations births, compared to the Canadian rate of 5.6%. First Nations and Inuit people have a birth rate that is double the Canadian average (Health Canada, 2005). Macrosomia, or high birth weight, occurs among First Nations infants at a rate of 18% compared to 12% among mainstream Canadians (Health Canada, 2005). This may be linked to obesity and gestational diseases, both higher in First Nations populations, and can result in neonatal morbidity, and neonatal

and maternal injury (Bloomgarden, 2000). Smoking rates are higher in pregnant First Nations women than in the general Canadian population, and the breast-feeding rate among First Nations is significantly lower, at 54%, compared to general Canadian population at 75% (Health Canada, 2005). Grossman and colleagues (2002) suggest that childbearing health disparities among Aboriginal populations are related to higher rates of poverty, lower levels of maternal education, and limited use of prenatal care.

Together, these indicators suggest that pregnant and postnatal women, as well as their infants, are important target populations for reducing health disparities for Aboriginal people. The past two decades have seen steady development in maternal child health programming targeted at Aboriginal communities. However, a recent analysis revealed that gaps in service remain (Stout and Harp, 2009). Persistent gaps in the provision of health services for First Nations populations contribute to continued health inequities (Ball, 2008) and must be remediated. The need for qualitative research to explore women's and health care providers' perceptions of barriers and facilitators to obtaining prenatal care has been identified (Heaman et al., 2007). Specifically, there has been a call to include community-based focus groups and one-on-one interviews to give voice to the experiences and perspectives of First Nations women on current maternal and infant programming (Stout and Harp, 2009).

Community Participation in the Development of Health Services

Indigenous communities are increasingly taking control of their own health services and health promotion efforts. This is in line with the World Health Organization's (WHO) definition of health promotion as a "process of enabling people and communities to take control over their health and its determinants" (WHO, 1984), which supports health promotion and enhancement by the community, rather than an expert-driven, top-down approach. A growing body of literature demonstrates that public health programs based on community participation reduce health inequities and promote social justice (Mooney, 1998; Potvin et al., 2003; Rootman et al., 2001; Tursan d'Espaignet et al., 2003; Waldram et al., 2006; Winkleby, 1994). Several evaluation studies with Aboriginal communities have found that community involvement in prenatal program design, implementation, and evaluation improved participant satisfaction, early access, and participation in care. This enhanced women's health behaviours such as improved nutrition, decreased

tobacco and alcohol consumption, and feelings of mastery related to infant care (Smith and Davies, 2006; Tursan d'Espaignet et al., 2003).

Barriers and Facilitators to Community Involvement in Health Services Programming in Aboriginal Communities

A number of barriers to community involvement have been identified. One study found that First Nations women conceptualized pregnancy in a spiritual context and believed it to be a healthy, natural process not requiring intervention (Sokoloski, 1995). Their expectations of friendly and nonauthoritarian care were not realized in the health care system and their beliefs about pregnancy conflicted with those of the non-Aboriginal health-care providers. This study suggests that barriers to prenatal care include health systems based on a biomedical model not consistent with Aboriginal perspectives (Sokoloski, 1995). Among many others, Warry (2007) and Wadden (2008) identify the historical paternalistic and controlling relationship governmental institutions have had with Aboriginal communities as a barrier to Aboriginal participation in program design and implementation. The literature recognizes that in order for Indigenous people to effectively participate in building healthier communities, the wounds caused by colonization; historical trauma; racism; and disparities in health, education, and living conditions must be acknowledged and measures put into place to begin treatment and healing (Chino and Debruyn, 2006).

Current developments in the field define various dimensions of capacity within Aboriginal communities that can contribute to, or facilitate, community involvement. These capacities include strong leadership, social support, a sense of community, and access to resources and skills (Chino and Debruyn, 2006). Another important concept in the literature on community capacity is social capital (Chandler and Lalonde, 1998; Chino and Debruyn, 2006; Mignone and O'Neil, 2005). Social capital is composed of a variety of elements including social networks, social norms and values, trust, and shared resources. It is a multidimensional concept and includes bonding social capital (the social relationships between individuals in a community), bridging social capital (the relationships between communities), and linkage social capital (the ability to leverage resources and support from external institutions) (Mignone and O'Neil, 2005; Woolcock, 2001). All of these concepts support use of local knowledge and power in reducing community health disparities.

Setting

Rapid Lake is a semi-isolated Algonquin community located 300 km north of Ottawa in La Vérendrye Park in the Old Gatineau region of Quebec. The nearest city is approximately 160 km away. There are 600 members of the community, with approximately 500 living within the community.

There are no stores in Rapid Lake. Overcrowding is a major problem and most of the houses are in ill repair. Most adult community members do not hold a high school diploma, and unemployment rates are approximately 80–90%. In June 2008, the province assumed control of the local police force related to outbursts of local violence.

