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Canadian First Nations Women's Beliefs About Pregnancy and Prenatal Care

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Les faits indiquent le lien entre des soins prénatals appropriés et de meilleurs résultats quant aux naissances. La recherche cependant montre que les femmes autochtones ne participent pas de façon régulière aux soins prénatals. Dans la présente étude, sept informatrices, représentant trois tribus autochtones, ont été longuement interviewées concernant leurs convictions sur la grossesse et leur participation à des soins prénatals. Les femmes autochtones conçoivent la grossesse selon un contexte spirituel et croient qu'il s'agit d'un processus sain et naturel qui ne requiert aucune intervention. Dans la mesure où elles estiment que la responsabilité leur incombe de «s'occuper d'elles-mêmes» pendant leur grossesse, elles font leur les pratiques culturelles censées favoriser une bonne grossesse. Les femmes autochtones semblent souvent insatisfaites des prestateurs de soins de santé dans les cliniques d'accouchements. Souvent, on ne satisfait pas à leurs attentes et leurs convictions par rapport à la grossesse sont en conflit avec celles des prestateurs de soins de santé. On pourrait briser les barrières qui empêchent le recours aux soins prénatals en améliorant la communication et en offrant des soins holistiques axés sur la culture spécifique.

Evidence links adequate prenatal care to improved birth outcomes. Research, however, indicates that First Nations women do not attend regularly for prenatal care. In the current study, seven informants, representing three First Nations tribes, were extensively interviewed to examine their beliefs about pregnancy and participation in prenatal care. First Nations women conceptualized pregnancy in a spiritual context and believed it to be a healthy, natural process requiring no intervention. Since they believed they were responsible for "taking care of themselves" during pregnancy, cultural practices that were thought to promote a healthy pregnancy were espoused. First Nations women were reportedly often dissatisfied with health-care providers in prenatal clinics. Their expectations of freely offered explanations and a friendly non-authoritarian approach were often not realized and their beliefs about pregnancy were in conflict with those of health-care providers. Barriers to prenatal care might be reduced by improving communication and providing holistic culture-specific care.

Considerable evidence links adequate prenatal care to improved birth outcome in Caucasian and various ethnic groups (Graham-Cumming, 1967; Morris, Berenson, Lawson, & Wiemann, 1993). Although it is not the only factor contributing to a healthy pregnancy outcome, it enhances the possibility for appropriate health-related interventions as required.

Research indicates that First Nations women do not regularly attend prenatal care (Baskett, 1977; Graham-Cumming, 1967), despite the fact that they tend to be a high-risk group for several health-related reasons. Baskett (1977) found that 14.3% of First Nations women received minimal prenatal care (fewer than four visits) and 9.2% received none; Graham-Cumming found that 30% made good use of prenatal services, 30% made fair use, while 40% made little or no use of these services. The First Nations population

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tends to have a high incidence of adolescent pregnancy, complications of pregnancy, grand multiparity, low and high birthweight babies, and greater infant mortality following preterm birth (Baskett, 1977; Community Task Force on Maternal and Child Health, 1981). Additional risk factors include inadequate nutrition during pregnancy (Bureau of Nutritional Sciences, 1975), high blood pressure, gestational diabetes, and antepartum bleeding (Wotton & Macdonald, 1981).

Background

Only six studies have explored First Nations women's beliefs and practices related to pregnancy. Hildebrand (1970) and Clarke (1990) focused on the Chippewa of the Great Lakes and the Salish of British Columbia, respectively, whereas other researchers studied American First Nation groups: Navajo (Loughlin 1965), Iroquois (Evaneshko, 1978), and Northwest Coastal (Bushnell, 1981; Horn, 1978) groups.

Reportedly, Canadian First Nations women believe that breaching traditional teachings surrounding pregnancy can result in harmful consequences (Clarke, 1990). Violating food taboos is believed to result in a difficult labour (Clarke, 1990; Hildebrand, 1970) and abnormalities in the baby (Clarke, 1990). Inactivity is believed to cause the placenta to adhere to the uterus (Hildebrand, 1970) or the baby to attach to the womb, resulting in a difficult labour (Clarke, 1990). Sensory experiences of the mother are believed to be passed on to the fetus. Women believe that by "listening" to their bodies they can learn what is beneficial or harmful for themselves and their babies (Clarke, 1990).

