

Résumé

Les expériences d'accouchement des femmes autochtones en région rurale, mises en contexte : les implications en matière de soins infirmiers

Helen Brown, Colleen Varcoe, Betty Calam

L'influence importante qu'exercent la pauvreté, l'isolement, les possibilités économiques limitées et la diminution des services de maternité sur les expériences d'accouchement et les résultats que vivent les femmes en région rurale est un fait indéniable. Par ailleurs, peu de recherches ont été réalisées concernant l'aggravement de ces problématiques entraîné par le recoupement de diverses formes d'oppression que subissent les femmes autochtones et l'impact sur leurs expériences d'accouchement et les résultats qui en découlent. Les conclusions de cette étude sur les soins maternels aux femmes autochtones vivant en région rurale, notamment dans quatre communautés en Colombie-Britannique, démontrent l'impact de siècles de colonisation sur la réduction des possibilités d'accoucher dans leur région et sur leurs luttes pour acquérir du pouvoir et exercer des choix et un contrôle sur leur vécu. Les questions posées dans le cadre de la recherche portent sur les expériences que vivent les femmes autochtones en région rurale en ce qui a trait aux soins à l'accouchement et aux soins maternels, dans un contexte néocolonial, et à leur désir d'accoucher dans des milieux soutenant. Un modèle participatif et ethnographique communautaire a été utilisé et les données ont été principalement tirées d'entrevues individuelles, de groupes de discussion et de commentaires de participantes. Bien que les expériences des femmes de chaque communauté aient été façonnées par des antécédents historiques, des traditions et des contextes économiques, politiques et géographiques distincts, l'impact de la colonisation et du paternalisme médical ainsi que la lutte pour le contrôle du corps des femmes pendant l'accouchement se recoupent et infligent aux femmes un stress supplémentaire. Les implications sur le personnel infirmier d'une approche tenant compte des dynamiques qui se recoupent et qui façonnent les expériences des femmes autochtones et les résultats générés font l'objet d'une discussion.

Mots clés : autochtones, expériences d'accouchement

The Birthing Experiences of Rural Aboriginal Women in Context: Implications for Nursing

Helen Brown, Colleen Varcoe, Betty Calam

It has been established that the birthing experiences and outcomes of rural women are shaped by poverty, isolation, limited economic opportunities, and diminishing maternity services. We lack research into how these dynamics are compounded by intersecting forms of oppression faced by Aboriginal women, to impact on their birthing experiences and outcomes. The findings of this study of rural Aboriginal maternity care in 4 communities in British Columbia show how diminishing local birthing choices and women's struggles to exert power, choice, and control are influenced by centuries of colonization. The research questions focus on rural Aboriginal women's experiences of birthing and maternity care in this neocolonial context and their desire for supportive birthing environments. A community-based participatory and ethnographic design was employed. Individual interviews, focus groups, and participant observation were the primary data sources. Although the women's experiences in each community were shaped by distinct histories and traditions, economics, politics, and geographies, the impacts of colonization and medical paternalism and the struggle for control of women's bodies during birth intersect, placing additional stress on women. The implications for nurses of accounting for the intersecting dynamics that shape Aboriginal women's experiences and birth outcomes are discussed.

Keywords: rural maternity care, Aboriginal, birthing experiences, medical colonialism, social determinants of health, maternity nursing practice

Introduction

Birthing and maternity care in rural communities in Canada has shifted dramatically over the past several decades (Benoit, Carroll, & Millar, 2002; Grzybowski, Kornelson, & Cooper, 2007; Kaufert & O'Neil, 1993). Increasing neoliberal economic priorities have led to hospital closures and consolidation of services, increasing urbanization, and regionalization of health care, all of which have led to a sharp decline in maternity services in rural locales and an increasing trend to evacuate women from their communities to give birth in urban settings. Rural women are impacted significantly by a lack of access to and choice of maternity care providers, discontinuous care, poor quality of care, and a lack of opportunity to have a voice in local health-service planning (Benoit et al., 2002).