Rapid Lake has been profoundly affected by colonialist relationships including an imposed reserve system, paternalism, and dependency created by the Indian Act (1876), and the pervasive negative effects of residential schools. Furthermore, the community has experienced ongoing leadership and financial crises for more than a decade. At the time of the study, the Indian and Northern Affairs Commission (2007) had recently recognized a new chief; however, some community members were contesting the new chief's authority and the process by which he was selected.

Rapid Lake is one of the few communities where Algonquin remains the first language. Although there is a local concern that cultural traditions are being lost, Rapid Lake is considered one of the more traditional Algonquin communities. Traditional activities include hunting and fishing, living in the bush during the summer months, and moccasin making.

There is a Health Canada-run nursing station in Rapid Lake, staffed with Aboriginal community health workers and non-Aboriginal nurses. In 2008, the nursing station developed a community Day Centre, located in a large room within the nursing station. The Day Centre is provides a positive space for members of the community to hold health related activities, and is the setting for the present study. Current health services for pre- and post-natal women include nursing appointments, prenatal workshops, and food subsidies. This project introduced a pre- and postnatal program within the Day Centre to expand existing services by building support networks and supporting community-identified health needs.

Methodology

A focused ethnography methodology was used to guide this study. Ethnography strives to understand human behaviour in the cultural con-

text in which it is embedded (Morse and Field, 1995). Focused ethnography is a small-scale ethnography used commonly in community-oriented health sciences for the purposes of program development in health services (Morse, 1994). It focuses on actions, interactions, and social situations (Knoblach, 2005). Focused ethnography was appropriate for this study to gain a better understanding the beliefs and values held by community members that reflect perceived barriers and facilitators to participation, and reflect health care professionals' need to adapt their practice to their patients' beliefs and social context (Morse, 1994). To this end, the field researcher who was a master's student in nursing at the time of the study, lived in the community for three months (Sept.–Dec. 2008) doing a clinical stage and research project. Methods supported by focused ethnography include focus groups, interviews, and participant-observation. Data collection and analysis were ongoing, and analysis in each stage was used to inform data collection in the next, as is consistent with ethnography.

The Canada Prenatal Nutrition Program (CPNP) framed the study. The aim of the CPNP is to attract vulnerable populations to prenatal care and support their connection to the broader community by strengthening health and social supports. While the CPNP was already operating in Rapid Lake, this study was designed to build on and improve the existing program.

The CIHR Guidelines for Health Research Involving Aboriginal People (2007) were used to guide this study. As indicated by the Guidelines, written consent was sought, but waived for verbal consent in circumstances where it was judged preferable by participants. Participants were assured of confidentiality, and identifying information was changed in this paper in order to protect their identity. The McGill University Institutional Review Board approved this study.

Participant Selection and Recruitment

Participants for the study were recruited in collaboration with key advisors from four groups identified in the literature: nurses, community health workers, women of childbearing age, and grandparents (Smith et al., 2006). Additionally, fathers emerged as important stakeholders in the projects, and were included in the study design. Participants were interviewed in focus groups and semi-structured interviews. Recruitment was conducted by approaching suitable candidates when they visited the clinic for nonemergency intervention. In total, 21 participants were included in the interview and focus group portion of the study including three non-Aboriginal nurs-

es, four Aboriginal community health workers, nine women of childbearing age, two fathers, and three grandparents. All participants in the focus groups and interviews were invited to be part of the two pilot programs, which were also open the general public. Home visits were made one to two days prior to the pilot programs to remind participants about the study. Six of the original study participants attended the first pilot program and eight attended the second pilot program, where they were again asked to provide feedback on the program. The findings of the study were communicated to participants on an ongoing basis to confirm or correct interpretations.

Methods

Two focus groups were held, one for nurses and one for community health workers. Focus groups, 60–90 minutes in length, took place in the clinic. On the advice of the key advisors, the remaining 15 participants were interviewed individually or with friends or family members. Interviews were between 20–60 minutes in length. Coffee and muffins were provided to promote a warm environment at focus groups and interviews (Ruppenthal et al., 2005). The time and place of the focus groups and interviews were arranged at the convenience of the interviewee.

Initial focus groups used predetermined guides that were verified for cultural appropriateness by key advisors before use. However, within each interview, participant replies gave rise to new questions that were important to explore within the context of this project. These new questions were developed by the field researcher in conjunction with key advisors. Key topics covered included the perceived health-related needs of pre- and postnatal families, services they would be interested in participating in, and the challenges and facilitators to participating in the programs. The participants were encouraged to talk freely about the topics on the list, and to tell stories in their own words.

