
Culturally Competent Care for Aboriginal Women:

A Case for Culturally Competent Care for Aboriginal Women Giving Birth in Hospital Settings

June Birch, B.A., Research Assistant, Misericordia Child Health Clinic, Misericordia Community Hospital, Edmonton, Alberta

Lia Ruttan, Ph.D., Research Associate, Misericordia Child Health Clinic, Misericordia Community Hospital, Edmonton, Alberta

Tracy Muth, M.Ed., Department of Educational Psychology, University of Alberta, Edmonton, Alberta

Lola Baydala, M.D., M.Sc., F.A.A.P., F.R.C.P., Associate Professor, Department of Pediatrics, University of Alberta, Edmonton, Alberta

ABSTRACT

Increasing numbers of Aboriginal women are using urban hospital settings to give birth. Culturally competent care, including an understanding of cultural, emotional, historical, and spiritual aspects of Aboriginal Peoples' experience and beliefs about health and healthcare, is important to the provision of quality care. While there is a body of literature on culturally competent care, no models specific to Aboriginal women giving birth in hospital settings exist. This article explores Aboriginal peoples' historical experience with western health care systems, worldviews and perspectives on health and healing, and beliefs regarding childbirth. Some of the existing models of culturally competent care that emphasize provision of care in a manner that shows awareness of both patients' cultural backgrounds as well as health care providers' personal and professional culture are summarized. Recommendations for the development of cultural competency are presented.

Acquisition of knowledge, self-awareness and development of skills are all necessary to ensure quality care. It is essential that - at both systemic and individual levels - processes are in place to promote culturally competent healthcare practices. Recommendations include: partnering with Aboriginal physicians, nurses, midwives and their representative organizations; conducting community-based research to determine labour and delivery needs; identifying and describing Aboriginal values and beliefs related to childbirth and its place in the family and community; and following Aboriginal women's birth experiences in hospital settings with the overarching goal of informing institutional practices.

KEYWORDS

Aboriginal women, culturally competent care, hospital birth, obstetrics

Giving birth is a major life event for Aboriginal¹ women and their families. The experience can be positively or negatively affected by the care received, (Callister, 2004; Carlton, Callister & Stoneman, 2005; Matthews & Callister, 2004; Ottani, 2002), which can affect subsequent interactions with health care providers (Carlton et al., 2005). Culturally competent care, pre-natally, during the birthing experience, and post-natally, is critical to the provision of quality care (Callister, 2001; Edgecombe, 1996; Foster, 2006; Martin-Misener & Black, 1996; Matthews & Callister, 2004; Ottani, 2002; Smith, Varcoe & Edwards, 2005). Social, political and cultural changes that Aboriginal women in Canada have faced have negatively affected their education and cultural identity and traditional values, as well as their health (Adelson, 2005; Carroll & Benoit, 2001; Dion-Stout, Kipling & Stout, 2001). Culturally competent care is more likely to be successful than culture-blind care in addressing population health disparities, including gestational diabetes, high birth weights and higher post-natal death, including Sudden Infant Death Syndrome (SIDS) (Adelson, 2005; Smylie, 2001b). Given the history of negative experiences with mainstream health care institutions and the impact these factors have had on health outcomes of Aboriginal women, providing culturally competent care is particularly important for Aboriginal women who are giving birth in Canadian hospitals.

Aboriginal includes First Nations, Inuit, and Métis Peoples of Canada.

Over the past 30 to 40 years, increasing numbers of Aboriginal women have given birth in large urban hospital settings. For many communities, this change began in the 1970s when the Canadian government established an evacuation policy for women living in remote northern communities (Hiebert, 2001; Inuit Tapiriit Kanatami, 2004; Kaufert, Koolage, Kaufert, & O'Neil, 1984; Smith, 2003; Smith et al., 2005). To give birth in urban facilities, women are often required to leave their families and communities, usually for several weeks at a time (Couchie & Sanderson, 2007). With the closing of many small, rural hospitals, women from reserve communities also give birth in large urban hospitals. In addition, half of all Aboriginal people in Canada now live in urban centres, adding another dimension to the picture of Aboriginal birthing. A needs assessment conducted by the National Aboriginal Health Organization (NAHO) (2006) found that 93 per cent (27 of 29) of the First Nations and Inuit women who completed the assessment questionnaire gave birth in a hospital setting. Efforts are being made to renew Aboriginal midwifery and

birthing in homes or community-based facilities. In the meantime, the majority of Aboriginal women, currently give birth in hospital settings (NAHO, 2006). While there is a rich body of literature on the general topic of cultural competence, little has been written about applying this concept to healthcare professionals working with Aboriginal women giving birth in Canadian hospital settings. The purpose of this article is to summarize the issues involved and to illustrate the need for increasing culturally competent care with Aboriginal women giving birth in hospital settings.

Models of culturally competent care

The concept of culturally competent care dates back to the mid-twentieth century and was used by increasing numbers of nurses and other health professionals throughout the 1980s (Leininger, 1988). Several nursing scholars have formulated models and frameworks of culturally competent care to guide practice and research (e.g., Campinha-Bacote, 2002; Davidhizar & Giger, 2001; Leininger, 1988; Purnell, 2002; Schim, Doorenboos, Benkert, & Miller, 2007; Spector, 2002; Suh, 2004). The development of these models was influenced not only by the needs of historically marginalized communities but by the increasing variety of immigrant ethnic communities in health service populations in Western countries. In Canada, an increasingly vocal indigenous critique of health care practices and the colonial practices endemic in western-based health systems contributed to the development of culturally competent care practices (Dion-Stout et al., 2001). The literature on models of culturally competent care is extensive and ongoing (Shen, 2004).

