

**MI'KMAQ WOMEN'S
CHILDBIRTH EXPERIENCES:
SUMMARY OF LITERATURE
REVIEW AND PROPOSED
STUDY FOR MASTER'S THESIS**

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ABSTRACT

The fundamental life changes that affect health and general well being make childbirth and the transition to motherhood a complex process for all women as the attitudes towards childbirth are culturally dependent. Among Aboriginal populations, such as the Mi'kmaq, the childbirth experience (having a baby) may be complicated by cultural differences, particularly when Mi'kmaq women deliver their babies in settings outside their culture. Health care that reflects cultural accommodation of such differences in these settings may not be provided, and may not be viewed as essential. Health care professionals often fail to understand the complexity of cultural differences and, as a result, may overlook their implications for health care outcomes (Salimbene 1999). Although there is a significant amount of literature on the concepts of culture and transcultural nursing, there is limited research that specifically explores childbirth experiences of Mi'kmaq women, particularly in relation to their experiences giving birth in settings outside their own culture. A literature review provided the basis for a proposed qualitative study for the purpose of providing new knowledge about Mi'kmaq women's childbirth experiences which occur in a large tertiary care centre outside their rural Nova Scotian community.

INTRODUCTION

Although there is a significant amount of literature on the concepts of culture and transcultural nursing, there is limited research that specifically explores childbirth experiences of Mi'kmaq women. This literature review will focus on Mi'kmaq culture and on Aboriginal health in an effort to provide an understanding of what is known about childbirth experiences of Aboriginal women and families. The literature review begins with a brief overview of the historical background, Aboriginal women's health, Aboriginal health model, historical evolution of childbirth, alternative birthing arenas, culture, and childbirth will be addressed. Socioeconomic issues, discrimination, and other societal factors affecting health, in particular as it relates to childbirth, will be included in the discussion. Based on the literature review, a proposed study describing the purpose, significance, and the method and methodology will be briefly outlined.

Childbirth, the time when a woman gives birth to her child, is a special life event for a mother and her family. Callister, Semenic and Foster (1999: 280) describe childbirth as "a deeply physiologic, cognitive, cultural, social,

and spiritual event." Labour and birth is generally a time of excitement and anticipation, in addition to uncertainty and fear for women and families (Health Canada 2003a). Having a baby is a major transition in women's lives as they learn to become mothers. Memories and experiences of the birth remain in their minds forever (Health Canada 2003a). Therefore, the care and support women receive during the intrapartum period is critical for maintaining health and preventing/minimizing complications.

Although a joyous event, childbirth is associated with perinatal risks and challenges for women, babies, families, and health care providers. Some Aboriginal¹ women have more serious health problems such as hypertension and diabetes during pregnancy, than the general population. This places them at higher risk for maternal and infant complications (Smylie 2001).

Pregnancy, labour, and delivery are normal life processes and most women have good outcomes with support and minimal medical interventions (Kendrick and Simpson 2001). However, in present-day birthing units, birth practices have been rigid because of strong beliefs about medical protocols. These birth practices and protocols include: continuous fetal monitoring, high epidural rates, generous use of episiotomies and induction of labour (Lothian 2001). While episiotomy rates may be still of concern in some institutions, obstetric outcome data suggests there is a decrease in this procedure. According to Wellbery (2005), the incidence of performing an episiotomy is 30-35 percent, a decline in the last 20 years. This is due to the risk of women experiencing anal sphincter and rectal injuries as well as other obstetrical complications. Savage (2002: 8) stated that "such practices are absolutes in obstetrical culture so that the medical establishment communicates that any deviations from the medical norm place mother and infant in jeopardy." The biomedical model defines contextually what most people think of birth. This model represents technology used during the birth process, which limits birth choices (Michaelson 1988). As pointed out by Savage, the birth practices and protocols described above are standard protocol for perinatal care. Prior to the medicalization of childbirth, Savage also claims that young women were told that giving birth was powerful and not a difficult and painful experience. The influence of modern medicine and technology has now essentially replaced women's ways of knowing about childbirth with fear.

