Envisioning a culturally safe midwifery model from the perspective of Indigenous families: A case study of midwifery care in inner city Winnipeg, Manitoba, Canada

By

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A thesis submitted to the Faculty of Graduate Studies in partial
fulfillment of the requirements for the Master of Indigenous Governance

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Master of Arts in Indigenous Governance Program
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Winnipeg, Manitoba, Canada
April 2020

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Abstract

Prenatal care is associated with improved outcomes for the mother and baby. Ongoing research in Winnipeg shows that pregnant people, especially Indigenous people, living in Winnipeg's inner city have significantly lower rates of prenatal care than others in the city. There are no specific predictors of inadequate prenatal care among Indigenous families. Instead, being Indigenous is in and of itself a risk factor for inadequate prenatal care.

This research project is a case study of culturally safe prenatal care and the role midwives can play in facilitating culturally safe prenatal care that is appropriate for Indigenous families living in Winnipeg's inner city. It examines the decolonization of midwifery practice using pragmatic and Indigenous research paradigms. The goal was to understand, from the perspective of Indigenous midwifery clients, how midwives and other care providers can shape the quality of prenatal care services to meet the needs of Indigenous families more effectively and in a culturally safe manner.

This research examines the prenatal care model of a group of midwives based out of an interdisciplinary health clinic called Mount Carmel Clinic (MCC) in Winnipeg, Manitoba. It finds increased rates of prenatal care for Indigenous families at risk of receiving inadequate prenatal care in pregnancy. It also finds that despite increased engagement in prenatal care, many MCC midwifery clients have their babies apprehended by Child and Family Services at birth. The findings suggest that the MCC midwifery model is on a continuum of culturally safe practice, and that the model of care could facilitate a deeper level cultural safety by expanding their care team to include Indigenous members and traditional knowledge about pregnancy, birth and parenting. Finally, it finds that Two-Eyed Seeing can be used by non-Indigenous healthcare practitioners as a tool for engaging in reflective practice to design a working model of cultural safety in the context of the local community.

Keywords: Indigenous, cultural safety, prenatal care, midwifery, child welfare

Acknowledgements

First and foremost, thank you to my clients, past, present, and future for being my greatest teachers. This thesis is dedicated to them.

Thank you to my thesis supervisor Dr. Shailesh Shukla for providing guidance and for helping me through this process. As well, thank you to my thesis committee member Dr. Julie Pelletier and to my external thesis committee member, Dr. Jaime Cidro for their insights into my work.

Thank you to all the speakers interviewed for this project for contributing their time and wisdom. Thank you to Cree Elder, Lorraine Cameron Munro, for supporting me through friendship. I would also like to acknowledge the contributions of the Indigenous midwives, Melissa Brown and Kerry Bebee for their suggestions based on their analysis of my initial program evaluation project.

Thank you to Clifford Hall and Dr. Norma Hall for reviewing my work, for teaching me about local First Nations and Metis history, and for hanging out around the fire.

Thanks to Jill McConkey for reading and sharing your thoughts on my original proposal.

Thank you to my students for all they have taught me.

Finally, thank you to my colleagues Kelly Klick, Gina Mount, Joan Keenan, Rebecca Wood, Amber Douziech, Melissa Brown, Jennifer Bamford, Nikki Ibbitt, Erin Vosters, Dr. Adelicia Yu, and the Mount Carmel Clinic team, for sharing the journey with me, and for supporting and advocating for the families we serve.