Participant observation is an essential method in ethnography, as it provides important social and cultural information that would otherwise be missed. Observations included characteristics and conditions of individuals, activities and interactions, verbal and nonverbal communication, and environmental characteristics (DeWalt and DeWalt, 2002; Polit and Beck, 2004). Semistructured observation occurred during all stages of data collection. Participant observation was an especially important strategy in evaluating the pilot programs, where it was used to observe attendance, participation, and comfort levels of participants. This method is particularly rel-

evant to working with First Nation populations because it has been shown that nonverbal communication can be equally or even more important that verbal communication in these communities (Sokoloski, 1995).

Data obtained from all methods were recorded in fieldnotes. The fieldnotes contained a narrative of what was happening in the field and served as the data for analysis (Bernard, 2002). Thematic analysis was used. This study was methodologically rigorous according to standards for focused ethnographic research (Morse, 1994). An iterative process occurred within the study whereby acquired knowledge was continually subjected to testing and reconfirmation with local people, during all data collection stages, to confirm that data was correctly interpreted. Audio recording assisted in "checking" the researcher's memory of the data. Only key pieces of the interviews were transcribed to provide verbatim quotations, due to time limitations. Finally, a clear audit trail was made with audio recordings and fieldnotes so that analytical decision-making could be followed (DeWalt and DeWalt, 2002), and academic supervisors provided feedback on the analysis.

Results

Barriers and Facilitators to Community Involvement

Thematic analysis revealed five barriers and five facilitators to community involvement in pre- and postnatal programs. Barriers included: a) internal political tensions, b) historical relationships with government institutions, c) cultural knowledge, d) language and literacy issues, and e) no history of health promotion efforts in the setting. Facilitators included: a) incentives, b) social capital c) trusted group leaders, d) regularity of activities, and e) a sense of community. Participants were easily able to identify barriers when asked, but less able to articulate facilitators. Therefore, identification of facilitators relied more heavily on participant observation. Interestingly, many of the barriers related to one or more facilitators (Table 1).

Barriers

Internal political tensions. Political tensions between the two political factions were the most frequently cited barrier to community involvement in programs. As one grandmother commented, "Right now it's this crisis going on, it's not everybody that agrees with everybody ... they don't want to come together." One father, when asked if he would participate in a program replied:

Table 1. Identified Barriers and Related Facilitators to Community Involvement in a Community-based Pre- and Postnatal Program in Rapid Lake

Barriers	*Facilitators*
	Incentives
Internal political tensions	Social capital
Historical relationships with government institutions	
Cultural knowledge	Trusted group leaders
Language and literacy	
No history of health promotion efforts in the setting	Regularity of activities
	A sense of community

> Well it depends on who might be in there. Because I'm pretty sure some guys don't want to see me inside.... No, too many grudges. Too many political problems, that's why. So it's a good idea but ... I don't think that people would really come there. Like if there's two factions here, and this side comes and the other side comes, then there's going to be problems.

Asked if political tensions would affect participation, another participant described violence between the two factions at a highway blockade earlier that year. Her story illuminated how strongly the division between the two political factions is felt, and that emotions regarding this event strongly reverberated through the thoughts and minds of many members in the community. Another participant offered a pragmatic explanation for how political tensions could affect participation: "Well some of them, they have restraining orders, and so everybody just stays away now."

While the notion that political tensions within the community would affect community involvement in programs was strongly held, one mother offered a different opinion: "Maybe, a little bit. But they usually come here and forget and get along." In fact, this is what was observed in the pilot programs. Mothers and children from both political groups came together and worked together in a way that did not suggest any tension between them. The first pilot program took place on a day when a highway blockade was held, and still no tension was observed in the attendees; members from both political groups attended and conversed in a friendly manner with each other. However, no fathers attended the pilot programs, even though some said they would like to come. Notably, seven grandmothers were in-

vited to participate in the second pilot program, and only two attended. Three grandmothers politely declined participation, citing political tensions as too high at the time.

Historical relationships with government institutions. Historically, Rapid Lake has been deeply and negatively affected by federal governmental policies, including, but not limited to, forced attendance in residential schools, the imposed reserve system, and governmental control of community services. The impact of these policies is still felt today. One nurse explains the experience of developing trust in the community, and how this has affected participation at the Day Centre:

> In the past they had some nurses who judged them. The elders, most of them heal with their products from nature and the doctor and the nurses said "oh it's not good," you know. They are always afraid of judgment, like the social worker is coming to take away [the children]. If you saw [the social worker] they will take away the children, you know. And sometimes it continues because it's included in their habits, when somebody comes here, something will happen. They are not sure, there is no trust. Because it's not long that we have organized some community activities, so they are scared, they think "why do they do that?"

Perhaps linked to this point, some community members preferred to avoid the government-run health clinic altogether: as another nurse commented, "there are some people who will not come period, ok. They don't like the clinic, and they come for the minimum." One grandparent said of the clinic: "I don't think I would want to go right now, to the government building. It's the politics, it's very tense right now. I never want to go to the government building." This may reflect a lack of community ownership of the building that contains the Day Centre.