In contrast to the medically managed hospital birth experiences, home births offer women more choice about the care they receive. While labouring

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

in their home, women tend to feel more active and positive because the person performing the delivery (most likely a midwife) is considered a guest in the mother's home (Spindel and Suarez 1995). Spindel and Suarez note "the choice of home birth can certainly be framed, in most cases, as a rejection of the more passive medical model of hospital birth" (p. 543).

Childbirth is a major transition and special celebration for all cultures (Callister 2001). Callister states that "healthcare beliefs and health seeking behaviors surrounding pregnancy, childbirth and parenting are deeply rooted in cultural context" (p. 68). Therefore, the extent to which women follow cultural practices and customs depends upon acculturation within the dominant culture, social support, and generation ties. Individual values, beliefs, and lifeways all affect cultural identity (Narayanasamy 2002). Since culture is one of the determinants of health, recognizing the impact it can have on health is critical. In order for nurses and other health care providers to identify the limitations of care provided to Aboriginal women and their families, it is necessary to be aware of the lack of knowledge regarding what constitutes culturally competent care.

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

HISTORICAL BACKGROUND

Colonization has had a disruptive effect on the health and well being of Aboriginal peoples (Smylie et al. 2000). Health care providers need to have some background history for the following reasons: 1) colonization has impacted the physical, mental, emotional, and spiritual dimensions of Aboriginal health; 2) today's relationships of Aboriginal people with health care professionals and the health care system are affected by the colonial system; and 3) policies and attitudes from the colonial system continue to

thrive (Smylie et al. 2000). Smylie et al. (2000: 1074) state "prior to colonization, Aboriginal communities in the Americas were diverse and thriving." Social and political issues impact many levels in health care. In Canada, the mainstream health care system has been shaped by years of internal colonial politics that have managed to marginalize Aboriginal peoples from the dominant group (O'Neil 1986).

ABORIGINAL WOMEN'S HEALTH

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

People's perception of their health and their ability to have control has an effect on overall health (Potter et al. 2001). Since Aboriginal women's cultural beliefs and traditions are interconnected with childbirth, recognizing and adhering to their cultural beliefs and practices can provide a more culturally appropriate environment for the birth experience. A culturally sensitive environment can help to empower women who ultimately can improve their health and that of their families. Culturally sensitive means that the provider has some knowledge of traditional health beliefs among diverse populations in which they are providing care (Spector 2004).

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

In 1999, the Mi'kmaq Health Research Group assisted The Unions of Nova Scotia Indians with the First Nations and Inuit Longitudinal Regional Health Survey, which studied the health of the Mi'kmaq population living on reserves in Nova Scotia. The participants (N=723) included children, youth, and adults, ranging in age from infancy to 55 years and older. Areas of concern relevant to maternal/child included Mi'kmaq women's smoking rate during pregnancy at 52 percent, compared to 24 percent among the general population of Canadian mothers. Breastfeeding rates revealed that 28 percent of Mi'kmaq mothers breastfed their babies in comparison to 72 percent for Canadian mothers. Both the high smoking and low breastfeeding rates can have a negative impact on an Aboriginal mother's health and the health of her baby (Mi'kmaq Health Research Group 1999). Smoking increases the incidence of premature labor and low-birth-weight babies (Freda 2001). Walker and Creehan (2001) reported that breast milk meets the needs of the infant to build an immune system needed for healthy brain development among other benefits, such as decreasing respiratory diseases, otitis media, and gastrointestinal illness. Although there is some research on childbirth issues among Aboriginal women, it is very limited.

Infant mortality is considered one of the main indicators of health of a population, and generally lessens with an increase in women's health (Adelson

2005). The infant mortality rate for First Nations is 8 deaths per 1000 live births, which is 1.5 times higher than the mainstream population (Adelson 2005). High birth weight (>4000 grams) is 18 percent in First Nations babies compared to 12.2 percent for other Canadian babies. Low-birth-weight babies <2500 grams, a group who are generally considered more at risk, is actually slightly less than the general Canadian population (Smylie et al. 2001).