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LIST OF ABBREVIATIONS

CFS ……………. Child and Family Services

CMM ………….. College of Midwives of Manitoba

REB …………… Research Ethics Board

EIA ……………. Employment and income assistance

MCC …………… Mount Carmel Clinic

NACM ………… National Aboriginal Counsel of Midwives

MMIWG ……… Missing and Murdered Indigenous Women and Girls

TRC …………… Truth and Reconciliation Commission

APWP …………. Aboriginal Prenatal Wellness Program

MIK ……………. The Mothering Project/ Manito Ikwe Kagiikwe

UNDRIP ………… United Nations Declaration on the Rights of Indigenous People

HDI ……………. Human Development Index

PIIPC …………….. Partner in Integrated Inner-City Prenatal Care

WRHA …………. Winnipeg Regional Health Authority

Chapter 1: Introduction

1.1 Background

Ongoing research in Winnipeg shows that Indigenous families in the inner city are significantly more likely to receive inadequate prenatal care than families in other areas of the city (Heaman et al., 2005; Knight et al., 2014). Inadequate prenatal care is associated with adverse outcomes for the mother and baby (Heaman et al., 2005, 2008; Knight et al., 2014). Since evidence shows that prenatal care can reduce health risks, Heaman et al. (2005, 2015a) suggest that these families would benefit from focused interventions to create equitable access to prenatal care services and reduce barriers to prenatal care.

The midwives at Mount Carmel Clinic (MCC Midwives), a multidisciplinary inner city health clinic in Winnipeg, provide a unique model of interdisciplinary prenatal care, which takes a holistic approach to care and strives toward culturally safe practice to address the complex health and psycho-social needs of Indigenous families in the inner city. Cultural safety is defined as the application of cultural understanding for the transformation of relationships between healthcare providers such that the patient's voice takes a predominant role (Wilson et al., 2013). Culturally safe healthcare is considered by many to be essential for facilitating healthcare for Indigenous people, and for fostering more trusting and effective relationships between Indigenous people and their healthcare providers (Abbott 2014; Di Lallo 2014; National Aboriginal Council of Midwives [NACM] 2016; Wilson et al., 2013).

1.2 Research Problem

Some regions of Manitoba have higher rates of inadequate prenatal care than others, with the highest rates of inadequate prenatal care in the northern parts of the province and in Winnipeg's inner city (Heaman 2007, 809) (See figure 1.1).