Cultural knowledge. An important theme that emerged was the belief that often, what was taught at the health centre was not consistent with traditional practices. For example, when one mother was asked what she thought about a pilot program that involved baby food making, she said, "We have some traditional ways too, to feed our babies when they're small. Well, when they're toddlers mostly.... Maybe one day we can come over and show you guys our traditional ways of baby food making." In response to this, a grandmother that was present replied: "Usually when women are pregnant we make something to drink too, like a medicine drink. We put something, like the trees in there ... not just any tree." The mother continued: "But there's lots of trees that we can use to make medicine drinks and usu-

ally women drink that so their baby can be healthy and strong. Maybe we can show you that here." When the field researcher began to work with these women to include traditional teachings in the programming, they became very excited and enthusiastic. The women suggested involving several of the grandmothers who are known to have a lot of traditional knowledge, and generally do not participate in events at the Day Centre. As a result, one grandmother who was known to strictly avoid community events held at the Day Centre participated in the second pilot program.

Similarly, two participants suggested that health programs were built by people who do not know and understand the lifestyles and realities of the community members. One community health worker said that it was important to have "Health Canada come and sit with us about the prenatal programs. For them to understand our knowledge too. The grandparents. The way they were teaching a long time ago has to come back." This worker felt strongly that the community was healthier in the past, and that was linked to living a traditional lifestyle. The worker felt that this point was not fully recognized and understood by non-Aboriginal health care providers.

Language and literacy. Language and literacy was another theme that came up repeatedly as a barrier to community involvement. Usually, the programs take place in English, the common language between the francophone nurses and the Algonquin people. All of the community members speak in Algonquin in their everyday lives and many find that switching languages is disruptive to communication. This was supported by a mother who said: "some people don't really speak English and some can't read, so they're going to feel left out." As said by one community worker:

> If they have the programs in our language, everybody will appreciate it. Like the grandparents, the parents, the women. Myself, because I'm speaking in my language almost all the time.... You have more expression in your own language about being pregnant and about everyday knowledge.... If it's really organized in our language, that's very important. It's the priority for me.

No history of health promotion efforts in the physical setting. The Day Centre is located in a large room within a part of the health clinic building. Community health events are relatively new phenomena within this setting, and it was found that most people associate the building with sickness and illness. There is not yet a strong association with the building and health activities and so, it was suggested, community members do not think to come here for health promotion activities. Two nurses shared their opinions related to this theme. One commented that:

> Sometimes in the community, when they talk about when the children are hyperactive, they say to the children "if you don't be quiet we will take you to the nurse and she will give you a needle." You know, they have some fear about the clinic, because when we come to the clinic we are sick, we don't come here for some teaching or something, you know they are not used to that.

Another nurse said that "we are kind of in a vicious cycle right now where there is no history here of community health activities, nothing used to happen here and we want to change that but it takes time." They both acknowledged that time and perseverance are required to make a strong association between the clinic building and health promotion activities.

Facilitators

Incentives. The facilitator most commonly identified by community members to promote community involvement in pre- and postnatal programs was incentives, such as food, games, and prizes. Food is perhaps the most obvious example, and it was found during the first several events held at the Day Centre that if food was offered, people would attend the programs even if only for the food. As one nurse said, "Everybody likes food, everybody like to eat." Games and prizes are also popular. As one participant said, "I like games there. I like to win prizes."

Social capital. Social capital is a multidimensional concept that includes bonding, bridging, and linkage social capital, and is a resource composed of elements including social networks, social norms and values, trust, and shared resources. While *bonding social capital*, or the social relationships between individuals in a community, is generally believed by the community to be weak within the community, individuals with greater bonding social capital were more involved in pre- and postnatal programs. Some community members, like the father mentioned earlier, did not feel comfortable coming to the programs because he was "pretty sure some guys [didn't] want to see [him] inside." Other community members — regardless of which political group they belong to — were able to participate comfortably in the programs. For example, two mothers from different political groups said that political tensions were not a barrier to involvement for them because they "leave their sh*# at the door" when they enter the building and are able to get along with everyone. It was clear in the pilot programs that they and many others were able to do just that, as evidenced by working together cooking meals and sharing their personal experiences with each other.

To a lesser extent, *linkage social capital*, or the community's ability to leverage resources from external institutions also emerged as an important factor. In the past, there were no programs in the community; forces within the community did not want programs implemented by Health Canada, an external institution, however they also lacked the resources to put programs on themselves. Now Health Canada is a partner with resources to make programs available driven by community ideas.