Maternity care for rural Aboriginal¹ women, as with any aspect of health care for Aboriginal people, can be understood only within the context of historical and ongoing colonization. Deep-rooted practices of gender subordination combined with destruction of economic and cultural resources intersect in ways that silence and oppress Aboriginal women in all regions of Canada (Tait, 2008). Because it is well established that social and economic factors affect pregnancy complications and birth outcomes (Giscombe & Lobel, 2005), and because for every indicator of risk during pregnancy and birth in Canada (e.g., teen pregnancy, preterm birth, low birth weight, high birth weight, infant and neonatal mortality), outcomes are two to five times worse for Aboriginal people (British Columbia Provincial Health Officer, 2009), it is necessary to investigate how the neocolonial context of Aboriginal women's lives shapes their health and experiences in pregnancy and their birth outcomes. Despite significant research attention to rural maternity care, there is little specific consideration of Aboriginal women's particular experiences in context, especially in relation to differential birth outcomes. Although the influences of the context of past and present "colonization of childbirth" have been analyzed (Benoit, Carroll, & Westfall, 2007), such work has not been widely integrated with research on rural maternity care, nor used to inform the design and delivery of health services or professional practice. This qualitative study sought to contribute to rural maternity care in Aboriginal communities by exploring birthing experiences and traditional birthing practices among the Haida, Kwakwaka'wakw, and Nuxalk First Nations.

Literature Review

Knowledge about the health of rural Canadians — particularly people experiencing intersecting forms of disadvantage on the basis of gender, race, and income, such as Aboriginal women — is considered "incomplete and unsystematic, with the social determinants of health virtually ignored" (Sutherns, McPhedran, & Haworth-Brockman, 2004, p. 3). Given that one in five Canadian women live in a rural area, research on their health across the lifespan has been limited. Women living in rural communities face particular health challenges related to poverty and iso-

¹ In Canada, the *Constitution Act* recognizes three groups of Aboriginal peoples: Indian, Inuit, and Métis. Under the *Indian Act*, the term "Status Indian" is used for a person whose name appears on the Indian Register maintained by the federal government. A 1985 amendment brought the *Indian Act* in line with the Canadian Charter of Rights and Freedoms. A non-Status Indian is a person of Indian ancestry who does not meet the criteria for registration under the *Indian Act* or who has chosen not to be registered (Muckle, 2007).

lation, economic opportunities, and health services in rural contexts (Ross, Scott, & Smith, 2000; Sutherns et al., 2004).

While Aboriginal women face the same health challenges as non-Aboriginal women who live in rural communities, they live with additional and intersecting forms of oppression that contribute to health inequities and poor access to health care (Fiske & Browne, 2004; Kurtz, Nyberg, Van Den Tillaart, & Mills, 2008; Tait, 2008). The history of the colonization of Aboriginal people in Canada by successive waves of European settlers has been characterized as welfare colonialism, in which Aboriginal people were forced into dependency through a system of reserves, compulsory residential schools for children, and a series of policies that prevented the people from pursuing their traditional ways of living and supporting themselves (Reinert, 2005). These factors have had profoundly gendered impacts (Fiske, 2006), with specific effects on mothering among Aboriginal women (Varcoe & Hartrick Doane, 2007). Contemporary health-care reforms, informed by neoliberal values, further disadvantage Aboriginal women (Fiske & Browne, 2004). According to Tait (2008), "In areas of health policy and delivery a growing association between health and personal responsibility has further added to the marginalization of Aboriginal women" (p. 2). With respect to maternity care, these political, economic, and social dynamics increase the risk among Aboriginal women for complications during pregnancy and adverse birth outcomes (Kaufert & O'Neil, 1993). Largely absent from research in the domain of rural maternity care and maternity nursing is a critical analysis of medicalization as the dominant frame contextualizing childbirth experiences, pregnancy risk, and maternal and neonatal outcomes (Fisher, Huack, & Fenwick, 2006). While there is growing evidence associating the neocolonial context of Aboriginal women's lives with ongoing inequities in health and access to health care, we have limited knowledge of how this context shapes maternity care and the birthing experiences and birth outcomes of rural Aboriginal women.