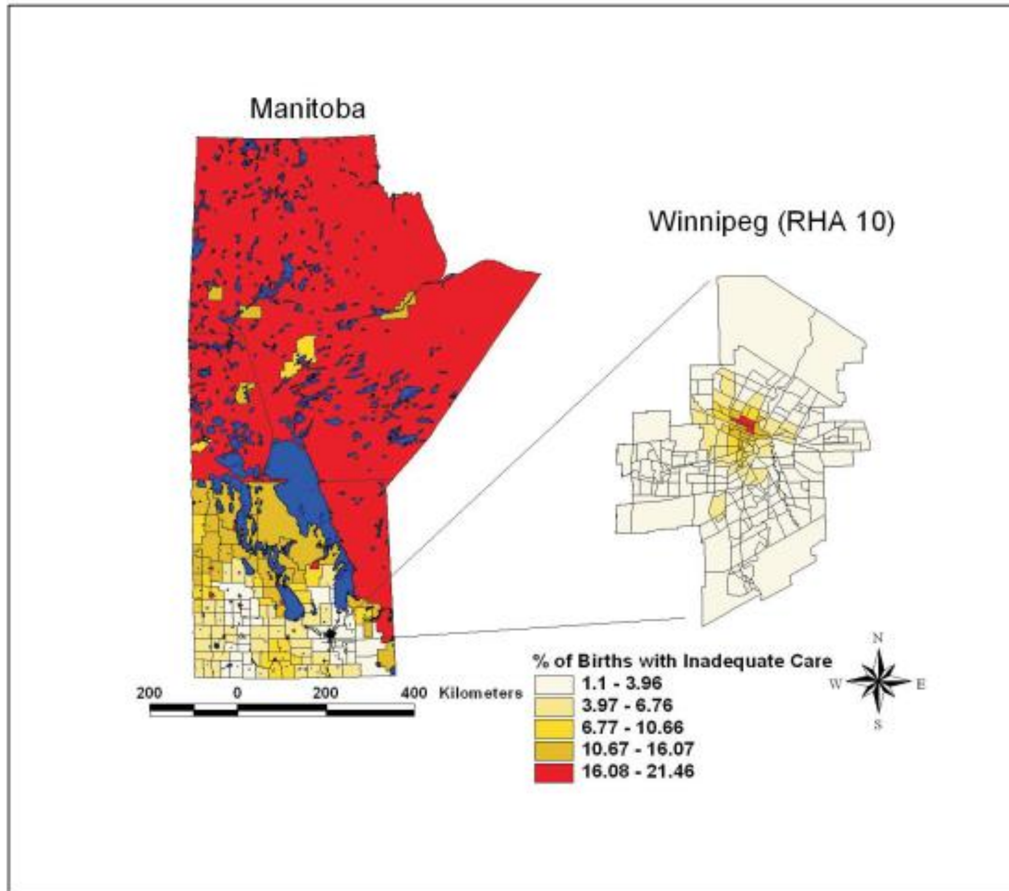

Figure 1.1 Thematic map depicting regional variations in prevalence of inadequate prenatal care (cases per 100 births, age standardized, smoothed) in the province of Manitoba and the City of Winnipeg (Heaman 2007, p. 809).

Two inner city communities in Winnipeg (Downtown and Point Douglas) have the highest rates of inadequate prenatal care in Winnipeg, which are substantially higher than all other areas of the city (Heaman et al., 2013, 2016b) (See figure 1.2). One study done at Women's Hospital in Winnipeg found that a large proportion of pregnant people who arrive at the hospital with *zero* prenatal care were from Point Douglas, the same community which houses Mount Carmel Clinic, a multidisciplinary inner city health clinic (Heaman et al., 2016a). This suggests that focused interventions to improve care are needed locally.

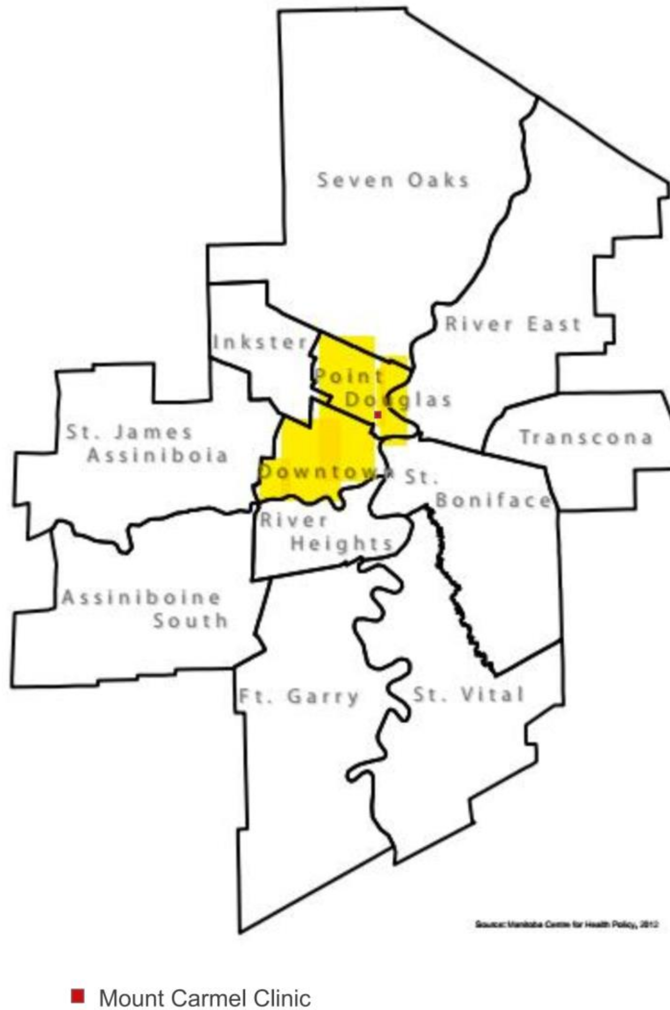

Figure 1.2. Map of Winnipeg Community areas adapted from Heaman & Manitoba Centre for Health Policy (2013, p. 6).