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

Aboriginal women's needs and concerns have been under represented in previous research studies. Including Aboriginal women in research studies to establish key priorities and strategies is an effective way of promoting Aboriginal health (Stout, Kipling, and Stout 2001). The Royal Commission on Aboriginal Peoples (1996) recommended that governments and organizations give Aboriginal women fair opportunity to participate in areas that affect the health and healing of their population. According to Health Canada (2003b), a significant challenge for health care providers is to acknowledge the strengths of minority people and to work with the minority populations they serve.

ABORIGINAL HEALTH MODEL

The paucity of research on the childbirth experiences of Mi'kmaq women necessitated a personal communication with Murdena Marshall, a Mi'kmaq educator/Elder and mother living in a First Nations Community in Cape Breton. Marshall discussed the beliefs about the Mi'kmaq people's views on health, including labour and childbirth in her unpublished manuscript titled "Parenting and Traditional Beliefs Are Essential" (1992). The following is a brief excerpt:

During labor and childbirth the mother is instructed not to make too much noise or use abusive language during delivery. The old ladies will ask that you maintain yourself so that when the baby is born, he or she will be in a world that is calm and peaceful. It's bad enough that the baby leaves the dark, warm cradle

to be exposed to cold, light and abusive language. They say at least eliminate the noise, it still will be cold and bright but it could be welcoming. (p. 4)

The health model in Aboriginal communities usually incorporates physical, mental, emotional, and spiritual health (Mi'kmaq Health Research Group 1999). According to Murdena Marshall (personal communication 2004), the above health model includes the same four components of a person who is "required to work together in harmony and balance for good health to happen." The physical represents the "body-birth" and the spiritual refers to the "soul and death," a "duality" which signifies opposites in meaning. Marshall stated "you have to overcome the negative for healing to begin" with four components integral to the healing process. For example, Marshall stated, "you will feel better even though you have cancer." Just "thank God" for what you have (personal communication 2004). Many Aboriginal people believe that traditional customs reflecting this balance of essential parts are necessary to help improve and maintain the health of Aboriginal societies (Mi'kmaq Health Research Group 1999). Understanding the beliefs of a well-respected Mi'kmaq educator provides insight into Mi'kmaq beliefs (i.e., balance and health). This suggests that providing culturally relevant childbirth care for Aboriginal women may have a direct positive impact on the physical and psychosocial outcome of the process.

HISTORICAL EVOLUTION OF CHILDBIRTH

Prior to the 17th century, birthing in most countries was considered within the realm of women and it occurred primarily outside a hospital setting (Johanson, Newburn, and Macfarlane 2002). Hospital births were essentially unheard of prior to the 20th century (Savage 2002). According to Lothian (2001: 13) "the social structure surrounding birth [has] changed dramatically" since a century ago when the labour and delivery of childbirth was considered an everyday event. During that time, women learned about childbirth from their mothers, sisters, other relatives, and friends; birth stories were passed down from generation to generation. Women delivered at home, often with midwives, and surrounded by their loving and supportive families. In North America, by the 1950s, a shift to delivering babies in hospitals had gradually occurred (Savage 2002). With this change came the idea that birth was a medical event (Jordan 1983).

Medicalization continues to be the principle ideology underlying current health policies and practices in the Aboriginal population (Royal

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

Women are vulnerable during childbirth and often have limited control over their childbirth experiences, including decisions surrounding the medical care they receive (Lazarus 1997, Esposito 1999). Lazarus studied three groups of women: a lay middle-class group, a health professional group, and a group of poor women (those with limited resources). She found those women with limited resources had fewer choices and less control over their care than did the rest of the population. The disadvantaged group of women reported being burdened with social and economic problems that left them feeling overwhelmed. Women in the poor group primarily focused on “continuity of care rather than on issues of control” (Lazarus 1997: 133). Because many of these economically disadvantaged women had given birth at a very young age, they were also unemployed and had limited education. Having choice and control over their childbirth experience was given low priority because of the urgent nature of their socioeconomic situation. Lazarus concluded that women with more education seemed to enjoy greater control over their childbirth experience.