Leininger's (1988, 2002) culture care model, an early approach to culturally competent care, is also known as "the sunrise model." With the aim of facilitating, enabling or maintaining well-being through transcultural care decisions and actions, it promotes nursing care that matches the worldview and experience of the patient through a process of cultural assessment (Shen, 2004). In another model, Spector (2002) integrates concern for what she refers to as heritage consistency (the degree to which people's lifestyles reflect their traditional culture), HEALTH traditions (the balance of all facets of a person, physically, mentally and spiritually, within a context that includes a person's family, culture, work, community, history, and environment), and a range of cultural phenomena. Spector draws on Davidhizar and Giger's (2001) six cultural phenomena that vary among cultural groups and affect health care: environmental control, biological variations, social organization, communication, space and time orientation. In another model, Campinha-

Bacote (2002) emphasizes that gaining cultural competence must be understood as an ongoing process consciously carried out to provide effective care to patients, while keeping in mind the variations that occur within ethnic groups. Campinha-Bacote suggests this process includes: developing cultural awareness, cultural knowledge, cultural assessment skills while engaging in cultural encounters, and having what she refers to as cultural desire or personal motivation to engage - with humility - in cultural learning.

These models have in common a focus on healthcare delivery in which the provision of care shows awareness of both the client's cultural background and one's own personal and professional culture. Culturally competent care is more than simply a matter of cultural sensitivity or awareness, culturally competent care is actions that change policy and procedure (Brach & Fraserirector, 2000).

Models for culturally competent care were initially developed to address appropriate care for immigrant populations. Studies specific to Aboriginal women giving birth in hospital settings are limited. Available literature suggests serious concerns about the lack of both cultural sensitivity and respect by non-Aboriginal people (Baker & Daigle, 2000; Browne, 1995). The term, culturally competent care, is, therefore, a generic term that was not designed for Aboriginal women. Because no hospital-based models exist specifically for Aboriginal women giving birth in hospital settings, research in this area is necessary to respond effectively to the health care needs of this population.

Implications from recent research

In considering the importance of culturally competent care, health care providers must be able to understand the vulnerability people feel and the potential loss of dignity they experience upon admission to hospital (Matthews & Callister, 2004). Respect, dignity, choice and empowerment, some of the characteristics that comprise quality care, decrease the influence of learned helplessness, increase autonomy and enhance health care outcomes (Waller, 2002). These factors are even more important when delivering healthcare to patients from diverse and marginalized cultures (Matthews & Callister, 2004; O'Brien, Anslow, Begay, Pereira, & Sullivan, 2002). Beliefs, practices and perceptions regarding pregnancy, birth and post-natal care vary worldwide. Particularly meaningful is an understanding of who should attend the birth, the gender of the physician, the role of the nurse as information provider or simply as comforter, the experience of pain, and of the degree of technology involved (Callister, Khalaf, Semenic, Kartchner, & Vehvilainen-Julkunen, 2003; Carlton et al.,

2005; Raines & Morgan, 2000). The post-partum period is often particularly sensitive and includes culturally-based differences regarding who is the primary focus of attention following birth, whether the mother and baby should be kept cool or warm, issues related to sleeping, breast feeding, the need for rest, the meaning and role of visitors, appropriate food, the need for prayer, and when to leave the hospital (Banks, 2003; Cioffi, 2004; Kim-Godwin, 2003; Raines & Morgan, 2000).

For Aboriginal women in North America, particularly salient issues include aspects of the holistic world view of Native American culture (Lowe & Struthers, 2001). Seven dimensions identified by Lowe and Struthers as useful in the development of nursing practices with Aboriginal people include spirituality, respect, trust, caring, traditions, connection, and holism. Spirituality, in the Aboriginal context, is the most important of the dimensions discussed, and yet is probably the least understood by health care providers. Traditionally, the relationship with the child is understood to begin before birth. Preparations for a good birth and a healthy baby include avoiding stress, listening to teachings of older women, remaining physically active, connecting with the child, and caring for oneself in a spiritually healthy way (L. Bill, personal communication, May 15, 1990; Long & Curry, 1998; Paulette, 1990, 1999; Sokoloski, 1995). In the context of health care and especially of birthing, cultural competence for Aboriginal women means that the whole person(s), both mother and baby, must be considered not only physically, but also spiritually, emotionally, culturally, and historically (Foster, 2006).

A recent study examining women's birthing experiences found that while the quality of the childbirth experience is enhanced by a sense of empowerment gained through the patient's involvement in decisions and interventions, the respect received from health care providers is even more important (Matthews & Callister, 2004). Respect must be understood in Aboriginal terms and applied to all interactions (Browne, 1995; Ellerby, 2001; Foster, 2006). Browne (1995) studied the meaning of respect in the context of interactions between Cree-Ojibway patients and health care providers. Respect was seen as a reciprocal process that acknowledges in word and action the equality of individuals and communities; respect was communicated through behaviours such as active listening, making genuine efforts to understand the patient's perspective, providing clear explanations and through demonstrations of personal integrity. In later work in Northern British Columbia, Browne, Fiske and Thomas (2000) confirmed this

concern for respect and found that First Nations women's experiences were enhanced when practitioners allowed for active engagement in health care decisions, projected genuine caring and affirmed respect for personal and cultural identity.

In their study involving interactions with health care providers and Indigenous women in Ontario, Manitoba and the North central United States, Dodgson and Struthers (2005) found three areas of concern: the experience of historical trauma as a continuing lived marginalization; the demands of biculturalism as marginalization; and the difficulties involved in interacting in complex health care systems. Concerns raised included experiencing a lack of understanding of Aboriginal decision-making processes, experiencing disrespectful treatment and hesitating in informing health care providers of sensitive details. Trust and the lack of it was a major issue and, in the case of some younger women living in urban settings, lack of trust meant they avoided health care services altogether (Dodgson & Struthers, 2005).