Inner city Winnipeg (Downtown and Point Douglas community areas)

Point Douglas is bordered by Carruthers Avenue to the Canadian Pacific Railyards, and McPhillips Street to the Red River (WRHA, 2006). This area is also known as the North End. It is a community that is currently and historically a place of socio-economic disadvantage. The cultural backgrounds of its residents have changed over time. At one time, it was the working-class enclave of immigrant and farming families moving into the city of Winnipeg, and then of refugees displaced by World Wars One and Two (Paskievich, 2017). As the original settlers moved into more prosperous neighbourhoods, the new poorer classes of the later twentieth century moved in, seeking homes and refuge (Paskievich, 2017). By [the 1970s], nearly a century after they were forced out of the area, the largest group of "new immigrants" were First

Nations and Metis people, moving into the city from the rural and remote areas of Manitoba (Paskievich, 2017). Between 1971 and 2001, the Indigenous population in Winnipeg increased substantially and many First Nations and Metis people settled in Point Douglas (Paskievich, 2017). Today Point Douglas has the largest urban population of Indigenous people in Canada (Paskievich, 2017).

Previous research found that there are no specific predictors of inadequate prenatal care among Indigenous families in Winnipeg, but rather, being Indigenous is a risk factor for inadequate prenatal care, in and of itself (Heaman et al., 2005; Knight, 2014). There is a growing consensus around the value of cultural safety for Indigenous people in healthcare systems in Canada and abroad (Abbott, 2014; Wilson et al., 2013; Di Lallo, 2014; Marsh, 2015). The lack of culturally safe healthcare systems has led to increased alienation for Indigenous healthcare recipients (Wilson et al., 2013; NACM, 2016; Smylie et al., 2016). A foundational element of cultural safety is that care providers serving Indigenous families must carry an awareness of the impacts of colonization on the lived experiences of Indigenous peoples, past and present, and how far-reaching and marginalizing the effects are (Abbott, 2014; Wilson et al., 2013; Iwama, 2009; Marsh, 2015). Linda Tuhiwai Smith (2012) cautions against viewing Indigenous people, "'Through imperial eyes'… which assumes that Western ideas about the most fundamental things are the only ideas possible to hold… the only rational ideas, and the only ideas which can make sense of the world, of reality, of social life, and of human beings" (58). Cultural safety measures are necessary to counteract this perspective (Abbott, 2014; Di Lallo, 2014, Marsh, 2015; Smylie et al., 2016).

This does not mean that non-Indigenous healthcare providers are expected to carry Indigenous knowledge or teachings; it does mean, however, that they must recognize the power imbalances that exist between themselves and their Indigenous patients or clients as a result of colonization. Health care providers need to know about colonization and health systems, as well as the impact of these factors on Indigenous people's access to healthcare (Di Lallo, 2014; Gurr, 2015; Heaman et al., 2015a; Sharma et al., 2016). Smith and others refer this as uncovering the imperialist underpinnings of approaches to institutions and governance (Martin, 2012; McClintock, 1992; Smith, 2012).

An appropriate understanding of Indigeneity in a local context is also essential to supporting Indigenous healthcare recipients in a culturally safe way (Yeung, 2016). What works

for one Indigenous group may not be appropriate for another. For this reason, it is always important that one not assume that what serves as a culturally safe model for one individual or family, is appropriate for another (Bell, 2018; Yeung, 2016). It is always necessary to ask questions and identify relevant cultural variables as well as to make ongoing assessments about the unique needs of each of each person or family (Yeung, 2016). This concept was a part of the mandate of the recent *National Inquiry in to Missing and Murdered Indigenous Women and Girls* which envisioned a process that would reclaim the rich diversity of Indigenous peoples, stating:

> First Nations, Métis, and Inuit peoples each have their own distinct cultures, languages, and ways of life. Their communities have their own distinct political, legal, social, cultural, and economic systems. There can be no one-size-fits-all, pan-Indigenous approach. Solutions must instead be culturally appropriate to First Nations, Métis, and Inuit women and girls, their respective communities, and their Nations (Bell, 2018, "Our Vision," para. 3).