Davis-Floyd (1992) reported similar findings when she interviewed 100 pregnant women in both the hospital and at home. Davis-Floyd described how most women in American hospitals were given hospital gowns, connected to fetal heart monitors, and administered intravenous therapy. Some women were given a synthetic hormone called pitocin to speed up ineffective labour contractions (changes in cervical dilatation less than 1 cm per hour). During the delivery of the baby, many received an episiotomy, which was performed to widen the birth outlet. Because most obstetricians used these obstetrical procedures, they were considered the norm in most urban settings or towns. Davis-Floyd described how childbirth action groups tried

to change the hospital environment to a more natural childbirth approach to eliminate technical rituals incorporated into the obstetrical interventions that women experienced as part of their childbirth experiences. Davis-Floyd acknowledged the importance of respecting women's birth choices stressing the need for a holistic approach instead of a technical model for childbirth.

Prior to the medicalization of childbirth, women in general listened to stories about the strength and power of giving birth rather than the pain they were about to endure (Savage 2002). Giving birth was considered a positive and empowering event. Savage claims that today, women are sharing their personal stories about traumatic birth experiences and medical interventions to save their baby with less emphasis on how powerful birth can be and the joy of maternal newborn bonding.

Farley and Widmann (2001: 22) described storytelling as "a culturally universal interaction" by which events in people's lives are shaped, thus enabling understanding of the meaning of a particular situation, so they can move forward. In a medicalized birth environment, sharing birthing stories is not visibly supported or enabled (Savage 2002). Savage described how the "cultural constructs of the twenty-first century overwhelmingly support the technocratic model" (p. 10). Increasing knowledge about historical childbirth practices that women have passed on for many generations is disregarded as a mechanical view emerges in birthing units. Strong influences from medicine and technology "have replaced women's ways of knowing" (Savage 2002: 9) about birthing practices resulting in fear of experiencing pain, fear of failure, and fear that if one does not follow the medical recommendation, there is a risk of birth complications and a "less than perfect birth and baby." In most birthing units today, medical equipment, fetal heart monitors, intravenous therapy, epidural anesthesia, oxygen therapy, and pain medications are used to assess and provide care to mothers in labour (Health Canada 2003a). However, Hiebert (2003: 47) claims "childbearing practices, heavily influenced by Western medicine, are in opposition to an Aboriginal worldview that embraces childbirth as an influenced natural event."

ALTERNATE BIRTHING ARENAS

In recent years, despite the belief of health care providers that the best place to give birth is the hospital, there has been no sound evidence to prove that the hospital setting is safer for women with uncomplicated pregnancies to deliver (Lothian 2001). Women with uncomplicated pregnancies have begun advocating for the establishment of birthing centres and home births.

Although this change is gradual in North America, women in general are beginning to make some significant strides toward natural childbirth. For example, the Reproductive Care Program of Nova Scotia (RCPNS) (2003) reported that, although most women in Canada deliver in hospitals, there are some free-standing birth centres and a small but increasing number of Canadian women are giving birth at home. Johnson and Daviss (2005) reported that women who planned on having a home birth with a midwife present at delivery, had minimal intrapartum and neonatal complications, comparable to women delivering in low-risk hospitals in North America. According to Bourgeault, Benoit, and Davis-Floyd (2004: 7), there has been a growing movement toward home births since the late 1960s and 1970s, with "lessening of trust in professional authority, an unprecedented decline in respect for medicine, and a growing recognition of emotional, social, and spiritual components of life and healing in particular." Bourgeault et al. report the anticipation that most areas in Canada will soon legalize midwifery and integrate it into the current health care system. Currently in Canada, midwifery has been adopted in Ontario, British Columbia, Alberta, Saskatchewan, and Manitoba (Potter et al. 2001). Thus, unique forms of midwifery practice will emerge, providing women the option of choosing home birth.