Mi'kmaq hospital patients in Eastern Canada also reported dilemmas related to bicultural issues stated as differences between "our ways, their ways" (Baker & Daigle, 2000). Current research being conducted with Mi'kmaq women by Whitty-Rogers (2006) will provide further insight. A common source of conflict is the definition of a family member – and who is considered to be one – that comes up when large numbers of hospital visitors present as family members. What made a difference in women's hospital experiences was respect and personalized care, treatment as equals of and as equals to non-Aboriginal patients and importantly, acceptance of often large numbers of visitors (Baker & Daigle, 2000; Sokoloski, 1995).

Other concerns involved discomfort with the degree of technological interference experienced; for example, induction and fetal monitoring, as well as choice regarding birthing positions and gender of physicians (Sokoloski, 1995). Concerns related to the proper care, rather than disposal of the placenta have been noted (Paulette, 1999). Avoiding conflict over the assumptions of hospital staff regarding the proper roles of mother and grandmother in postnatal care is important. For example, physicians and nurses may not realize that for some families the grandmother holds the baby first. Beliefs regarding appropriate weight gain during pregnancy and weight loss while breast-feeding may also be quite different from those held by medical staff and judgmental attitudes must be avoided (Vallianatos et al., 2006).

Effective communication is essential to culturally competent care. In order for Aboriginal people to be fully involved in their own care, services must be available in Aboriginal languages (Smylie, 2001b). Foster (2006) notes that, "cultural and language differences can lead to miscommunication, misdiagnoses and inappropriate treatments" (p. 28). Understanding non-verbal communication is also important (Ottani, 2002). For example, norms for eye contact or the absence of it, tone of voice, and degree and forms of participation in discussion and decision-making vary across cultures, and are often misinterpreted (Davidhizar & Bechtel, 1998; Ellerby, 2001). As noted by Ellerby (2001), avoiding eye contact and speaking softly, both signs of respect in Aboriginal cultures, are often misperceived by western professionals as avoidance. To communicate effectively, it is important for health care providers to allow for the time, pacing and acknowledgement of nonverbal communication that may be needed for the patients to express their questions comfortably (Dobbelsteyn, 2006).

Dissatisfaction with service provision was found in mothers who perceived a lack of support, control and communication throughout their birthing experiences (Fowler, as cited in Matthews & Callister, 2004). Taylor and Dower's (1997) study also found dissatisfaction with services due to lack of cultural sensitivity by health care providers. Loneliness, misunderstandings of cultural or spiritual beliefs, and fear are also cited as maternity experiences for Indigenous women worldwide (Watson, Hodson, Johnson, & Kemp, 2001). Cultural needs not being met may result in women avoiding utilization of a health care system during pregnancy until critically necessary, followed by early leave taking (Browne et al., 2000; Kaufert et al., 1984; Petten, 2002; Rankin & Kappy, 1993). Browne (2005) describes how popular societal discourses, which marginalize Aboriginal Peoples, influence the perceptions and attitudes of nursing staff. Aboriginal women are often represented in medical discourses both as having easy births and as being high risk, in each case differentiating them from the mainstream population. These stereotypes must be examined as such.

The need for culturally competent care for Aboriginal women to develop an understanding of Aboriginal Peoples' worldviews on health and western healthcare, it is necessary to consider the following issues: (a) respect for health, healthcare and childbirth beliefs and practices (Davidhizar & Bechtel, 1998; Milligan, 1984a); (b) diversity of perspectives within and between Aboriginal communities; and (c) potential for conflict in cross-cultural interactions.

Healthcare providers must also develop greater awareness of their own assumptions regarding health, illness and appropriate care (Dobbelsteyn, 2006; Edgecombe, 1996; Foster, 2006; Kulig et al., as cited in Leipert & Reutter, 1998; Lowe & Struthers, 2001; Mattson, as cited in Callister, 2001; Spector, 2004).

Spector (2004) points out that “to understand health and illness beliefs and practices, it is necessary to see each person in his or her own unique sociocultural world” (p. xiv). Many Aboriginal people tend to view health holistically, as the balanced interaction of the whole person including physical, mental, spiritual and emotional aspects (L. Bill, personal communication, May 15, 1990; Dobbelsteyn, 2006; Mussell, Nicholl & Adler, as cited in Health Canada, 2001; Paulette, 1999; Waldram, Herring & Young, 2006). In this context, health does not stop at the individual; it includes the relational aspects of life in community. Good or poor health occurs within the experience of family and community health and relationships.

Prior to colonization, Aboriginal people relied on their own beliefs, knowledge systems, practices and practitioners for health and healing. Results of a NAHO telephone survey with First Nations Peoples across Canada suggest that these traditional practices still exist. In this survey, 51 per cent of respondents had relied on traditional Aboriginal healers or medicine over the past 12 months, 72 per cent of the respondents agreed with the statement, “I trust the effects of traditional medicines or healing practices,” and 68 per cent indicated they “would use traditional medicines or healing practices more often if they were available through [the] local health centre” (NAHO, 2004, p. 99). Acknowledging and showing respect for traditional beliefs, practices and healers would enhance the cultural competency of current health care systems (Chen, 1999). Canadian examples exist in which health care institutions have successfully integrated both traditional and western medical philosophies (Smylie, 2001b). While keeping in mind that not all Aboriginal patients have the same history or the same preferences, Smylie describes “the use of traditional medicines, including the burning of sage, cedar, sweetgrass or tobacco in the hospital setting” (p. 8). By supporting cultural practices and healing, conditions of safety, respect and prayer are created.