Indigenous healthcare recipients must be given appropriate information to empower them to make suitable decisions regarding their health and healthcare. Their decisions need to be respected, as the patient is the one in charge when cultural safety is a guiding principle. Cultural safety is based on respect and its most vital component is enabling Indigenous individuals and communities to have control over their own health, hence facilitating self-determination (Gunn, 2014).

MCC Midwives strive to address Indigenous families in a culturally safe manner. As a part of this, it became necessary to evaluate the care the midwives provide to their Indigenous clients by consulting with the families themselves. While some studies suggest midwifery care as a facilitator to prenatal care for Indigenous families (Di Lallo, 2014; Heaman et al., 2015b; Heaman et al., 2017) there have been no studies performed to date specifically about the role of midwifery care in inner city Winnipeg. While there is some research in other parts of the country which feature Indigenous people's voices regarding prenatal care (Di Lallo, 2014; Sharma et al., 2016), research on the perspectives of pregnant Indigenous people in Manitoba is limited to women's experiences of receiving care that relates only specifically to gestational diabetes (Sharma et al., 2016). Addressing these gaps may aid in shaping more appropriate and effective midwifery services for Indigenous families in Winnipeg.

1.3 Purpose

The purpose of this research is to examine the effectiveness of MCC Midwives' prenatal care model at providing culturally safe prenatal care services to Indigenous families. The research uses principals and protocols of an Indigenous research paradigm (described in greater detail in 3.1) (Chilisa, 2012, Weber-Pillwax, 2001; Wilson, 2008) and will be a case study of Indigenous families' experiences of prenatal care with MCC Midwives. The analysis is meant to create a decolonizing lens though which to look at the midwifery practice, and to sensitize the midwifery profession and its stakeholders to the needs of Indigenous families and the role midwifery care can play in addressing those needs. The research seeks to answer the following three questions:

1) Does the MCC midwifery model facilitate prenatal care engagement for Indigenous families at risk of receiving inadequate prenatal care?
2) What Does a culturally safe midwifery model look like in inner city Winnipeg?
3) What lessons can healthcare providers learn about cultural safety by applying Two-Eyed Seeing to their relationships with Indigenous healthcare recipients?

1.4 Significance of this Research

If the MCC midwifery model of care is found to be successful at providing effective and appropriate prenatal care to Indigenous families, it could protect the model of care practiced by MCC midwives, influence funding for midwifery supports, and further enable midwives to provide their clients with accessible care that is holistic and culturally safe. It could influence midwives elsewhere to adopt and integrate evidence based (Cluett, 2002; Mander, 2001) cultural safety into their clinical practice. If through examining the experiences of the Indigenous families served, the research supports the MCC midwifery model of care as improving the healthcare experiences of the families, it will contribute to the growing body of evidence supporting culturally safe practice in healthcare; highlight the benefits of using Indigenous research methodologies to better understand the healthcare needs of Indigenous people; and show ways to decolonize healthcare. This research will also contribute to the large body of research regarding access to prenatal care in Manitoba and Winnipeg, which has made recommendations for increased midwifery involvement for facilitating access to prenatal care for Indigenous families in inner city Winnipeg, but has not yet explored the effectiveness of cultural safety as a means of doing so (Heaman et al., 2016; Heaman et al., 2017).

1.5 Self Positioning

I have been a practicing (non-Indigenous) midwife at MCC since 2011. I have pursued an Master of Arts in Indigenous Governance because I am invested in the families that I serve, and I want to aid in holding space for Indigenous voices and healing. I am an advocate for Indigenous families, and I wish to contribute to respectful research in the fields of Indigenous maternal-child health and reproductive justice.