Trusted group leaders. The personal qualities of the group leaders of the pre- and postnatal program emerged as an important factor in fostering community involvement. In particular, it was clear that the leaders must be trusted by the community, and able to promote a relaxed, nonjudgmental atmosphere. One nurse explained: "they have to know you, they have to trust you." Another nurse elaborated:

> I think it's a matter of putting a nice atmosphere between them and nurse, or whoever, to make them want to come, I think that's big because they're big on the feeling. If they don't like the atmosphere, they'll leave. It has to look like it's going to be fun, just light. Because I guess when they come they don't want to be judged, they don't want to be put on the spot. So I think it has to be in a light way, a fun way, they like to laugh a lot.

This was observed in the pilot programs as well. The first pilot program provided a lot of information, including a PowerPoint presentation, which the field researcher felt was formal and distanced her from the community members. In the second pilot program, efforts were made to keep the teaching lighter and focus on group discussion, which resulted in more participation. It was also observed that when the people leading the program included Aboriginal people, there was more discussion and laughter in the group. Participants were seen to more readily share their stories with each other, perhaps related to the ability to use their own language.

Regularity of activities. Because of the lack of health promotion activities in the clinic building in the past, many people do not yet think of the Day Centre as a place to go for health. Some programs have been held, but they occurred sporadically and not according to a consistent time or schedule. With regularity, the community may begin to see that something is happening and they may think to come more often. As one nurse explained:

> Because I find with people, when it's just words, they have a hard time believing it's going to happen, but when it keeps happening, with the regularity, and with activities happening, and people going, and people having a good time,

> and people coming back with food at home, then I think that slowly the word is going to spread and there's going to be more people involved.

This was in fact observed in this study. Five women attended the first pilot program, eight attended the second pilot program as well as two grandmothers, and even more attended the next maternal child program after the research was finished, including three fathers.

A sense of community. While some might say that "a sense of community" is lacking within this community given the political division, the community members of Rapid Lake hold strong community values and are able to come together for a common cause. Every participant walked into the pilot programs and joined in the cooking without asking or being told what to do. Meat was donated for the program by a community member without accepting payment even when it was offered. The women listened to each other and supported each other's ideas respectfully. Perhaps this is because historically, the whole community participated in supporting pregnant couples. As a community worker explained:

> Because it's special, a long time ago it was special to be pregnant because of all the community involvement. The help, they gave guidance, they gave skills, how to take care of the woman, her body. And the medicine, the plants they had to take for a baby to be healthy. And there's many around a woman who could help.... There were lots of people all the time at my house. Different people, they used to come and help, do chores, or go take a walk, go visit friends.... We saw our people a long time ago, the way they taught each other, they helped each other.

This community worker explained one traditional way in which the grandparents would evaluate if their children needed to learn more from other members of the community:

> My mom was implicated in helping her daughter. At certain times, the grandparents, they're going to observe through the window, to see if their kids need more skills. They could ask the other grandparents what she didn't do. To go sit for more advice. Long time ago, this was the kind of conditions they had, to help each other.

Although community mobilization of this magnitude to support expecting or new families may not be seen as readily today, it is still a part of the community's collective memory and values.

Needs of Pre- and Postnatal Women in Rapid Lake

Before the pre- and postnatal community programming was developed and implemented, it was necessary to involve women and other stakeholders in

identifying their needs. Four major categories of needs were identified: alcohol/drug related needs, nutrition, exercise, and social support.

Alcohol/drug related needs

Reverberating through nearly all of the interviews, and raised in the pilot programs, was the urgent need for programs and services to support pregnant women to reduce or stop using drugs and alcohol. One community worker said:

> It's urgent to talk about prenatal programs here. I find it really urgent. Because young people today they drink too much, and me, sometimes I'm very very worried when I see them carrying the baby. Because I see them drinking last night here, they're taking drugs, it's really urgent for them. The baby she's going to have it for sure, the brain is already affected by all those drugs and the alcohol. Who's going to take care of those babies in the future? We need a program they're going to respect, to involve them in the workshop, and fast, we have to do it fast. That's what I'm worried about. Because I've been here and I saw lots of women drink. There are some pregnant women, they need help, and they're never going to tell people right away.

When asked what was the greatest challenge to taking care of yourself when pregnant, most women answered staying away from drugs and alcohol. One mother provided a graphic description of this challenge:

> There is a lot of partying and everybody does cocaine. When you get pregnant it's hard to stop. Like me with one of mine, I did cocaine. It's the story of all of us here, all the way to [the city]. Someone I knew, she was pregnant and she was doing cocaine all the time. I told her she has to stop and she told me I can't. We need to help the women with this. She felt really bad about it. We all do.... Some kids are like why is she drinking, you know? Beer bottle and big belly. And they drink for two or three days straight sometimes. And that's the hardest part I find.

While some women were reticent to discuss their experiences with drugs and alcohol in pregnancy, others were not. Concerns about fetal alcohol spectrum disorders were widespread. Community members generally seem to know that drugs and alcohol harm the fetus and have lasting impacts on the child, but when a woman already has these habits before pregnancy it is difficult to stop, especially given the lack of support available in the community. As pointed out by several participants, "it's not just a problem here, it's everywhere," meaning in all communities.