A traditional Indigenous understanding of health is developed from a collective standpoint (Mussell et al., as cited in Health Canada, 2001) where “one’s position and relationships in society and one’s surroundings determine the state of one’s health” (Eby, 1996, p. 64). Culturally competent care during childbirth is important not only because it is a major life event, but also, more importantly,

because childbirth practices are rooted in culture (Ottani, 2002). Where and how one is born has an important impact on who one is and who one may become (Paulette, 1999). Health care providers who understand and show respect for cultural beliefs and practices are much better equipped to understand the cultural meanings of life events, including birth (Browne, 1995; Davidhizar & Bechtel, 1998). From an Aboriginal point of view, childbirth is a significant but normal event; it is a matter of wellness, not illness, and should not be unduly interfered with (Sokoloski, 1995). Many Aboriginal women have their own knowledge systems, traditional competencies, preferences and methods for prenatal care and birthing (Long & Curry, 1998; Paulette, 1999). Pregnancy involves taking care of oneself and the baby by eating the right foods, being active, avoiding stress and focusing on the developing relationship with the baby rather than on external issues (L. Bill, personal communication, May 15, 1990). Postnatal care occurs as a part of everyday life and involves the extended family; mothers and their newborns are cared for by older women and family members (Kaufert et al., 1984; Milligan, 1984a; Sokoloski, 1995; Vallianatos et al., 2006).

Hospitalization for the purpose of giving birth is a foreign and often isolating event for many Aboriginal women. For example, the shift from family and community control of the childbirth experience to hospital births in far away urban centres, without family members present, has had far reaching implications for the Inuit community (Douglas, 2006). Chamberlain and Barclay (2000) explored the psychosocial outcomes of Inuit women who were required to leave their communities to give birth. The most frequently cited stressor among these women was enforced separation from family, culture and community. Mothers reported being bored, homesick and lonely in unfamiliar surroundings, and concerned for the well-being of other children left behind; they wished family members were there to participate in the birth.

It is paramount that health care providers understand and appreciate the importance that family and community play in the lives of Aboriginal Peoples. The Society of Obstetrics and Gynecology Canada (SOGC) policy document points out that “the concept of family is culturally specific.” For example, in Aboriginal culture, “aunts, uncles, grandparents, cousins, and older siblings may play a role comparable in significance to the western European ‘parent’” (Smylie, 2001b, p. 7). The role of mothers and grandmothers as essential to maintaining the cultural nature of birthing, and pre- and post-natal care cannot be overemphasized.

A diversity of perspectives exist within and between Aboriginal communities. Creating environments where traditional practices are accepted is important, but it is also important to acknowledge that Aboriginal Peoples and their beliefs, experiences and values are not homogeneous (Callister, 2001; Ellerby, 2001; Foster, 2006; Seideman, Haase, Primeaux, & Burns, 1992). "Aboriginal Peoples in Canada embody approximately 50 culturally diverse groups, the roots of which are found in distinct languages and land bases" (Smylie, 2000b, p. 5). Further, members of any one Aboriginal community vary in the degrees to which they identify with indigenous or western belief systems. To develop a truer perspective of patients and their families, individual life experiences and the meaning of those life experiences within variable cultural settings must be understood (Callister, 2001; Smith et al., 2005). Care must be taken to avoid stereotypes and to evaluate individual beliefs and practices regardless of cultural background (Davidhizar & Bechtel, 1998; Ottani, 2002).

The potential for conflict in cross cultural interactions must be acknowledged. Spector (2004) warns that "extreme events . . . can occur when two antithetical cultural belief systems collide within the overall environment of the health care delivery system" (p. 4). Jones and Spector (as cited in Callister, 2001) remark that health care involves three perspectives: the culture of the health care provider, the culture of the woman and her family, and the culture of the health care delivery system. Assumptions from within any single standpoint may result in cultural blindness (Callister, 2001), which may then lead to potential conflict when interacting with persons who hold other perspectives. Tensions are inevitable when individuals come together in a specific health care situation lacking understanding of others' points of view. Conflicts can arise from different cultural views on health care (Callister, 2001; Milligan, 1984a); strongly held expectations regarding what constitutes appropriate birthing practices and a good birth can heighten this dilemma. These differences can result in the patient feeling isolated, disrespected and disempowered (Paulette, 1999; Smylie, 2001b).

Holistic views on health - in which one works towards balance to maintain or achieve health, and an illness is often thought to represent an imbalance in one or more areas - are common among many Aboriginal Peoples (Eby, 1996; O'Brien, et al., 2002; Stevenson, as cited in Health Canada, 2001). Wellness requires a commitment to work towards correcting imbalance through spiritual, mental, physical and emotional processes. The western view on health is individualistic and emphasizes a mind/body

dualism. In addition, western health care systems and service providers have traditionally seen the health care provider as the expert and decision maker. Ellerby (2001) reminds us that "socio-political power relationships are epitomized and maintained through cultural dominance of Western medical practitioners" (p. 7). This situation often exacerbates the power dynamic with people whose voices have already been marginalized (Eby, 1996). In addition to developing a greater understanding one's own beliefs and practices on health, as well as a greater understanding of Aboriginal beliefs and practices, exploring the larger social and political influences on different health models and practices is key to becoming truly culturally competent (Eby, 1996; Foster, 2006; O'Brien et al., 2002).