MCC Midwives participated as members of the front-line healthcare team in the PIIPC Project. This project was based out of the University of Manitoba via the Faculty of Nursing and was led by researcher, Maureen Heaman. It involved midwives, physicians, nurses, social workers, and other healthcare professionals. The roles of the midwives included providing prenatal care at MCC as well as in community prenatal groups as a part of a collaborative project focused on reducing inequities in access to and use of prenatal care in Winnipeg's inner city. The intent of the project was to integrate prenatal care services in the inner city and to develop a collaborative approach towards providing that care among frontline health providers, clinics and the Women's Hospital (Heaman, 2016a). This approach was found to make it easier and more likely for vulnerable pregnant people to get the care they need (Heaman, 2016a). The research portion of the project was completed in the fall of 2015. MCC Midwives advocated for transportation incentives (bus token and taxi slips) to remain available to our clients to facilitate access to prenatal appointments, ultrasounds, triage assessments, Birth Centre tours, Child and Family Services (CFS) appointments, and other important occasions. PIIPC has evolved into an unfunded network of healthcare and social agencies working together to facilitate access to healthcare for those facing barriers to access to prenatal care in Winnipeg.

My Indigenous Governance research project is inspired, in part, by the participation of MCC Midwives in the PIIPC Project, which illuminated gaps in the research, as the PIIPC literature does not specifically centre on the worldviews of Indigenous people, despite First Nations and Metis people making up a significant number of the participants, thus being the cultural group with the highest level of inadequate prenatal care (Heaman et al., 2017).

My goal here, is to facilitate research that focuses on the voices of local Indigenous families and employs principals of an Indigenous research paradigm to determine what Indigenous families consider to be helpful to themselves, their communities, and what changes

they envision. It is important to me that I incorporate Indigenous engagement into my research process because it centres Indigenous people as producers of knowledge, rather than minimizing them as subjects within the research (Chilisa, 2012; Wilson et al., 2013; Wilson, 2008).

1.6 Definition of Terms

1.6.1 Cultural safety. The application of cultural understanding for the transformation of relationships between healthcare providers such that the patient's voice takes a predominant role (Wilson et al., 2013).

1.6.2 Decolonization. The process of deconstructing Eurocentric worldviews of Indigenous peoples, acknowledging their disparate experiences of the colonial world, and allowing for the dismantling and redefining of power structures, such that the concerns and worldviews of Indigenous peoples are at the centre of issues relating to them (Chilisa, 2012).

1.6.3 Harm reduction. The practice of minimizing the negative impact of illicit substances on patients, with expressed respect for a person's choice to use the substances (Dell, 2007).

1.6.4 Inadequate prenatal care. Five or fewer prenatal appointments (Heaman, 2005).

1.6.5 Indigenous. The Constitution Act of Canada 1982, Section 35, 2, defines Canada's Indigenous peoples as First Nations (including status/non-status Indians, and on/off reserve Indians), Inuit, and Métis peoples (Canada, 2001).

1.6.6 Indigenous research methodologies. Involves a research paradigm which confronts the limitations of traditional approaches to research in addressing how research problems involving Indigenous peoples should be understood and addressed, maintaining cultural considerations throughout its ontology, epistemology and axiology (Chilisa, 2012).

1.6.7 Inner city Winnipeg. For this study, inner city Winnipeg is defined as being within the boundaries of the Downtown and Point Douglas community areas, as defined by the Winnipeg Regional Health authority (WRHA, 2006).

1.6.8 Pregnant people. This gender inclusive term is used in this paper to include trans, gender queer, and intersex people. According to the Canadian Association of Midwives, such inclusive language "does not erase the existence of women, it simply extends basic human rights to all midwives, and the people they serve." (Canadian Association of Midwives, 2015). Sometimes the terms women, woman, and female are used, as these are what is mostly

associated with childbearing in the existing literature. When possible, gender neutral or other appropriate terminology, such as people, person, parents, individuals, and families are used.

1.6.9 Prenatal care (standard Canadian frequency). Prenatal appointments every four to six weeks until 30 weeks' gestation. After 30 weeks, visits every two to three weeks; after 36 weeks, visits every one to two weeks until delivery (9-17 appointments) (The Society of Obstetricians and Gynecologists of Canada, 1998).