Birthing and Maternity Care in Rural Aboriginal Communities

Maternity care for Aboriginal women has evolved within the history of colonialism and the accompanying gendered experiences of oppression. Health care, and the specific domain of maternity care, has evolved within this context. The marginalization of Aboriginal women through colonial government policy and the decimation of indigenous reproductive health practices effectively destroyed traditional ways of birthing and shifted control over childbirth to colonizing medical forces (Benoit et al., 2002). Suffice to say that "doctor- and hospital-centred" childbirth practices in the early 1900s placed Aboriginal communities in the precarious

position of having to fend for themselves during childbirth or, at other times, requiring access to “modern” medical services. Colonization undermined the self-sufficiency of Aboriginal women during childbirth and destroyed Aboriginal midwifery (Benoit et al., 2007).

Thus, in the intersection between loss of traditional practices and marginalization from “modern” health care, Aboriginal women fell through the maternity care cracks. Increased pregnancy- and birth-related complications for Aboriginal women followed colonization, loss of traditional occupations and natural resources, reliance on “white” food, and the erosion of traditional care. However, drawing on Western health models, colonial policy-makers and medical practitioners have attributed Aboriginal women’s poor health outcomes to inadequate medical care and lack of contact with the colonizing society. Those within the colonizing society have believed Aboriginal women to be at higher risk of adverse birth outcomes than the rest of the Canadian population because of a lack of contact with health care and poor “choices,” such as failure to regularly attend prenatal care, adolescent pregnancy, and inadequate nutrition during pregnancy (Kaufert & O’Neil, 1993).

The mechanism of colonization as a major determinant of health is often overlooked, and explanatory models appear to “blame the victims” — for example, for not having better nutrition and not accessing prenatal care — rather than attending to how poverty, appropriation of traditional food-gathering and hunting territories, destruction of wildlife and fisheries habitats, and rural transportation challenges lead to poor nutrition and health-care access.

The widespread perception of greater risk for Aboriginal women intensified surveillance and evacuation efforts by health-care providers, with discourses of “risk” encouraging and sustaining the trend towards evacuation to urban settings for birthing (Kaufert & O’Neil, 1993). Medical control over birth continues to serve as an expression of power in relation to all women, and Aboriginal women experience specific types of power relations in the form of “medical colonialism.”² Because racism is a constant companion of colonization, and because research shows how racism operates to create the conditions for adverse birth outcomes (Parker Dominguez, 2008), we need to examine how the neo-colonial context of women’s lives causes inequities in maternal-infant health and infant mortality and their leading antecedents, low birth weight (LBW; < 2,500 grams) and preterm delivery (PTD; < 37 weeks).

² “Medical colonialism” refers to how “colonial governments appropriated medical power by encouraging the production of knowledge about indigenous bodies that justified racial hierarchies . . . where those hierarchies became reified by providing segregated and inequitable services on the basis of race” (Kelm, 2004, p. 335).

There exist wide knowledge gaps in relation to how differential perinatal outcomes and inequities in maternal-infant health are shaped by historical and ongoing “medical colonialism” (Kelm, 2004). This research project was developed to examine these gaps, particularly given that research on maternity care has focused on the experiences of health-care providers and predominantly non-Aboriginal women (Kornelson & Grzybowski, 2005).

Research Questions

The Rural Aboriginal Maternity Care project was a collaboration among Aboriginal women from the Nuxalk, Haida, and Kwakwaka'wakw First Nations and academic researchers from nursing, medicine, and counselling psychology. The research questions were as follows: 1. *How are rural Aboriginal women's birthing experiences and outcomes shaped by the context of their lives?* 2. *What issues are important to the communities in the area of maternity care and birthing?* 3. *How can knowledge about past, present, and desired future birthing practices inform maternity care priorities and women's choice and methods for birthing that meet the cultural, spiritual, and physiological needs of women, their families, and their communities?*

Method

In order to build positively on previous research, and to more fully engage Aboriginal women through collaborative inquiry, it was clear that a “typical” research approach was inappropriate. In the spirit of a participatory design (Kemmis & McTaggart, 2000), any ideas about research needed to come from the communities themselves. Thus, we used an iterative process of discussion among academic and community-based researchers to investigate maternity care issues of relevance to each community. Ethical agreements were signed in communities where they existed and ethical approval was obtained from the University of British Columbia Behavioural Research Ethics Board.