RECOMMENDATIONS

The provision of culturally competent care for Aboriginal people must include an understanding of the history and impact of colonization (Adelson, 2005; Browne, Smye & Varcoe, 2005; Polashek Wood & Schwass, as cited in Smith et al., 2005; Smylie, 2000a). As Smith et al. (2005) stress, "health status and experiences like pregnancy and parenting must be seen within a broad understanding of the impact of colonization on Aboriginal people" (p. 55). This includes sending children away from parents and communities as experienced in residential schooling and the placement of many children in non-Aboriginal foster or adoptive homes in a phenomena referred to as "the sixties scoop." Moreover, it is important to understand the various terms used to refer to Aboriginal people and the legal and cultural implications associated with such terminology. Understanding the difference between status and non-status, treaty and non-treaty would enhance the development of culturally competent practices and reduce stereotypes (Smylie, 2001b).

Only 56 per cent of respondents of the NAHO (2004) poll agreed that "Aboriginal peoples are treated, as well as non-Aboriginal people in the health care system" (p. 129). In fact, 15 per cent of respondents reported unfair or inappropriate treatment "by a health care provider because they are Aboriginal" (p. 16). Understanding the roots of respondents' views is important. Much can be learned from situations where there has been a lack of cultural sensitivity or appropriateness; these cases should be highlighted and discussed with an eye to effecting change (Kaufert et al., 1984).

There is ample support in the literature for the benefits of developing cultural competency in health care providers (Callister, 2001, 2005; Davidhizar & Bechtel, 1998; Martin-

Misener & Black, 1996; O'Brien et al., 2002; Ottani, 2002; Smith et al., 2005; Spector, 2004; Taylor & Dower, 1997; Watson et al., 2001). This is particularly important, considering the historical experiences of Aboriginal people in Canada with health care systems, health care providers and differential health care legislation. Cultural competency can be enhanced through acquiring knowledge, examining attitudes, engaging in new experiences, changing behaviour, and developing appropriate skills. A variety of methods are available to do this. Learning through open experiences with patients is probably one of the most important. Another method, described by Edgecombe (1996), is the use of value orientation profiles, which provide information on how individuals or groups rank-order the values in their society. This tool could be utilized in learning both about healthcare practitioners' own values and about other culturally-based value systems in order to recognize potential areas of misunderstanding. Similarly, completion of a cultural assessment model, as Leininger advocates, can give health care providers insight into their own beliefs and practices related to health and illness, as well as those of their patients (Mattson, as cited in Callister, 2001).

Providing cross-cultural education to healthcare providers is another means of moving forward (Baker, Findlay, Isbister, & Peekeekoot, 1987; Foster, 2006; Petten, 2002; Rankin & Kappy, 1993). Reading literary works that address cultural beliefs, practices, and issues at staff meetings (Callister, 2001), participating in cultural events, and attending workshops would enhance the education of health care providers (Ellerby, 2001; Smylie, 2001b). Following up initial educational activities with mentoring could precipitate learning through role modeling while providing opportunities to discuss experiences, and reinforcing good practice.

However, while increasing cultural sensitivity is necessary, it is insufficient if it does not lead to behaviour change; staff must be supported systemically at all levels in using knowledge gained to change practice. Particular systemic interventions may include using cultural brokers, partnering with traditional healers, developing culturally appropriate teaching practices and materials, initiating and maintaining training programs for all staff, and recruiting professionals who have relevant background and experience in policy development (Callister, 2005; Brach & Fraserirector, 2000).

Partnering with Aboriginal health care providers (Hart-Wasekesikaw, 1999) including the Aboriginal Nurses Association of Canada (ANAC), the National Indian and Inuit Community Health Representatives Organization

(NIICHRO), the Indigenous Physicians Association of Canada (IPAC), the Native Mental Health Association of Canada (NMHAC), the Institute of Aboriginal Peoples' Health (IAPH), and the National Aboriginal Health Organization (NAHO) can provide valuable connections for learning about ways of implementing cultural approaches to healthcare and, also, about common areas of sensitivity (Smylie, 2001b). Engaging in two-way knowledge translation and capacity building activities with these and other organizations is important (Smylie et al., 2004).

The need for more research in this area is evident (Whitty-Rogers, 2006). In their review, Brach and Fraserirector (2000) indicate more research on the beneficial impact of culturally competent techniques on outcomes, including the reduction of health inequity, is needed to determine if the practice of culturally competent care actually makes a difference in the experience of patients. Another recommendation is to conduct culturally appropriate community-based research to discover knowledge deficits, determine best practices and explore the healthcare delivery experience and needs of Aboriginal women (Kuptana, 1996; Petten, 2002; Smylie et al., 2004). Narrative inquiry and other qualitative methods are appropriate for exploring Aboriginal women's birth experiences in hospital settings and can be instrumental in informing institutional practices (Callister, 2004; Matthews & Callister, 2004; Watson et al., 2001). As well, further research to determine whether changes in staff and organizational attitudes and behaviours have indeed occurred will be necessary following the implementation of culturally competent practice policies (Brach & Fraserirector, 2000).

CONCLUSION

As the literature reveals, a key component in the provision of quality health care practices is the development of cultural competency. Culturally competent care includes honouring the birthing practices respected by each culture (Matthews & Callister, 2004). Health care providers must be willing to "integrate traditional practices or approaches to health care when the client needs or wants them" (Dobbelsteyn, 2006, p. 34). However, care must be taken to acknowledge the diversity that exists amongst Aboriginal Peoples in order to avoid engaging in further stereotyping. Incorporating a reflective and learner-based approach in health care delivery would greatly assist health care providers in achieving culturally competent practices. Recognition of the influence on any one health care provider of the biomedical "provider

culture” (Spector, 2002, 2004) with its own normalized beliefs and assumptions regarding appropriate health choices is also essential.