The introduction of the family-centred care concept into hospitals, where the birth experience belongs to the mother and her family, has significantly changed maternal-child practices (Kendrick and Simpson 2001). Birth is increasingly being seen as a family event where women select their support people during the childbirth experience. According to the RCPNS (2003: 1), "in a truly family-centered care environment, women are active participants in every aspect of their care." Therefore, families are visible and part of the decision-making process. Respect is given to women for their knowledge of their own health and that of their families (RCPNS 2003). Aboriginal families are allowed to take their women to the hospital and remain with them during the childbirth experience. However, in some remote areas such as in the Northwest Territories, Aboriginal women are transported out of their community to deliver in larger hospitals leaving their husband and children at home (Paulette 1990).

The delivery of safe and competent care, that meets the needs of women and their families, is a major priority. Evidence is growing to support the benefits of having a normal and natural birth experience (Lothian 2001). By choosing a home birth, women and their families share responsibility for care and the outcome with the labour attendants (Vedam and Kolodji

1995). Tremendous effort goes into assessing the mother to determine if she is a candidate for home birth, and the benefits of being able to deliver their babies in the home environment make the entire process satisfying for mothers and families. Since Aboriginal people value the importance of sharing the birth experience with members of family and community, being able to deliver in their own communities in a birth centre or home birth could help to build strong bonds and caring relationships between community members (Paulette 1990).

CULTURE AND CHILDBIRTH

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

Callister (2001) asserted that one's healthcare beliefs and behaviours about the childbirth experience are deeply entrenched in cultural context. She contends that culture represents women's identity. Women's cultural practices, beliefs, and traditions are complex and depend on factors such as support and acculturation into a dominant culture within society (Callister 2001). It is important to remember that, even though individuals share a common birthplace, their cultural traditions may be different. Sokoloski's (1995) qualitative study of First Nations women reported similar findings. The First Nations women viewed pregnancy as a very natural and normal event, requiring neither medical interventions, nor attending to prenatal care.

In Canada, cultural minority groups often find themselves receiving health care from people who have beliefs, values, and attitudes different than their own (Baker and Daigle 2000, Sokoloski 1995). Clarke (1997: 12) emphasized that research approaches, in addition to being culturally appropriate, need to be culturally suitable to the population being studied in order "to generate valid knowledge about culture, to develop theory, and to translate this into culturally suitable nursing and health care." Since feminism has historically focused on valuing women and challenging injustices based on gen-

der (Dugas, Esson and Ronaldson 1999), a feminist perspective for this study would explore the importance of gender in relation to Mi'kmaq women's childbirth experiences.

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

First Nations women hold traditional healing knowledge in high regard because this knowledge is passed down from female Elders (Browne and Fiske 2001). For many women, exposure to this knowledge helps to validate their cultural identity and improve relations with health care providers. According to Anderson (2005: 8-9), Aboriginal people's health is rooted in

... oppression and dispossession. ... Aboriginal women suffer the ill effects of material poverty, but they also suffer from a poverty that happened when our traditional knowledge, cultures, and identities were stripped away from us through aggressive policies of assimilation and cultural genocide.

If Aboriginal people are going to get better they need to reclaim the cultural, intellectual, and spiritual ways that were taken away. If isolated from their culture, they will "experience an intellectual, emotional and spiritual rupture" that can create illness (Anderson 2005: 9).

Brown and Fiske (2001) describe First Nations women's health care experiences from a reserve in northwestern Canada. Some informants described situations where their health concerns were not taken seriously. For example, some participants reported that when they arrived at the clinic, nurses told the women there was nothing wrong with them and sent them home. As a result, they became more ill. The participants described some of the clinic nurses as being intimidating. Yet, a memorable experience occurred when a nurse, rather than leaving at the end of her shift, remained with a mother and held her hand while she gave birth to a premature baby. When health care providers provided emotional support and medical care, the participants felt they received outstanding care.