1.6.10 Self-determination. [Indigenous] people have the right to take control over their own decisions as individuals and communities and to freely pursue their economic, social, and cultural development (Brascoupé, 2009; UN Office of the High Commissioner for Human Rights (OHCHR), 2013).

1.6.11 Trauma-informed care. The practise of understanding, recognizing, and responding to the effects of trauma and intergenerational trauma in the lives of patients (Torchalla 2014).

1.6.12 Two-Eyed Seeing. Incorporating the strengths of western and Indigenous knowledges to generate a deeper perspective. It provides a means of walking in two worlds: embracing the contribution of the holistic Indigenous view of health (which includes spiritual, emotional, physical & intellectual aspects) within the modern healthcare system to create greater health (Greenwood, 2015, Martin, 2012, Iwama, 2009).

1.7 Thesis Organization

This thesis is organized into 6 chapters. The introduction provides an overview of the subject, identifies the research problem, provides a glossary of terms, describes the purpose, paradigm and research question, as well as explaining the significance of the research, and reasons for my interest in the research. Chapter two is a review of the literature. Chapter three outlines the research design, data collection methods, data analysis, and ethics. Chapter four examines access to prenatal care with MCC midwives, including analysis of their clients' rates of prenatal care and other relevant statistical data. Chapter five examines the MCC midwifery model in relation to cultural safety to determine the quality of culturally safe practice the midwives provide. Lastly, chapter six applies the theory of Two-Eyed Seeing to the analysis of culturally safe healthcare, and includes a analysis of how the Truth and Reconciliation Commission of Canada's (TRC) calls to action (2015) can be honored by taking action on lessons learned from the from this research project.

Chapter 2: Literature Review

2.1 Introduction

For definitions of terms, see section 1.6 above.

Indigenous people in Canada experience inequitable access to healthcare services compared to the general population (Wilson et al., 2013; Martin, 2012). This includes their access to prenatal care. Research performed in Winnipeg has shown that Indigenous women from the inner city are far more likely to receive inadequate prenatal care than non-Indigenous women (Heaman et al., 2013; Knight et al., 2014). Inadequate prenatal care results in higher incidence of poor pregnancy outcomes for the mother and baby (Heaman et al., 2005, 2008; Knight et al, 2014). Since evidence shows that prenatal care can reduce health risks, Indigenous families benefit from focused interventions to create equity to access and to reduce barriers to accessing prenatal care (Heaman et al., 2005, 2015a).

The following is a literature review of a series of peer reviewed and grey literature, as well as other relevant sources. The articles were found by searching various keywords in the University of Winnipeg library website and Google Scholar. It consists of five sections. This first section is the introduction. The second, third, and fourth sections contain the main body of the literature review. They are organized into three broad themes that are derived from several smaller, interconnected themes drawn from existing related research. The first theme looks at the barriers and facilitators to access to healthcare, which stems from the subthemes: Marginalization of Indigenous people in the healthcare system and Inadequate prenatal care for urban Indigenous families. The second theme examines a path of decolonizing midwifery care, by examining the subthemes of Indigenous midwifery and Indigenous self-determination. The third explains the theoretical perspective of *Two-Eyed Seeing*, which will be applied to the MCC midwifery model (in the thesis) and two sub-themes: cultural safety, and trauma-informed care and harm-reduction. Similar studies are grouped under the same theme to emphasize the interrelation between them. The fifth and final section provides a summary of the work, with conclusions and highlights of the literature under review.

The literature map below (Figure 2.1) shows the how the major themes and subthemes are grouped together in the literature review.