Although models for culturally competent care exist, research outcomes on culturally competent practices for Aboriginal women giving birth in hospital settings in Canada are sparse. Additional research on the needs of Aboriginal women delivering babies in hospital settings is vital not only to informing health care policies and practices, but to address gaps and barriers that prevent access or effective access to the health care system. Culturally competent care is important; developing and using cultural sensitivity and relevant practice skills is critical to good care, as is institutional responsiveness to this issue. Moreover, understanding the historical and sociopolitical dynamics involved is an essential component of respect and may influence not only current encounters but women’s willingness to engage in health services during both the pre- and postnatal periods. Forming partnerships with Aboriginal communities and professionals to develop policy and conduct research on these issues is important; doing so may assist in addressing the power imbalances between Aboriginal peoples and those working in the health care system. While awareness of the issues discussed in this article is increasing among health professionals, it continues to be critically necessary to develop a dialogue resulting in policy change and the application of strategies and practices that will promote an increased level of culturally competent care for Aboriginal women in hospital labour and delivery wards.

REFERENCES

- Adelson, N. (2005). The embodiment of inequity: Health disparities in Aboriginal Canada. *Canadian Journal of Public Health, 96*, S45-S61.
- Baker, C. & Daigle, M. C. (2000). Cross-cultural hospital care as experienced by Mi’kmaq clients. *Western Journal of Nursing Research, 22*, 8-28.
- Baker, F. W., Findlay, S., Isbister, L., & Peekeekoot, B. (1987). Native health care: An alternative approach. *Canadian Medical Association Journal, 136*, 695-696.
- Banks, J. W. (2003). Ka’nisténhsera Teiakotihnsniés: A Native community rekindles the tradition of breastfeeding. *AWHONN Lifelines, 7*(4), 340-347.
- Brach, C. & Fraserirector, I. (2000). Can cultural competency reduce racial and ethnic disparities? A review and conceptual model. *Medical Care Research and Review, 57*(1), 181-217.
- Browne, A. J. (1995). The meaning of respect: A First Nations perspective. *Canadian Journal of Nursing Research, 27*, 95-109.
- Browne, A. J. (2005). Discourses influencing nurses’ perception of First Nation patients. *Canadian Journal of Nursing Research, 37*(4), 62-87.
- Browne, A. J., Fiske, J. & Thomas, G. (2000). *First Nations women’s encounters with mainstream health care services and systems. Women’s Health Reports*. Vancouver, B.C.: British Columbia Center of Excellence for Women’s Health.
- Browne, A. J., Smye, V. L. & Varcoe, C. (2005). The relevance of postcolonial theoretical perspectives to research in Aboriginal health. *Canadian Journal of Nursing Research, 37*(4), 16-37.
- Callister, L. C. (2001). Culturally competent care of women and newborns: Knowledge, attitude, and skills. *Journal of Obstetric, Gynecologic, and Neonatal Nursing, 30*(2), 209-215.
- Callister, L. C. (2004). Making meaning: Women’s birth narratives. *Journal of Obstetric, Gynecologic, and Neonatal Nursing, 33*(4), 508-518.
- Callister, L. C. (2005). What has the literature taught us about culturally competent care of women and children? *MCN, 30*(6), 380-388.
- Callister, L. C., Khalaf, I., Semenic, S., Kartchner, R., & Vehvilainen-Julkunen, K. (2003). The pain of childbirth: Perceptions of culturally diverse women. *Pain Management Nursing, 4*(4), 145-154.
- Campinha-Bacote, J. (2002). The process of cultural competence in the delivery of healthcare services: A model of care. *Journal of Transcultural Nursing, 13*(3), 181-184.
- Carlton, T., Callister, L. C. & Stoneman, E. (2005). Decision making in laboring women: Ethical issues for perinatal nurses. *Journal of Perinatal & Neonatal Nursing, 19*(2), 145-151.
- Carroll, D. & Benoit, C. (2001). Aboriginal midwifery in Canada: Blending traditional and modern forms. *Canadian Women’s Health Network Magazine, 4*(3). Retrieved October 14, 2006, from <http://www.cwhn.ca/network-reseau/4-3/4-3pg2.html>