Among American First Nations women, pregnancy is believed to be a normal, natural process requiring no intervention (Bushnell, 1981; Horn, 1978; Loughlin, 1965). Little preparation is made for the coming baby (Bushnell, 1981; Loughlin, 1965) because it is believed that illness, injury, or even death of the unborn child could result (Loughlin, 1965). Women believe they give care to their babies through their own good health and nutrition (Bushnell, 1981), and are encouraged to maintain a normal work schedule (Evaneshko, 1978) without any extra support (Bushnell, 1981).

Canadian and American First Nations women identified barriers to prenatal care attendance, including dislike of vaginal examinations (Hildebrand, 1970), lack of continuity of care (Hildebrand, 1970; Horn, 1978), communication difficulties (Hildebrand, 1970), transportation problems (Hildebrand, 1970; Horn, 1978), and attitudes of prejudice on the part of the health-care workers (Horn, 1978). Women questioned the value and need for prenatal care (Bushnell, 1981; Horn, 1978; Loughlin, 1965) and the appropri-

ateness of prenatal classes as a source of information because the family (especially grandparents) has primary responsibility for teaching (Clarke, 1990). In summary, they embrace a natural approach to pregnancy and rely on culturally prescribed practices to maintain a healthy pregnancy.

Factors Associated With Prenatal Care Attendance

Numerous studies have investigated factors associated with prenatal care attendance, although none were based on First Nations women. Socio-demographic variables that have been found to improve attendance were: older age of the mother (Lia-Hoagberg et al., 1990; McDonald & Coburn, 1988), higher education of the mother (Lia-Hoagberg et al., 1990; Parken, 1978), lower parity (Kaliszer & Kidd, 1981; Kieffer, Alexander, & Mor, 1992), married marital status (Collver, Have, & Speare, 1967; McDonald & Coburn, 1988) and employment of husbands (Kaliszer & Kidd, 1981; McKinlay, 1973). Psychosocial factors found to enhance prenatal care attendance include available support, such as verbal encouragement and provision of transportation to appointments (Lia-Hoagberg et al., 1990; Poland, Ager, & Olson, 1987), planned pregnancy (Lia-Hoagberg et al., 1990; McKinlay & McKinlay, 1972), and previous pregnancy complications (McKinlay & McKinlay, 1979; Parsons & Perkins, 1982).

In contrast, several factors have been identified that appear to deter prenatal care attendance: impersonal treatment, long waits to see the doctor, rushed visits (Curry, 1989), fear of medical procedures (Lia-Hoagberg et al., 1990), lack of continuity of nursing care (Poland, 1976), lack of child care, and transportation problems (Curry, 1989; Lia-Hoagberg et al., 1990). Negative feelings toward pregnancy (Watkins, 1968) and fear of pressure from a doctor to have an abortion (Simms, 1984) also have been found to delay prenatal care attendance.

Research Questions

Few studies have investigated the cultural, psychological, and decision-making processes of women seeking prenatal care; notably these were not studies of First Nations women. If prenatal care attendance by First Nations women is to be improved, more research is needed. Therefore, the purpose of the current qualitative study was to explore the health beliefs of Canadian First Nations women regarding pregnancy and prenatal care. The research questions were:

What are the health beliefs of First Nations women about pregnancy?

What are First Nations women's beliefs about prenatal care?

What factors influence First Nations women's participation in prenatal care?

Method

Informants

Seven English speaking key informants residing in a Canadian urban centre, participated in the study. An *N* of seven was considered an appropriate number based on previous studies where six to 12 informants were used to gather qualitative cultural data (Evaneshko & Kay, 1982; Horn, 1978). Informants were selected on the basis of three criteria suggested by Spradley (1979): they were familiar with, and currently involved with the First Nations culture; and they had adequate time. In addition informants were 18 years of age or older, had one or more children, had previously attended prenatal care, and were leaders in First Nations women's health. Informants represented three First Nations tribes located in Canada: Cree (n=3), Saulteaux (n=2), and Ojibway (n=2). One of the seven informants completed only part of the study because she moved to another province; the information was nevertheless included in the analyses. All informants had lived on a First Nations reserve for 8 to 15 years.