In each community, we employed a purposive sampling strategy; that is, we followed the lead of the community researchers and participants on how to publicize the project and recruit participants. Using ethnographic methods, we participated in community events where potential participants could also express an interest in joining the study. We began by interviewing women who had given birth recently, and then purposely included other women, family members (including fathers), health-care providers, and community leaders. The sample size was determined in collaboration with the community researchers. Recruitment ended when community researchers indicated that a limited number of new insights and experiences were being shared by participants in each community. In

total, 125 individuals participated in audiorecorded individual or focus group interviews: 66 mothers and 1 father participated in individual interviews; 36 mothers and 2 fathers joined focus groups; separate focus group interviews were held with 5 youths and 11 Elders; we also interviewed 4 health-care providers and local health leaders in two communities.

Guided by the principles of participatory and community-based research (Varcoe, 2006), we also collected data through participant observation and field notes, while the academic and community researchers joined in local events and meetings relevant to the research questions (e.g., Mother's Day luncheon, mother-and-tot groups, Christmas school celebrations, visits to traditional territories, baby-welcoming ceremonies). Guided by the research questions and the principles of respect, relevance, reciprocity, and responsibility as set out by the British Columbia Aboriginal Capacity and Developmental Research Environment, the community researchers developed interview questions and discussion guides relevant for their community. The questions were not identical for each community and the community researchers were encouraged to enlist their own skills and knowledge of their communities when developing questions. Despite the different words used, all community researchers conducted the interviews and focus groups by inquiring about (1) participants' birth experiences; (2) how history and tradition shaped the participants' experiences, hopes, and needs with respect to maternity care; and (3) the kinds of birthing environments that would best support participants, their families, and their communities.

We considered interviews and discussions with the women to be the main "primary" data, and used the other information to enhance the thematic approach to analysis to create an understanding of the women's experiences. In all communities, the community-based researchers led the analysis because they had the most extensive understanding of the community, history, and people. Together we used the principles of thematic and ethnographic analysis, reading the transcribed interviews together, coding the meaning of each section, and then comparing the meanings across interviews until no new information emerged. In this article we present the cross-community analysis, emphasizing those aspects of greatest relevance for nursing practice.

Findings

The central dynamics underlying rural Aboriginal women's birthing experiences in the four communities involved the intersections among the effects of historical and ongoing colonization, concurrent efforts towards cultural revitalization, self-determination and reclamation, and

rural geography. The availability of birthing and economic resources in the wake of colonization created specific birthing expectations and stresses on birthing, both of which have shaped women's, families', and community-specific experiences. Thus, women's sense of power, control, and choice in each community, and various points of tension and resistance to local service models for low-risk maternity care, reflect both historical and ongoing power relations and the degree of colonial appropriation of resources in the community.

The Neocolonial Context of Birthing and Economic Resources

Although each community had unique experiences of colonization, and although the geography of each community has likely affected the dynamics of colonization, there were significant commonalities. The Haida, Kwakwaka'wakw, and Nuxalk peoples all suffered devastating population losses from diseases introduced post-contact (Kelm, 2004). The dynamics of colonization and appropriation of resources and control over those resources has had different impacts in each community. Consequently, different levels of affluence exist in each community and the resources available to individual women therefore differ. For example, in one community many of the women had very low incomes compared to non-Aboriginal women. A lack of economic resources had direct effects on prenatal nutrition, which affected women's health during pregnancy and constrained their birthing choices. Several women, with no car or access to money, were unable to go to an urban centre to give birth and had to stay in their home community regardless of medical recommendations or their own preferences. Even Aboriginal women who had "status" and were thus eligible for a travel allowance found the allowance inadequate for travel, accommodation, and proper nutrition. Many spoke of having to choose between incurring significant debt or not having their family close by when living away from home prior to or even during birth. The wealth of nations and bands was viewed by women as facilitating or limiting birthing options; women were able to cope with being shipped "off island," "out," or "away" if additional resources were provided so family members could accompany them. All of these dynamics illustrate the impact of historical and ongoing forces on women's birthing experiences and outcomes.