The value placed on cultural identity was evident in a qualitative study conducted by Browne (1995) with Cree-Ojibway people in northern

Manitoba. The participants described instances in which they perceived the nurse as insincere during clinic visits for health care. The informants quickly sensed whether the nurse was in a hurry or did not want to answer their questions. The health care providers' verbal and nonverbal behaviours in the initial contact with the patients were interpreted as a sign of respect. Being sensitive to the importance of respect during interactions with First Nations people was considered highly important. Trust developed when First Nations people believed that health care providers genuinely care.

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

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

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

PURPOSE OF THE STUDY

A review of the literature regarding Mi'kmaq women's childbirth experiences provided direction for a proposed qualitative research study. The purpose of the study is to provide new knowledge about Mi'kmaq women's childbirth experiences, which occur in a large tertiary care centre outside

their rural Nova Scotian community. The study will provide a greater understanding of Mi'kmaq women's childbirth. The research will explore Mi'kmaq women's perceptions of their birth experiences to help ensure that culturally appropriate care is provided to this population.

The research questions posed for the study include:

1. What is the experience of Mi'kmaq women giving birth outside their First Nations community?
2. What do Mi'kmaq women perceive to be an optimal birth experience from their own cultural perspective?

SIGNIFICANCE OF THE STUDY

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

As Mi'kmaq women deliver their babies in a culture different from their own, dissimilar values, beliefs, and attitudes, may result in greater vulnerability in their transition to motherhood (Meleis et al. 2000). Moffitt and Wuest (2002) noted that Aboriginal people living in the Northwest Territories believe that individual and community values are directly related to individual health and recovery from illness, and if not acknowledged, recovery may be hampered. Moffitt and Wuest recommended that cultural caregivers include

customary healing traditions and the use of interpreters as active participants in the care process.

In a society dominated by non-Aboriginal culture, women from a minority group such as the Mi'kmaq may experience childbirth in an arena that is not culturally sensitive to their needs. Enang (1999) maintained the link between culture and health is apparent with marginalized groups, in reference to racially visible individuals experiencing social and economic hardships as a result of unemployment. According to Willis (1999: 58) "models of care that are patient-driven and that respect cultural preferences and motivations are most likely to promote the desired health behaviors and positive health status." For example, culturally competent care that respects cultural strengths is a key factor in helping families feel empowered and, therefore, enabling them to maintain their cultural beliefs, values, and health practices throughout health care experiences.

Since there is very little literature available about the experiences of Mi'kmaq women during childbirth, it is hoped that the knowledge and insights will assist health care professionals to provide more culturally appropriate care. Receiving culturally competent care could enable Mi'kmaq women to have healthier outcomes for both themselves and their babies. It is anticipated that the findings from the study may also be used to inform policy development for Aboriginal health.

METHOD AND METHODOLOGY

A qualitative study to explore Mi'kmaq women's childbirth experiences outside their cultural context will be conducted. Qualitative research designs take place in real life settings and the researcher does not influence the phenomenon being studied (Patton 2002). There is a natural unfolding process, where the researcher observes and interviews participants in familiar surroundings that are comfortable to them. A qualitative method is suited to the study, as the purpose is to provide new knowledge about childbirth experiences and to explore Mi'kmaq women's perceptions of their birth experiences.

Feminist methodology forms the guiding principle for the study. According to King (1994), feminist methodology refers to questions that affect women, are important to women, and occur as a result of their struggles in society. Feminist research is particularly appropriate to the study of childbirth experiences of Mi'kmaq women. Since childbirth is about women having babies, and the family is one of society's most important institutions

(Wong, Perry, and Hockenberry 2002), then the care of women by health care professionals requires cultural sensitivity and competence. Since this study will be about women, and traditionally women have been oppressed, not only the participant but the nursing profession who are predominately female, can benefit from using a feminist approach to doing research. Enang (1999: 47) asserts "as nurses become more involved with feminism, we must not ignore the feminist perspective that is relevant to the experiences of women of colour and other marginalized groups." Evans (1993) added that feminist research could in fact act as a healer regarding issues related to equality and social justice for women.