- Chamberlain, M. & Barclay, K. (2000). Psychosocial costs of transferring indigenous women from their community for birth. *Midwifery*, 16(2), 116-122.
- Chen, Jr., M. S. (1999). Informal care and the empowerment of minority communities: Comparisons between the USA and the UK. *Ethnicity & Health*, 4(3), 139-151. Retrieved July 6, 2006, from Health Source: Nursing/Academic Edition.
- Cioffi, J. (2004). Caring for women from culturally diverse backgrounds: Midwives' experiences. *Journal of Midwifery & Women's Health*, 49(5), 437-442.
- Couchie, C. & Sanderson, S. (2007). A report on best practices for returning birth to rural and remote aboriginal communities. *Journal of Obstetrics and Gynaecology Canada*, 29(3), 250-260.
- Davidhizar, R. & Bechtel, G. (1998). A model to enhance culturally competent care. *Hospital Topics*, 76(2), 22-26. Retrieved July 5, 2006, from Health Source: Nursing/Academic Edition.
- Davidhizar, R. & Giger, J. N. (2001). Teaching culture within the curriculum using the Giger-Davidhizar model of transcultural nursing assessment. *Journal of Nursing Education*, 40(6), 282-284.
- Dion-Stout, M., Kipling, G. D. & Stout, R. (2001). *Aboriginal Women's Health Research Synthesis*. Ottawa: Centres of Excellence for Women's Health.
- Dobbelsteyn, J. L. (2006). Nursing in First Nations and Inuit communities in Atlantic Canada. *Canadian Nurse*, 102(4), 32-35.
- Dodgson, J. E. & Struthers, R. (2005). Indigenous women's voices: Marginalization and health. *Journal of Transcultural Nursing*, 16(4), 339-346.
- Douglas, V. K. (2006). Childbirth among the Canadian Inuit: A review of the clinical and cultural literature. *International Journal of Circumpolar Health*, 65(2), 117-132.
- Eby, D. (1996). Traditional healing and allopathic medicine: Issues at the interface. In R. Fortuine, G.A. Conway, C.D. Schraer, M.J. Dimino, C.M. Hild & J. Braund-Allen (Eds.), *Circumpolar Health 96: Proceedings of the Tenth International Congress on Circumpolar Health: Vol. 57* (pp. 62-66). Anchorage, AK: American Society for Circumpolar Health.
- Edgecombe, N. A. (1996). Value orientation of the Copper Inuit. In R. Fortuine, G.A. Conway, C.D. Schraer, M.J. Dimino, C.M. Hild & J. Braund-Allen (Eds.), *Circumpolar Health 96: Proceedings of the Tenth International Congress on Circumpolar Health: Vol. 57* (pp. 55-61). Anchorage, AK: American Society for Circumpolar Health.
- Ellerby, J. H. (2001). *Working with Aboriginal Elders*. Winnipeg, Canada: University of Manitoba Native Studies Press.
- Foster, C. H. (2006). What nurses should know when working in Aboriginal communities. *Canadian Nurse*, 102(4), 28-31.
- Fry, S. T. (1992). The role of caring in a theory of nursing ethics. In H. B. Holmes & L. M. Purdy (Eds.), *Feminist Perspectives in Medical Ethics* (pp. 93-106). Bloomington, IN: Indiana University Press.
- Hart-Wasekeesikaw, F. (1999). Aboriginal health nursing – a cultural approach. *Aboriginal Nurse*, 14(2), 3.
- Health Canada. (2001). *It Takes a Community: Framework for the First Nations and Inuit Fetal Alcohol Syndrome and Fetal Alcohol Effects Initiative*. Ottawa, ON: First Nations and Inuit Health Branch, Health Canada.
- Hiebert, S. (2001). The utilization of antenatal services in remote Manitoba First Nations communities. *International Journal of Circumpolar Health*, 60(1), 64-71.
- Inuit Tapiriit Kanatami. (2004). *Evaluation of models of health care delivery in Inuit regions*. Retrieved July 4, 2006, from <http://www.itk.ca/publications/200403-healthcare-evaluation.pdf>
- Kaufert, J. M., Koolage, W. W., Kaufert, P. L., & O'Neil, J. D. (1984). The use of "trouble case" examples in teaching the impact of sociocultural and political factors in clinical communication. *Medical Anthropology, Winter*, 36-45.
- Kim-Godwin, Y. S. (2003). Postpartum beliefs and practices among non-Western cultures. *MCN, American Journal of Maternal Child Nursing*, 28(2), 74-78.
- Kuptana, R. (1996). Address by the president of the Inuit Circumpolar Conference. In R. Fortuine, G.A. Conway, C.D. Schraer, M.J. Dimino, C.M. Hild & J. Braund-Allen (Eds.), *Circumpolar Health 96: Proceedings of the Tenth International Congress on Circumpolar Health: Vol. 57* (pp. 6-9). Anchorage, AK: American Society for Circumpolar Health.

- Leininger, M. M. (1988). Leininger's theory of nursing: cultural care diversity and universality. *Nursing Science Quarterly*, 1(4), 152-60.
- Leininger, M. (2002). Culture care theory: A major contribution to advance transcultural nursing knowledge and practices. *Journal of Transcultural Nursing*, 13(3), 189-92.
- Leipert, B., & Reutter, L. (1998). Women's health and community health nursing practice in geographically isolated settings: A Canadian perspective [Electronic version]. *Health Care for Women International*, 19(6), 575-588.
- Long, C. R. & Curry, M. A. (1998). Living in two worlds: Native American women and prenatal care. *Health Care for Women International*, 19, 205-215.
- Lowe, J. & Struthers, R. (2001). A conceptual framework of nursing in Native American culture [Electronic version]. *Journal of Nursing Scholarship*, 33(3), 279-283.
- Martin-Misener, R., & Black, J. (1996). Using the evaluation of the Dalhousie Outpost Nursing Program for responsive social action. In R. Fortuine, G.A. Conway, C.D. Schraer, M.J. Dimino, C.M. Hild & J. Braund-Allen (Eds.), *Circumpolar Health 96: Proceedings of the Tenth International Congress on Circumpolar Health: Vol. 57* (pp. 96-99). Anchorage, AK: American Society for Circumpolar Health.
- Matthews, R. & Callister, L. C. (2004). Childbearing women's perceptions of nursing care that promotes dignity. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 33(4), 498-507.
- Milligan, B. C. (1984a). Nursing care and beliefs of expectant Navajo women (part 1). *American Indian Quarterly*, 8(2), 83-101.
- National Aboriginal Health Organization (NAHO). (2004). *What First Nations think about their health and health care*. Ottawa, ON: Author.
- National Aboriginal Health Organization (NAHO). (2006). *Exploring models for quality maternity care in First Nations and Inuit communities: A preliminary needs assessment*. Ottawa, ON: Author.
- O'Brien, B. L., Anslow, R. M., Begay, W., Pereira, S. B. A., & Sullivan, M. P. (2002). 21st century rural nursing: Navajo traditional and western medicine. *Nursing Administration Quarterly*, 26(5), 47-57.
- Ottani, P. A. (2002). Embracing global similarities: A framework for cross-cultural obstetric care. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 31(1), 33-38.
- Paulette, L. (1990). The changing experience of childbirth in the western N.W.T. In J. D. O'Neil & P. Gilbert (Eds.), *Childbirth in the north: Epidemiological, clinical and cultural perspectives* (pp. 45-50). Winnipeg, Manitoba: Northern Health Research Unit, University of Manitoba.
- Paulette, L. (Speaker). (1999). *Ethics and cultural diversity in northern birthing. 11th Annual Canadian Bioethics Society Conference: Expanding the Boundaries of Ethics*. Edmonton, AB: Kennedy Recordings.
- Petten, C. (2002). Aboriginal women badly served by health care. *Windspeaker*, 20(5), 26.
- Purnell, L. (2002). The Purnell model for cultural competence. *Journal of Transcultural Nursing*, 13(3), 193-196.
- Raines, D. A. & Morgan, Z. (2000). Culturally sensitive care during childbirth. *Applied Nursing Research*, 13(4), 167-172.
- Rankin, S. B. & Kappy, M. S. (1993). Developing therapeutic relationships in multicultural settings. *Academic Medicine*, 68(11), 826-827.
- Schim, S. M. Doorenbos, A., Benkert, R., & Miller, J. (2007). Culturally congruent care: Putting the puzzle together. *Journal of Transcultural Nursing*, 18(2), 103-110.
- Seideman, R. Y., Haase, J., Primeaux, M., & Burns, P. (1992). Using NCAST instruments with urban American Indians. *Western Journal of Nursing Research*, 14(20), 308-321.
- Shen, Z. (2004). Cultural competence models in nursing: A selected annotated bibliography. *Journal of Transcultural Nursing*, 15(4), 317-322.
- Smith, D. (2003). Maternal-child health care in Aboriginal communities. *Canadian Journal of Nursing Research*, 35(2), 143-152.
- Smith, D., Varcoe, C. & Edwards, N. (2005). Turning around the intergenerational impact of residential schools on Aboriginal people: Implications for health policy and practice. *Canadian Journal of Nursing Research*, 37(4), 38-60.