In each community, we asked about issues that were important for understanding birthing and maternity care. The loss of traditional knowledge of birthing traditions was a dominant theme, described as central to understanding key issues facing the communities. In two communities, few women had memories of their traditional practices. In the other two communities, however, the Elders recalled how women routinely helped each other, how certain women constantly checked on pregnant women,

supporting, encouraging, and teaching them as their pregnancy progressed. One Elder said, “They walked around and around, and they knew that was going to help the mother . . . and they never laid the way we lay.” In each community, questions were raised about whether modern medical practice was necessarily a benefit. One Elder stated, “Everything’s changed . . . that’s the way it was . . . they introduced you to something different. It seems they always told you it was better, but whether it was or not, I don’t know.”

Ongoing colonization and economic erosion affected each community and differential material and cultural resources seemed to be related to the extent to which the women described experiences of racism within the context of maternity care. Women from one community described overt racism, while women from another community spoke about how they would not tolerate any form of discrimination. Thus, women’s sense of personal power was often constituted by race relations, which in turn were shaped by various efforts to reclaim resources, culture, and independence. There continue to be efforts in all of the communities to reclaim governance, settle land claims, and develop economic opportunities, all of which were seen by participants in the study as integral to meeting the communities’ maternity care priorities: promoting choice and methods for birthing that respond to cultural, spiritual, and physiological needs to create the context for healthy mothers, healthy babies, healthy families, and healthy communities.

Rural Geography as Birthing Context

Rural geography shaped participants’ birthing experiences, first through the availability of employment and economic resources generally, then through the availability of resources for birthing, and, finally, through the challenges of travel for birthing outside the community. Together, these contextual factors created significant emotional and financial burdens. One woman said, “Becoming poorer and poorer, having to live down island, and being alone is the absolute worst stress when you’re having a baby.”

The geography of the communities, their degree of remoteness, and local natural resources determined the pattern of colonization and continue to shape the colonial dynamics. The four communities are located in remote coastal British Columbia. Thus, pregnant and labouring women in each of the communities have to cope with — to varying degrees — hours of road and ferry travel and air medevac across open ocean and inlets in order to travel “up,” “down,” and “off” island, “out” and “away.” Snow-covered roads and reduced daylight hours in winter added to the stressful circumstances for women leaving their home communities to give birth.

In spite of the perception of greater “safety” for a baby born in an urban context, the impacts of evacuation on the mother, the children and families left behind, and even on medevac personnel are not well understood. All communities were faced with the effects of birthing outside the community, but the logistics and politics of evacuation varied. A number of women expressed fear for the safety of the children they had to leave behind; even when they had reliable, safe child care, they worried about the impact of weeks or months of separation from their children and infants while they awaited birth, alone, elsewhere. These dynamics are similar to those reported by Kaufert and O’Neil (1993), who examined how risk discourses operate to the detriment of Inuit women’s birth experiences. Although nurses and physicians spoke of making birth “safe” by having the women leave the community, women described the safety of their other children, and their own emotional safety surrounded by culture and connection to family and community, as overlooked in the structure and delivery of health care. Rural geography and the related dynamics of planned or urgent evacuation profoundly impacted women’s birth experiences. Although these dynamics played out differently in the participating communities, they affected the birthing expectations and birth stresses of all the women and in all four communities.

Birthing Expectations

The extent to which women, families, and communities felt that they had power, choice, and control intersected with community histories and resources to shape expectations about birthing. These expectations set up the possibilities and, depending on the extent to which expectations were met, influenced the stresses and tensions that accompanied birthing experiences. Expectations operated in relation to four key areas that set the context for women’s experiences: the location of birthing, the meaning of giving birth in one’s home territory, the presence of family, and the meaning and importance of a “natural birth.”