Nutrition

Women had a lot of questions about nutrition, including healthy eating during pregnancy, concerns about gestational diabetes, breastfeeding, and how to feed their children. There are many cultural traditions about nutrition in pregnancy, and feeding children as well. It is clear that nutrition is high on the list of priorities during this phase of the lifecycle and there is a widespread belief that community members and especially pregnant women are not eating well. One mother illustrated this point when she said:

> Most people eat ... not healthy. Like fried foods, it's all you see around here mainly. I think it's because there's no nutritional programs, they never experienced it.... Because most of us grew up, like my mom she only used to make foods that were like greasy, greasy, greasy. And she only started to eat healthy when she got diabetes. And we were stuck with her old ways.

Another mother said that she wanted to eat healthy but did not know how:

> I just found out I was diabetic in March. But my doctor was always telling me ... but I *asked him*, you know, what to eat and all he ever said was eat healthy. And I didn't know what healthy *was*. How to cook, what to eat.

One grandmother raised concerns about the changing diet of pregnant women and its effects on the baby:

> They should eat soft meats, like fish and rabbit. Sometimes moose is ok. But beaver is too tough for pregnant women. Soft meats help the baby to grow and develop. This is the traditional way for the pregnant women to eat. Today women are not eating like that. They are eating candy and drinking pop and eating greasy foods. It's not good for them, it's not good for the baby because the baby gets all the things the mom eats.

Almost everyone interviewed raised concerns about eating habits and thought that pregnancy and becoming parents was a good opportunity to learn how to improve eating habits.

Exercise

There is a widely held belief in the community that pregnant women need to exercise, especially walk, and that they should wake up early to do this. One grandmother explained this belief and the story behind it:

> The baby needs to be moved around a lot, daily. If the mom doesn't exercise, the baby gets stuck there. A long time ago they told this stories that this woman

> was treated as a very fragile thing, she was pregnant, she couldn't do any housework, or dishes, or to do exercises. So when she got into labour, the baby didn't come out, it got stuck there, and she died.

Every community member interviewed knew this story, and many women reported that their family members woke them up early during pregnancy to go walking. However, most women complained that they didn't like to go walking by themselves:

> Like when I was pregnant I liked to walk around with my girlfriends, not alone. And like I said they're always on drugs, they're so lazy to move, to go out. You don't want to be one big person walking around.

Social support

Women pointed out that these lifestyle changes required social support that was lacking in the community. On quitting drugs and alcohol in pregnancy, one mother said, "but we can't stop it by ourselves and there's no support for us ... it's hard here when everyone's doing it, you need support." Social support was also linked to making changes in nutrition, and in exercising during pregnancy. Expecting families also mentioned that it was helpful for them together with other new parents so that they could receive advice on what to expect. One new dad said, "It helped us a lot actually, their advice, their different advice about what might happen. They told me to rub her back for her not to feel pain [during labour]." The mother said this advice was helpful, "especially the first time, because we were all curious and stuff."

Meeting the Needs of Pre- and Postnatal Women in Rapid Lake within the Community's Current Context and Available Resources

Community members were asked what kinds of services they wanted and how programs should be delivered to best meet their needs. The researcher and key advisors took these ideas and created pilot programs for participation and feedback. There were three main themes: sharing the knowledge and experiences of community members, including families in the programs, and integrating traditions into health teaching. Community members provided more ideas for future programs, listed at the end of this section.

Sharing the knowledge and experiences of community members

Participants felt that women, grandmothers, and families in the community had gained a lot of specific knowledge in relation to pregnancy and child-

bearing through their own experiences, and they wanted to learn directly from them. This emerged as a dominant theme through most of the interviews. One community worker describes how this kind of teaching has been an important part of the community's culture:

> The woman who is going to be giving birth soon? You can notice a difference right away if you have a woman who already has 2, 3 children, then she can work with that couple. Those are the connections, it gives you a lot of knowledge, the way you're going to deal in 9 months, and the development after. It's going to be so easy if you involve another couple. There are so many aspects they can explain.

She also explains that grandparents can share their experiences for the good of the community as well:

> Grandparents that already have their grandkids, they have some good experiences and they have some bad experiences, like everybody. So I'm pretty sure there are some grandparents that we could have here to promote better futures. Because it's important when you have a baby and there's lots of knowledge they forgot in the past. And those grandmothers, they're able to share what knowledge they have.

Put simply by one grandparent: "[have] one of the mothers to come in, and let them do the teaching, and you just be there." One mother explained, "there's *a lot* (of knowledge to be shared). Because people went through it, so that's how we learn." The field researcher observed that birth and pregnancy stories, both recent and those passed through generations, were an important method for couples to learn and teach about pregnancy and birth.