After approval was obtained from an Ethical Review Committee, potential informants were telephoned or personally approached and invited to participate in the study. Names of potential informants were obtained from acquaintances of the researcher and from informants who participated in the study. Ten potential informants who met the study criteria were identified and contacted, but three refused to participate.

Data Collection

During the initial interview the study was explained more fully and consent was obtained. Interviews were conducted by the researcher at the informant's convenience in the informant's or researcher's home or the informant's work place. Four to five in-depth, tape-recorded interviews of one to three hours each were conducted with each of the six informants, and one and one quarter hours with one informant, for a total of 45 hours.

An interview guide was developed by the researcher and reviewed by a First Nations nurse with a baccalaureate degree in nursing and two non-First Nations nurses with masters of nursing degrees. The interview guide consisted of general topics such as beliefs about spacing of children, prenatal practices, pregnancy, and prenatal care. Examples of specific questions asked during the interviews were: "What do First Nations women generally think about having children?" and "What do First Nations women think are things that are good for them and their babies during pregnancy?" Initial interviews were based on the interview guide, but as concepts and themes for further exploration emerged, these became the focus of subsequent interviews. For example,

when some informants began discussing support for single mothers, this topic was explored.

The tape-recorded interviews were transcribed verbatim and content analysis was used to code the data and identify themes and categories (Holsti, 1969). In the development of categories, frequency counts were used. Thus, if four or more informants concurred on a belief, this was subsumed as a category under a particular theme.

Findings

Seven major themes were identified from the interviews. These related to beliefs about pregnancy, children, spacing of children, helpful prenatal practices, harmful prenatal practices, prenatal care, and interactions with health-care providers.

Beliefs About Pregnancy

Traditional beliefs were those that informants identified as being part of their culture. Informants consistently stated that pregnancy is traditionally believed to be a blessing from the creator. "And if you were pregnant...that was a blessing for you....You were being blessed and you were chosen to carry this new baby." Because pregnant women are believed to be carrying extra life for the creator and because of changes and risks associated with childbearing, pregnant women are respected and hold special status in First Nations society.

First Nations women also believe pregnancy to be a natural process, maintained by nature and requiring no interference:

> It's seen as a very natural process. It's nature....the nurturing is done by Mother Nature. And of course the baby is taken care of by nature in a similar way. And you don't want to interfere too much with the growth.

Informants cited indicators of pregnancy such as a missed period, morning sickness, and weight gain. Some women "just know" that they are pregnant before any signs appear due to a "feeling" they have. It also is believed that pregnant women have a certain look in their eyes. "My mother was saying that there is that certain spark or twinkle in the eyes. That is because of this new life that is beginning inside you."

Informants unanimously stated that pregnancy is not believed to be a sickness. "Grandma will teach that it's [pregnancy is] not a sickness. It's a natural process." Most also thought that First Nations women believed they were not susceptible to sickness during pregnancy; half reflected the view that

sickness during pregnancy was not serious, while the rest thought that sickness during pregnancy could be somewhat or very serious. "No, it [pregnancy] is considered such a normal process that you would not anticipate problems or difficulties unless there is some previous experiences."

The conceptualization of pregnancy as a normal, natural process was also evident from First Nations women's beliefs about who should attend them during childbearing. It was believed that attendants during pregnancy and childbirth should be older, experienced women, not doctors, although physicians are considered appropriate consultants for medical problems. Men are believed to be harmed by participating in pregnancy-related affairs.

> I was told it's a woman's role and it's not for a man to be there when a child is being born because that can affect the man as well.... The reason it could be harmful to the man is because of the power behind it.

Beliefs About Children

Children are considered to be a gift from the creator and each one is welcomed and treasured. Although it is believed that marriage should precede childbearing, it is thought that mothers should keep out-of-wedlock babies. Unwed mothers and their children tend to be accepted and supported.

Another belief is that the role of parents is only temporary. Parents have a responsibility to care for a child for the creator until the child becomes independent. First Nations people believe the responsibility for children should be shared by the entire community. The application of this concept is evident in the case of the childless couple. It is common for a family member or friend to offer their own child for adoption by a childless couple.

Beliefs About Spacing Children

Traditional First Nations women's beliefs about spacing children are linked to their view of pregnancy as a natural process and a blessing from the creator: people "should not specify the number of children to have," but rather children should be accepted naturally as they come.