The location of birth varied greatly among communities, from no birthing facilities, to limited options due to inconsistent resources and personnel, to comprehensive low-risk maternity care, all of which depended on the policies of the local health authority and the availability of skilled personnel. Women spoke of the meaningfulness of being able to give birth in or near their home community, where their families could be present to welcome the baby and support the mother; giving birth in one’s community created a meaningful and long-lasting connection to the community, tradition, and territory. In one community an Elder said:

There is a breakdown in the traditional family structure, as the mom is away from her community and family while she is giving birth. The family is excluded from the joy of being at the birth — this is important to our community, to our families.

Indeed the levels of stress and depression expressed in one of the study communities call into question whether births are being made “safer” through the structures and processes of care. The presence of family at birth was often a point of tension between hospital staff and women and their families. Women spoke repeatedly about efforts by hospital staff to limit visiting and their opposition to family presence, despite the support and understanding expressed by many health-care providers regarding the importance of family presence.

The idea of a “natural” birth seemed to be part of the women’s expectations or hopes. Many women in each community said they wished to have a natural birth, were pleased to have had a natural birth, or were disappointed not to have had a natural birth. However, the meaning and importance of a natural birth seemed to vary from woman to woman and between the four communities. When women were put in the position of “choosing” early induction or evacuation, a natural birth was viewed as going into labour without medication or intervention. In these instances it was evident that the women’s experiences and the meaning of “natural” were shaped by local hospital politics, maternity resources, and women’s opportunities to be involved in decision-making that may or may not respect their needs and hopes. One woman said:

All of a sudden I had the gel, and then my water . . . broke and then, boom, I was in labour, like, right after, so I don’t know what it’s like to . . . go through the natural process. . . . I had them both vaginally, but I still don’t know what [a natural birth is] like.

Stresses on Birthing

The loss of traditional practices was extensive and the inability to give birth as a family and community threatened to complete the destruction. In all communities, there was expressed hope to reclaim traditional practices; reclaiming birthing and strengthening culture were seen as inseparable and necessary for enhancing the health of mothers, babies, families, and communities. As dynamics and impacts of rural geography, economics, and race relations differed in each community, the effects on women and their birthing experiences also varied. These contexts gave rise to a system-centred approach to maternity care that structured relationships with nurses and other health-care providers in ways that limited women’s power, choice, and control, thereby increasing stress for all. The system-

centred approach set a specific context for birthing. Maternity care was described as medicalized, technologized, and regionalized, and was only occasionally referred to as woman- and/or family-centred or responsive to the cultural, spiritual, and physiological needs of women.

Relationships with nurses and other health-care providers and negotiation of control over birthing were enacted within that specific context and within the colonial and rural context. Both the system-centred approach and the relationships created tension and stresses for the women. Women spoke of a “revolving door” experience with nurses and physicians that caused anxiety, undermined trust, and limited their options for developing a relationship with care providers who would see them through pregnancy and birthing. Several participants explained that positive relationships with nurses could mitigate the stresses associated with a lack of continuity of medical care. For example, a perinatal nurse working in one of the local hospitals was described as a “godsend” for women arriving at the hospital in labour.

Power, Choice, and Control

The dynamics of rural and colonial contexts shaped the power, choice, and control that communities, families, and women possessed generally but also in relation to maternity care and birthing. Women’s economic power, political power, and support varied within and between the communities, and thus there was diversity in individual women’s expectations and their power, choice, and control with regard to their birthing experiences. Women in the four participating communities had different experiences of the stresses associated with birthing. Themes of power, choice, and control were expressed variably across communities and often related to the style and attitude of specific nurses and physicians. In one community the overall impression was of women consistently exercising their power, choice, and control in birthing decisions, either through direct discussion and negotiation with their health-care providers, family members, and support people or through acts of resistance and empowerment. Women took matters into their own hands and delayed contacting their doctor or the hospital while they were in early labour, waiting until after the last ferry had left. However, in other communities the overarching theme was “no choice, no power, no control.” The women described multiple ways in which their wants and needs were overridden: “I wasn’t allowed an escort”; “I was refused care”; “I was all alone”; “they said, you can be sent out, or you can be induced now . . . I had a choice, if you call that a choice.” They described their concerns and wishes being routinely dismissed. Most of the women who felt they lacked control described their birth experiences in negative terms: “I wouldn’t wish inducement on my worst enemy.” Stresses and points of

tension, however, did not dissolve merely because a woman was able to give birth in her home community.