Including family members in programs

Almost all participants wanted to bring their family members along. This was important for several reasons. First, the women thought it would make them feel more comfortable at the programs. Second, it was important to include the fathers because, as one community worker said, "we can't forget him too. He's a part of this, he too has to learn from day one. He has lots of responsibilities with the baby and with the other kids." Mothers felt that it was important to include the fathers so that they can learn how to support them during their pregnancy. One mother said, "It would be great for the man to watch how the woman's supposed to eat. So they can learn to cook. So like my friend's boyfriend, he wants to cook for her but he doesn't

know *how*." Importantly, grandmothers should be included in the programs because, as one grandmother says:

> It is the role of the grandmothers to give teachings to the young families about health in pregnancy and about how to raise the kids. It doesn't have to be the real grandmother of the baby, it can be any grandmother in the community.

Grandmothers were heavily implicated in health teaching throughout all phases of the research.

Integrating traditional knowledge into health teaching

Most participants in the study were using or had used traditional health practices related to pregnancy, and believed that the perinatal period was a particularly important time for using traditional knowledge. Specifically, teachings from grandparents in the community emerged as important to the participants. As described by one participant:

> I think it's very important because if I look back, like way back from now, I see that traditionally the way they ate, the way they lived, they were healthier than now.... I think it's important to have tradition. Because there is a lot of gestational diabetes. I guess if they would go back to the traditional way of what they eat they would be a lot healthier.

Another participant explains:

> It's always lots of experience I learned from the grandparents, different grandparents, like many years ago. And I learned from it a lot. So if the community wants to help the pregnant women, we need to put a little bit of our sense and our knowledge too. To harmonize both parts, our native knowledge and the nonnative health part.

These findings suggest that incorporating traditional knowledge into community programs and specifically including the teachings of elders would increase cultural sensitivity and create programs that are more relevant to the lived experiences of the families in the community.

Programming Implications

Our second pilot program specifically took into account the information gained from this study. Program participants wanted the program to have an Algonquin name. *Kadiminekak Kiwabigonem* was chosen, which roughly translates as "to grow the beautiful flower." During this program, we addressed some nutrition-related concerns and skill building by making piz-

zas together with healthy ingredients. We included traditional foods by using moose, rabbit, and deer in the meal. We also played a breastfeeding game that elicited the knowledge and experiences of the women involved, stimulated an open dialogue on the subject, and created social support for women in the group. Elders were invited to share their traditional knowledge on cooking and breastfeeding and took a lead role in facilitating the activities. Discussion in Algonquin was encouraged and widely used. Prizes were given for participation. Outcomes included that a healthy recipe was made and consumed, women shared their breastfeeding knowledge and experiences, and learned traditional knowledge on the topic. Participants reported that sharing their experiences was the best part of the program and even the most reserved women participated. One outcome we saw for the first time at this program was that the participants did not immediately leave after the program and instead hung around and talked afterwards. We also found that holding the programs increased attendance to prenatal nursing appointments and more women picked up their food subsidies. Table 2 shows how needs, barriers, facilitators, and programming suggestions were addressed.

Other specific ideas that community members suggested to meet pre and postnatal health needs within their current context included cooking groups, walking groups, baby moccasin making workshops, support groups for pregnant women to reduce or quit using drugs and alcohol, inviting elders and young mothers to give advice, including traditional foods and medicine teas in the programs, and programs for fathers. These suggestions address all four of the health related needs elicited by community members.

Table 2. Implications of Study Findings in Practice: How Study Findings Fostered Community Involvement in the Pre- and Postnatal Program

Needs Addressed	*Barriers Addressed*	*Facilitators Utilized*	*Programming Suggestions*	*Outcomes*
• teach what is healthy food • skill building: how to cook healthy food • information related to breastfeeding • social support	• cultural knowledge • language and literacy	• incentives • trusted facilitators • a sense of community • lack of other activities	• sharing knowledge and experiences of community members • traditional knowledge and elder's teachings • inviting other family members	• made and ate healthy food • shared experiences and advice • learned traditional knowledge • enjoyed getting together • supported linkages to other services

While they could not all be undertaken within the context of this study, these suggestions may serve as activities for future programs.

Discussion

Barriers identified in the literature, such as historical trauma and language barriers were similar to the findings of this study (Chino and Debruyn, 2006; Heaman et al., 2007). Some facilitators, including social capital and a sense of community were also identified in the literature. The main differences between the literature and the findings in this study were that many facilitators in the literature were not present in Rapid Lake, which may reflect the particular struggles Rapid Lake has had and continues to endure. For example, community readiness to address issues of community participation was identified as a facilitator in the literature. However, it is recognized that the need to manage more pressing issues, such as political problems, may divert community resources and will to address less immanent issues, such as participation in a prenatal program (Salsberg et al., 2007).