Childbearing is closely aligned with womanhood. "You are a woman and a woman is made to have children, to have babies, and if you don't have babies, then you are looked at as being not really a woman." As a consequence a tubal ligation and hysterectomy are unacceptable to traditional First Nations women. Since life is believed to begin at conception, therapeutic abortion is also not accepted. ("It's almost like saying you got rid of that life you were blessed with.") Guilt and an inability to bear future children are thought to be consequences of having an abortion.

However, informants concurred that beliefs about spacing children have changed and some women now choose various available methods to limit family size. It is believed to be a woman's decision to have children or to take measures to prevent pregnancy.

Among urban-dwelling women, a range of two to four children is currently considered ideal with a period of one to five years between pregnancies. Breast-feeding is believed to be an effective method of birth control. Herbal preparations, which are considered natural, are used by some First Nations women to prevent pregnancy.

Helpful Prenatal Practices

First Nations women believe that various practices implemented by the expectant woman will promote a healthy pregnancy. Women are responsible for "taking care of themselves" so that the outcome of pregnancy will be a healthy baby. This was illustrated by an informant when she described the advice of an elder to a pregnant woman: "...take care of yourself as the way that the creator would want you in order for your child to be healthy....You don't drink, you don't smoke, you eat properly and that type of thing." Women believe that miscarriages and preterm births result when they do not take care of themselves during pregnancy.

A well-balanced diet and moderate portions are believed to help maintain a healthy pregnancy. Foods such as wild meat or fish, white carrots, potatoes, rice, and berries are thought to be particularly beneficial. Exercise in moderation is believed to be a healthy practice during pregnancy. Walking is thought to be particularly suitable because groups of First Nations people walked from camp to camp. Adequate rest, sleep, and quiet times are also thought to be important.

It is believed that the mother's emotions can be transmitted to her baby during pregnancy. As a consequence, expectant women are encouraged to have positive, pleasant thoughts during pregnancy and to communicate with the baby.

Harmful Prenatal Practices

First Nations women believe that during pregnancy strenuous activity, consumption of chemical substances such as alcohol and drugs, and smoking can endanger the health of a mother or baby.

Informants unanimously stated that strenuous maternal activity is thought to result in miscarriages or preterm births. Controlled breathing and physical exercises (such as those taught in prenatal classes) are believed to affect the baby adversely; no further explanation of consequences was offered.

Consumption of alcohol during pregnancy is believed to cause miscarriage. Smoking is also considered harmful, although no explanation of the harmful effects had been given by those who taught the women. Traditional First Nations women believe that taking medications during pregnancy is unnatural.

Technological interventions during pregnancy are believed to be detrimental and some women are fearful of them. Ultrasound, for example, is thought to affect the baby's development, delay delivery, and interfere with the communication between mother and baby. Artificial induction of labour, fetal monitoring, pelvic examinations, and the use of obstetrical forceps are also considered harmful interferences.

Beliefs About Prenatal Care

Some First Nations women believe that prenatal care is beneficial, but many perceive no benefits. They think that the frequency of visits during normal pregnancies could be reduced, but increased if complications arise: women should develop a pattern of attendance based on their own perceived needs.

Informants specified that the primary factor enabling prenatal care attendance was the belief that problems would be identified and treated so the outcome would be a healthy baby. Problems encountered in a previous pregnancy would be a factor strongly motivating women to attend prenatal care.

The primary factors limiting prenatal care attendance were a lack of babysitting services and the absence of past or current problems during pregnancy. Informants consistently identified the prospect of pelvic examinations as being a deterrent, especially if performed by a young male doctor; an older female doctor was preferred. An additional limiting factor was the belief that staff would pressure women into having an abortion. One informant recalled: "I thought maybe the doctor might want to talk me out of my pregnancy.... So I stayed away from the doctor for as long as I could."

Interactions With Health-Care Providers

First Nations women believe that communication with staff during prenatal care visits is less than ideal, yet they desire positive interactions. They find such appointments to be rushed, cold, and impersonal, with long waiting periods to see the doctor. Satisfying visits occur when staff offer explanations freely and a friendly non-authoritarian approach is taken. The following narrative by an informant illustrates a personalized caring approach:

> The nurse would come in there and tap somebody on the shoulder ...and say, "How are you?" You know that touch on the shoulder is a connection to say you are important too. And she would tell them

> who she is and shake hands with them. So she'd introduce herself to them.... And then she would...sit there and talk to them.... It's almost like she centred her whole attention on you. It really made you feel comfortable. All of a sudden she made you feel you are so important.