Points of Tensions and Acts of Resistance

Points of tension arose (a) at the community level, in relation to the degree of service provided; (b) between health-care providers and patients and their families and among providers with respect to how patients were treated regardless of birthing location; and (c) between health-care providers and patients and their families with respect to the birthing location.

Birthing expectations in light of community resources and power led to different points of tension and forms of resistance to control over the birthing process. Points of tension also arose between the community, the health authority, and the federal government regarding the level of services to be provided in a given community. In each community, birthing options were dictated by the availability of birthing facilities and professional support, for both first-time and experienced mothers. For example, in one community, because of the relatively consistent availability of birthing facilities and nearby professional support for first-time and experienced mothers, women were usually able to deliver near their home if they wished. In the other communities, where consistent surgical or anesthesia back-up for emergency Caesarean sections were not available, women faced decisions about the levels of risk associated with staying or going. Consequently, “acts of resistance” centred around the woman acting on her own evaluation of her capacities, beliefs, and worries balanced with her family’s wishes and local traditions. Women spoke of feeling they had the “right” to give birth in their home community:

They have it. You know they have it . . . and that room across from the nurse’s station here is all set up for it. So . . . if I can, I know I won’t send my girls away. I don’t want them to go through what I went through down there. And, who knows, by then there [may] be no monies to send anybody down there. So it would be nice if we could have our own here [at home].

Discussion

Based on the above findings, our recommendations for nurses engaged in maternity care in rural Aboriginal communities are founded on two discussion points: the need to (1) account for the complex intersections shaping rural Aboriginal women’s and families’ birthing experiences and outcomes, and the need to (2) engage in culturally safe practice, to optimize birth experiences and outcomes in a rural Aboriginal context.

***Accounting for Complex Intersections
Shaping Birthing Experiences and Outcomes***

A long history of colonization, systemic discrimination, and experiences such as residential schooling are considered root causes of inequities in maternal–infant health for Aboriginal peoples (British Columbia Provincial Health Officer, 2009). Thus, women’s birthing experiences and their hope for change ought to be understood as integrally connected to efforts towards cultural (re)vitalization, self-determination, and the reclaiming of indigenous traditions and heritage. Improving the birthing experiences of women in our study was determined to require community-specific strategies aimed at supporting and optimizing women’s choice, power, and control with respect to birthing.

Redressing such inequities and enhancing women’s power, choice, and control requires a shift in how nurses view women’s birth experiences and perinatal outcomes. These are not of women’s own making, but are shaped by the social, cultural, political, and economic contexts of care. For example, promoting prenatal nutrition in the context of poverty and the lack of affordable fresh foods requires more than teaching about the nutritional values of particular foods. Healthy birthing is inseparable from the sociocultural, historical, and gendered contexts of women’s lives. Therefore, strictly “lifestyle,” individual prevention and “personal choice” understandings of health are inadequate and will do little to facilitate good birthing experiences and positive perinatal outcomes for Aboriginal women, families, and communities. Such understandings of maternal–infant health may in fact reinforce the very inequity that nurses aim to redress.

***Culturally Safe Practice as Health Promoting
Rural-Aboriginal Maternity Nursing Care***

Our findings also illustrate the importance of maternity care that is culturally safe — that is, relevant for and responsive to women’s and families’ needs, strengths, and desire for control and choice in the birthing experience. Several studies suggest that “culturally appropriate” perinatal services improve indigenous women’s satisfaction with care, although there is still no consensus on what makes particular practices “culturally appropriate” (Long & Curry, 1998). We propose that enhancing the cultural appropriateness of individual practices and maternity services for Aboriginal women fails to account for how ongoing colonial relations create *unsafe* rather than just inappropriate care. Unsafe care was created through the erosion of services and dismissive practices and contexts that impacted women’s power, choice, and control with regard to birthing and that shaped their health outcomes. The silencing of women’s voices is an

act of “structural violence” (Kurtz et al., 2008); the limiting of power, choice, and control is a form of silencing.