Doering (1992: 26) defined feminism as "a world view that values women and confronts systematic injustices based on gender." Feminist theory and research are focused on women with a major emphasis on class and race bias (Wuest, 1994). Feminist theories have progressed by placing gender first, by including women in the dialogue of social and political theory, and by raising awareness of women's needs (Morse 1995) and the oppression of women (MacPherson 1983). They also offer the potential for new visions of justice and freedom for women (MacPherson 1983). The purpose of feminist research is to create a social system that represents equality, questions the status quo, challenges existing social systems, creates new personal choices related to health/life choices, and shifts the balance of power (Wuest 1994). In the study, feminist methodology is the most suitable choice for exploring women's experiences of childbirth because it addresses Mi'kmaq women's lives, thus valuing women and women's experiences. Enang (1999) asserts that feminist methodology provides the flexibility that is required to comprehend women's views and their experiences.

According to Wuest (1994: 578), "a major goal of feminist research is seeing the world through the eyes of 'the other' for the purpose of emancipation." Streubert-Speziale and Carpenter (2003) add that feminist researchers strive to see the world from the viewpoint of the women being studied, attempt to be analytical in examining the issues, and advocate for improving the lives of those being studied. Using feminist theory moves the concept of emancipation closer and specifically addresses women's lives (Streubert-Speziale and Carpenter 2003). In the proposed study, the findings generated have the potential to improve the birth experience of Mi'kmaq women if shared with health professionals and Aboriginal women.

Keddy (1992) asserts that schools of nursing and health care institutions are slowly embracing feminism as a means of hope for a discordant nursing

profession. Researchers are beginning to re-examine their traditional methods for examining questions and are seeing the value of having a feminist perspective in the nursing theories they are using. By using a feminist approach, the hierarchical relationship is avoided, and power differences between the researcher and the participants are reduced. In this way, feminist research gives an opportunity for the participants' voices to be heard. Hence, in this study, a feminist approach would help to diminish the power difference.

In addition to using a feminist approach in this study, an Indigenous Framework will be used to help understand First Nations people, make connections, and recognize Indigenous knowledge and pedagogy. Indigenous knowledge

[includes] a web of relationships within a specific ecological context; contains linguistic categories, rules, and relationships unique to each knowledge system; has localized content and meaning; has established customs with respect to acquiring and sharing knowledge...." (Battiste 2002: 14).

Battiste (2000) asserts that Indigenous knowledge, including oral modes of transmission, is an essential and significant process for Indigenous educators and scholars. The Supreme Court of Canada recognizes oral modes of transmission as a legal form for transmitting and understanding Indigenous knowledge. Battiste (2000) adds that, if the courts are required to uphold Indigenous knowledge, then others in society should value oral traditions and recognize them as an important source of knowledge and scholarship. Knowledge from a First Nations perspective is a process that comes from creation and is considered sacred. Learning is considered to be a life-long journey. Knowledge educates people about how to take responsibility for their lives, helps to develop relationships with others, and guides First Nations people to use respectful behaviour. Traditions and ceremonies are considered part of everyday life.

Using a qualitative method will facilitate the study of Mi'kmaq women's childbirth experiences in more depth and detail (Patton 2002). King (1994) adds that qualitative research methods, which tend to be used in feminist research, are able to assist with identifying the most important issues concerning women. Qualitative methods can go beyond the traditional methods to create effective change.

Approval to engage in this study will be obtained from the Human Ethics Review Committee of Dalhousie University. Following approval, an applica-

tion will be submitted to the Mi'kmaq Ethics Watch Committee to gain additional approval, prior to commencing the research study.