According to the informants, First Nations women are characteristically shy and reluctant to ask questions during prenatal visits. They believe it is inappropriate for others to ask them too many direct questions or to discuss personal matters such as their menstrual periods.

> You don't talk about your periods, your menstrual cycle.... If you ask a woman when was her last menstrual period, they will just ignore you. They will not look at you, they will not respond, they will just clam up.... They would become embarrassed and they would become uncomfortable.

First Nations women tend to refrain from giving feedback to staff and generally do not express satisfaction with care. Dissatisfaction with care is customarily expressed to a third person, who in turn discusses the situation with the health-care worker involved.

Some First Nations women tend to identify the timing of events by occurrences in nature, rather than stating a precise date (e.g., they may identify the date of their last menstrual period as being when the leaves started to come). As described in the following excerpt, nonverbal communication is believed to be more critical than verbal communication.

> Indian people communicate very much through body language and they also look at how the next person behaves through their body language. We refer more to their actions.... It has so much weight. More so than any words that you can say, is the way that your actions are.

Discussion

The current study had two major limitations. Non-English-speaking First Nations women, whose beliefs may be different from those who are English-speaking, were excluded. Additionally, since three different First Nations tribes were represented by seven informants, there were too few representives of each tribe to examine inter-group differences.

Results indicate that discrepancies exist between the beliefs of First Nations women and those of health-care providers. The former explain pregnancy in a spiritual context. This is a basic concept underlying many of the explanations they give for behaviours and practices related to pregnancy and

for their attitudes towards children. Pregnancy is viewed as a natural, normal process requiring no intervention. Similarly, Bushnell (1981), Horn (1978), and Loughlin (1965) found that First Nations women question the need for prenatal care. Clarke (1990) also found that First Nations women believe in "no change required" during pregnancy. In contrast, health-care providers in Canadian society (especially male medical personnel) often view pregnancy as a medical event. In a study of four national cultures Jordan (1980) found that American health-care providers view pregnancy as a medical event and take a technological approach in managing pregnancy and birth. As revealed in the current study, some First Nations women do not believe they are susceptible to serious illness during pregnancy, whereas health-care providers focus much of their care on monitoring for complications of pregnancy. These cultural differences may be obstacles to effective inter-ethnic relations (Boyle & Andrews, 1989), and signs of conflict and stress may occur if health personnel impose their ideas and practices upon clients (Leininger, 1991).

The current study reveals that spiritual, social, and psychological factors motivate First Nations women to bear children, and that womanhood is closely linked to childbearing. Horn (1983) also found that American First Nations teenagers believed the feminine role to be most clearly identified through pregnancy and childbirth.

The barriers to prenatal care attendance cited in the current study were babysitting problems, the belief that attendance is required only in the event of present or past problems with pregnancy, and dislike of pelvic examinations. First Nations women in Hildebrand's (1970) research also delayed initiating prenatal care because of dislike of vaginal examinations.

The current findings indicate that healthy prenatal practices such as a well-balanced diet, walking, avoidance of stress, and adequate rest and sleep are advocated. Bushnell (1981) and Evaneshko (1978) also found that First Nations women are encouraged to walk during pregnancy and to avoid emotional stress. So why do First Nations women have birth outcomes that tend to be unhealthy? This is a complex issue. Two possible factors may be the loss of traditional lifestyles because of social change, and poverty with its attendant stress. Furthermore, cultural beliefs may be espoused without being acted on. For example, women may believe that foods from the land provide a healthy diet during pregnancy but have no access to such foods. Perhaps health-care providers need to place more emphasis on promoting healthy traditional practices and reducing poverty in order to enhance pregnancy outcomes.

Because the current study was exploratory in nature, it would be premature to draw from it any implications for nursing. However, informants did offer recommendations for improving prenatal care attendance: interactions

in prenatal clinics should be enhanced by providing non-authoritarian, individualized care in a quiet, unhurried fashion. Consideration should also be given to providing nurse-midwifery services, First-Nations health-care workers, and continuity of health-care workers.

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