Nursing Implications

The results of this study indicate that any experience of childbirth and pregnancy and birth outcomes can be understood only in context; this includes the impacts of colonial relations as they continue to shape women’s experiences. To understand the health of rural Aboriginal women and infants in context, nurses must ask several questions: (1) What circumstances (i.e., knowledge, ideologies, assumptions, worldviews, values) are shaping my response to this women/family? (2) How does my social location enhance or constrain my ability to listen to what women need and expect in relation to birthing? (3) What are this woman’s/family’s experiences, needs, and hopes for birth? What choices can I facilitate? (4) What knowledge or ways of practising are dominant in this health centre/unit/clinic, and how might they hinder women’s power, choice, and control? By bringing these kinds of questions to rural nursing contexts, we may help to develop knowledge about the unique pregnancy and birth needs and hopes of Aboriginal women, families, and communities, while also informing a “rural lens” for health policy, planning, and practice in order to promote health in rural and remote communities (Canadian Health Services Research Foundation [CHSRF], 2004).

A rural lens has been proposed as a way to uncover the realities of rural practice to realize “continuity of care and culturally appropriate care” (CHSRF, 2004). Based on our findings, we propose that a rural lens for maternity nursing practice be informed by the development of nurses’ capacity to work from an understanding of birthing experiences and outcomes in context; that is, specifically how “medical colonialism” operates as a social determinant of health. Our findings indicate, however, that culturally appropriate care, while necessary, is not sufficient. Nurses need to engage with women, families, and communities in ways that are culturally *safe*, to specifically consider how traditional knowledge of Aboriginal childbirth practices can inform their practice in ways that best meet local cultural, spiritual, and physiological needs.

Culturally safe care requires that nurses (1) examine how the culture of Western biomedical approaches to childbirth is dismissive of Aboriginal knowledge and traditional practices, and (2) practise from a contextualized understanding of Aboriginal women’s birthing experiences and perinatal outcomes. Addressing these aims in rural and remote nursing practice also requires the skills of reflective practice. This requires that nurses engage in reflective practice to develop a critical conscious-

ness of how their own power, knowledge, and privilege is operating and how “system-centred” maternity care creates stressful birth experiences and contributes to adverse birth outcomes. Nurses practising in rural and remote Aboriginal communities are well positioned to advocate for the inclusion of women’s voices in maternity care and the preservation of traditions and practices that bond babies to the community and the community to babies. Nurses can attend to this need for inclusion through one-to-one clinical encounters or at the organizational level. For example, in one community a perinatal nurse understood the importance of singing Kwakwaka’wakw songs to newborn infants. This nurse sought out women Elders who knew the songs in their original language and arranged for their regular attendance at prenatal classes and mother-and-baby drop-ins at the local health centre. This is an example of a nurse practising from a view of the inseparability of cultural revitalization and the health of mothers, infants, and families. Nurses working in partnership with rural Aboriginal communities are well positioned to facilitate meaningful birthing experiences and positive birth outcomes that promote health equity and well-being for mothers, babies, families, and communities.

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Acknowledgements

It is with respect and appreciation that we acknowledge the cooperation of the communities and men and women involved in the study and the community researchers: Miranda Talio and Thelma Harvey (Nuxalk Nation); Myrna Bell Wilson, Laura Bell, Mary Ann Wilson, and Melissa Edgars (Haida Nation); and Vera Newman, Karen Cook, and Barb Cranmer (Kwakwaka'waka Nation).

We wish to thank the Canadian Institutes for Health Research for their financial support of the research.

There is no conflict of interest to be reported related to the submission of the manuscript nor are there relevant financial disclosures to be made.

Helen Brown, RN, PhD, is Assistant Professor, School of Nursing, University of British Columbia, Vancouver, Canada. Colleen Varcoe, RN, PhD, is Professor and Director (Pro Tem), School of Nursing, University of British Columbia. Betty Calam, MD, is Associate Professor, Department of Family Practice, University of British Columbia, and Site Director, St. Paul's Hospital, Vancouver.