Participants will be purposively selected (Patton 2002) on the basis of the following criteria:

- Mi'kmaq women;
- 19 years or older;
- living in a First Nations community in Cape Breton, Nova Scotia;
- are first-time mothers;
- have given birth within the past 2 years at a health care centre geographically separated from their community.

If the Mi'kmaq women are not fluent in English, or need assistance in understanding some questions in the interview, a Mi'kmaq interpreter (with the permission of the participants) will be present to assist with interpretation.

The community health nurse, a Mi'kmaq woman, will approach Mi'kmaq women, according to the criteria described above, when they come to the health centre for their postnatal care and/or contact them by telephone. As appropriate, she will hand out or mail potential participants a copy of a letter of introduction to the study. The community health nurse will verbally clarify information in the letter of introduction, if necessary, to ensure that potential participants understand the purpose of the study and the nature of participation. This letter will describe the research, its purpose, and the nature of Mi'kmaq women's participation. It will also ask potential participants to contact the researcher if they would like more information or want to participate in the study. The researcher's phone number will be provided. However, the community health nurse will not be aware of the women's intention to participate in the study. Additionally, a stamped envelope and a participation form will be provided with the letter of introduction. Consent will be obtained from each Mi'kmaq woman prior to beginning the study.

Data will be collected by means of a one-on-one, in-depth interview developed by the researcher and a focus group discussion. Interviews and a focus group meeting will enable the researcher to obtain information from the participants in order to gain an understanding of their situations and obtain details.

Interviews will be audio-tape recorded and transcribed verbatim to ensure accuracy of the data. The researcher will write field notes after each interview has been completed. Data will be examined using thematic analysis. In this study, the researcher will evaluate data through participant validation

followed by a focus group meeting after the initial interview and analysis is completed, to ensure trustworthiness of the data. The participants will be assured that confidentiality is maintained throughout the research process and in the dissemination of information by the researcher.

CONCLUSION

The literature review demonstrates that research is ongoing in the area of culture; more specifically cultural identity, cultural awareness, and cultural competence. However, minimal research has been undertaken in the area of Aboriginal women's childbirth experiences and less research on this topic has been conducted with Mi'kmaq women.

Aboriginal women view health as inseparable from their families and communities (Stout, Kipling, and Stout 2001). Their major role consists of being caregivers, leaders, and nurturers to people in their community (Stout, Kipling, and Stout 2001). However, because these women have a high incidence of medical conditions, such as diabetes and hypertension during pregnancy, they often become high-risk and require more intensive medical interventions. As a result, they are often cared for in a tertiary health care setting by health care providers who may have very different beliefs and values regarding their health and childbirth. This study will provide some new insights into this childbirth experience of Mi'kmaq women.

This research will help to build Aboriginal health research capacity by establishing trust between the participating Mi'kmaq women and the researcher. The women will understand that the purpose of the study is to explore their childbirth experiences outside of their cultural context and not meant to inform them about what the experience should be like for them. Interviewing Mi'kmaq women one-on one and inviting them to participate in a focus group session will help to identify issues, share ideas, and develop strategies that may benefit Mi'kmaq women and families during childbirth. Participating in this research will give Mi'kmaq women a voice and a forum to tell their birth stories and support their feelings and concerns related to such a personal experience. It is anticipated that asking the women to participate will enable them to feel empowered and therefore serve as a means of improving their lives and health.

This study will also build health research capacity by developing a supportive partnership between Aboriginal communities and non-Aboriginal communities. Becoming familiar with each other's communities helps to

foster stronger relationships and improve cultural awareness, cultural safety and cultural sensitivity.

Dissemination of the findings to the First Nations communities and others in Nova Scotia in a manner that is understandable and meaningful will be carried out. Presenting health research to Aboriginal people in a way that is accessible, appropriate, and easily understood can also help to build health research capacity. The findings will be presented at peer reviewed conferences and workshops, interested groups in universities, health care settings, and other communities for the purpose of increasing knowledge about Mi'kmaq childbirth and culturally competent care.

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