- Smylie, J. (2000a, December). *A guide for health professionals working with Aboriginal peoples: Executive summary* (SOGC Policy Statement No. 100). Retrieved February 16, 2006, from http://www.sogc.org/guidelines/index_e.asp
- Smylie, J. (2000b, December). *A guide for health professionals working with Aboriginal peoples: The sociocultural context of Aboriginal peoples in Canada* (SOGC Policy Statement No.100). Retrieved February 16, 2006, from <http://www.sogc.org/guidelines/public/100e-ps2-december2000.pdf>
- Smylie, J. (2001b, February). *A guide for health professionals working with Aboriginal peoples: Cross cultural understanding* (SOGC Policy Statement No.100). Retrieved February 16, 2006, from http://www.sogc.org/guidelines/index_e.asp
- Smylie, J., Kaplan-Myrth, N., Tait, C., Martin, C. M., Chartrand, L., Hogg, W., et al. (2004). Health sciences research and Aboriginal communities: pathway or pitfall? *Journal of Obstetrics and Gynecology Canada*, 26 (3), 211-216.
- Sokoloski, E. H. (1995). Canadian First Nations women's beliefs about pregnancy and prenatal care. *Canadian Journal of Nursing Research*, 27(1), 89-100.
- Spector, R. E. (2002). Cultural diversity in health and illness. *Journal of Transcultural Nursing*, 13(3), 197-199.
- Spector, R. E. (2004). *Cultural diversity in health & illness* (6th ed.). Upper Saddle River, NJ: Pearson-Prentice Hall.
- Suh, E. E. (2004). The model of cultural competence through an evolutionary concept analysis. *Journal of Transcultural Nursing*, 15(2), 93-102.
- Taylor, D. & Dower, C. (1997). Toward a women-centered health care system: Women's experiences, women's voices, women's needs. *Health Care for Women International*, 18(4), 407-422. Retrieved July 5, 2006, from Health Source: Nursing/Academic Edition.
- Vallianatos, H., Brennard, E. A., Raine, K., Stephen, Q., Petawabano, B., Dannenbaum, D., et al. (2006). Beliefs and practices of First Nation women about weight gain during pregnancy and lactation: Implications for women's health. *Canadian Journal of Nursing Research*, 38(1), 102-119.
- Waldram, J. B., Herring, D. A. & Young, T. K. (2006) *Aboriginal Health in Canada: Historical, Cultural, and Epidemiological Perspectives* (2nd ed.). Toronto: University of Toronto.
- Waller, B. N. (2002). The psychological structure of patient autonomy. *Cambridge Quarterly of Health Care Ethics*, 11(3), 257-265.
- Watson, J., Hodson, K., Johnson, R., & Kemp, K. (2001). The maternity experiences of Indigenous women admitted to an acute care setting. *Australian Journal of Rural Health*, 10, 154-160.
- Whitty-Rogers, J. (2006). Mi'kmaq women's childbirth experiences: Summary of literature review and proposed study for master's thesis. *Pimatisiwin*, 4(1), 68-93.

END NOTES

1. For the purposes of this study, women's health is defined as mental and emotional health, physical health, and social well-being. When health is defined as mental, physical and social well-being, and not merely the absence of disease and infirmity, cultural and social practices become critical contributing factors to health (Arctic Council, 2004).
2. Obstetric evacuation is a mandatory practice in most Nunavut communities, except for Iqaluit where there is a hospital, and Rankin Inlet, where a low-risk delivery birthing centre is located.
3. Inuktitut word meaning "people of Nunavut."
4. Inuit is the Inuktitut word for "people." Inuk is the singular form meaning "person."

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.