Another factor affecting this study is that due to few employment opportunities and political conflict in Rapid Lake, most people are unemployed and there are no other organized activities for adults. Participants often cited a feeling of having "nothing to do" as a reason for participating in the program. This further reflects the struggles in the community to organize itself and as a result, participation in the study programs may have been higher in Rapid Lake than would be expected in other communities.

The strongest barrier to community involvement was generally believed to be political tensions between community members. It is interesting to note, however, that this barrier was stronger for men than women, and strongest for older people in the community. When this finding was discussed with participants, they believed it was related to men as culturally more implicated in politics, and the lasting memories in the lives of older people from disruptive events in the past (e.g., residential schools). This finding could have implications for other health services programs targeting these populations.

Many of the barriers to community involvement (e.g., political conflict, historical relationships with government institutions) are daunting and will take many years and extensive efforts to address. Identification of such barriers support broader economic and development efforts, such as ramping up education in Aboriginal communities so that community members have a better chance to become health care providers themselves. Warry (2007)

asserts that capacity for culturally specific and appropriate health services can only be accomplished by the next generation of Aboriginal health care workers.

In contrast, some of the facilitators identified are amenable to health service programming. Programs can be developed to incorporate incentives such as food, games, and prizes, and program leaders can be trained to promote a comfortable, nonjudgmental atmosphere. A sense of community can be promoted by including cultural traditions. Other facilitators, such as social capital, may be more difficult to develop.

The Assembly of First Nations (Andersson et al., 2003) evaluated CPNPs in First Nations communities across Canada and provided community-led solutions to improve the program. These solutions included promoting social wellness and including topics such as healthy lifestyles, family relations, and partner support in the programs. Most importantly, First Nations women said that they wanted the programs to be designed with the input of community members, and include gatherings and teachings of traditional knowledge with Elders (Andersson et al., 2003). These results are confirmed in recent reports exploring gaps in maternity care in Inuit and First Nations communities, (Bird, 2006; Stout and Harp, 2009).

The needs of the women in the community and how to best address these needs closely resemble the results of previous studies, specifically the need to address social issues and lifestyle choices in programs, involving partners in programs, and traditional teachings from elders (Andersson et al., 2003; Bird, 2006; Public Health Agency of Canada [PHAC], 2007; Stout and Harp, 2009). What surprised health care staff was how important it was for women to get together with each other to support and learn from each other. The difficulty in implementing this facilitator is that community members are often very reluctant to share their experiences. Innovative ways to promote sharing knowledge, skills, and experiences with each other is needed to draw out the capacities within the community to help women achieve what is most important to them.

Limitations

Time was a major limitation to this study. Time is needed to establish trust in Aboriginal communities as well as to engage in ethnographic research (DeWalt and DeWalt, 2002; Morse, 1994; Voyle and Simmons, 1999). The field researcher was new to the community and lived in the community for three months, the time permitted by her degree program. Establishing

trust necessary to engage community members was an ongoing process that continued for the length of study; it was facilitated by involvement with the community through her nursing capacity in the health clinic, and engaging socially at community events and celebrations. Trust was also facilitated by having key advisors that were well respected in the community introduce the field researcher to potential participants. A second limitation inherent to ethnographic methodology is that the researcher is the "research tool" and is constantly changing and evolving based on her experiences (DeWalt and DeWalt, 2002). Measures were taken to control for this, including keeping a journal of the field researcher's feelings, methodological fieldnotes explicating the decision-making process that led to methods development, on-going contact with supervisors exterior to the setting, and triangulating findings to ensure that the supporting data came from several methods.

Knowledge Translation and Implications

Clinical implications have largely been discussed above in the findings. Some implications merit special consideration. This study is timely in Rapid Lake, where new Maternal Child Health Program workers will soon be hired from the community to hold workshops and visit families in their homes. Implementing this new role will help to address cultural and language barriers, as well as the barrier that some community members experience against entering the clinic building, in a way that the community has not previously had the capacity to address. The new workers can be trained using the results of this study to maximize community involvement and satisfaction with programs. A special report disseminating the findings of this study has been produced for the Maternal Child Health Program workers to this end.

This study highlighted the strong priority community members place on addressing issues related to drugs and alcohol in pregnancy. This finding has been taken seriously; already a program focusing on fetal alcohol syndrome has been given by a collaboration of nursing and social services. It was well received by community members, who suggested holding support groups for women twice a month. Organization of this group is underway.

In the process of decolonization and healing, many Aboriginal communities undergo similar social, political, and economic struggles to those experienced in Rapid Lake (Wadden, 2008). Slowly, communities are recovering and are beginning to build capacities through community involvement in health services programming (Warry, 2007). Identifying the bar-

riers and facilitators to community involvement in health services is the first step toward fostering community involvement, which in turn contributes to community capacity building and may ultimately help Aboriginal communities to take control over their own health promotion efforts.

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