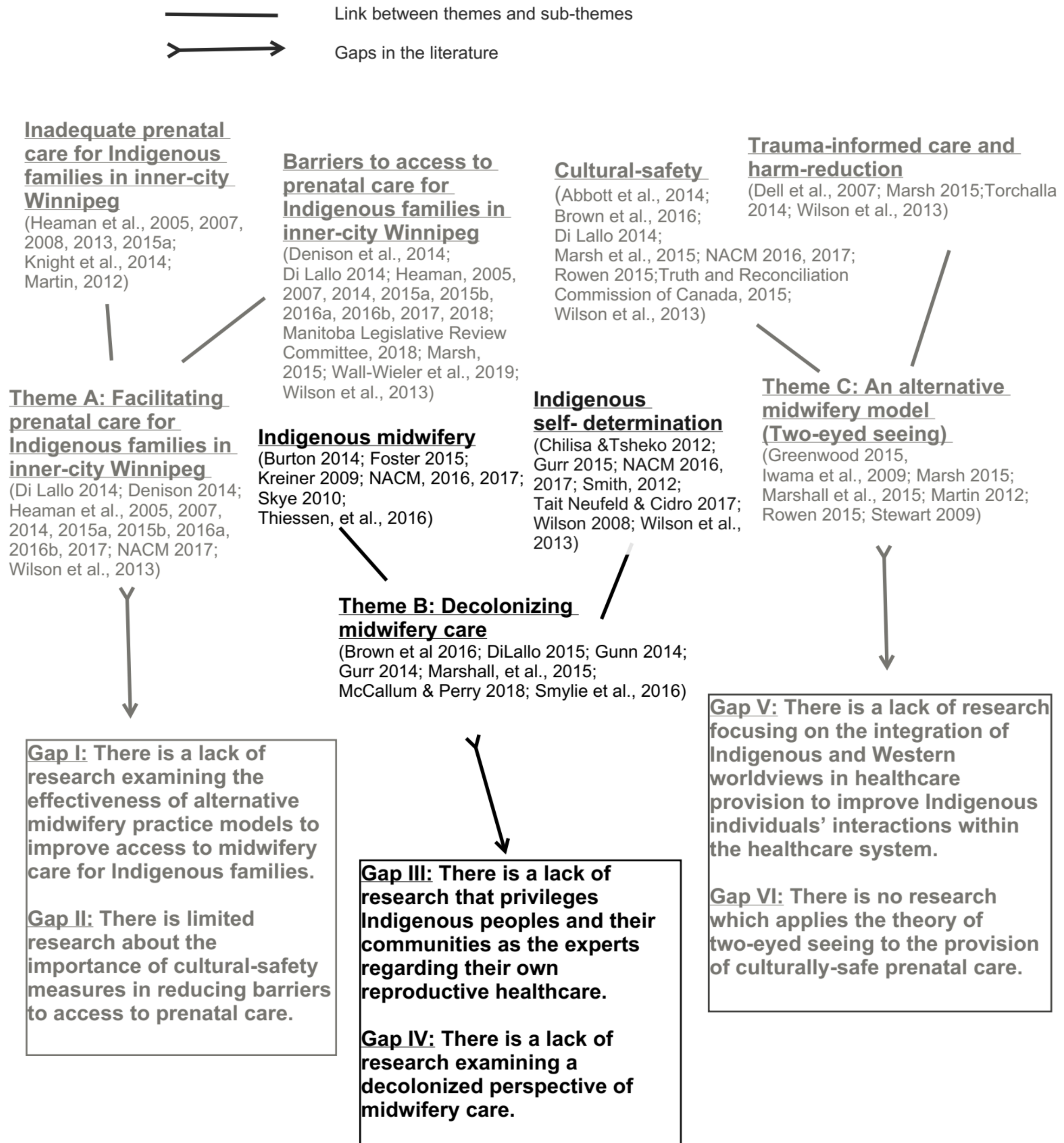

Figure 2.1. Literature map. Source: Self-compiled, J. Dawn Wiscombe, 2019.

2.2 Theme A: Facilitating Prenatal Care for Indigenous Families in Inner City Winnipeg

This theme is derived from two sub-themes: Marginalization of Indigenous people in the healthcare system (see 2.2.1) and Inadequate prenatal care for urban Indigenous families (see 2.2.2). There is also a concluding analysis of Theme A (see 2.2.3). These issues will be examined in such a way as to highlight the barriers and facilitators to access to healthcare and more specifically, prenatal care in pregnancy. This is the more empirical aspect of the literature review, as it holds the statistical data which makes this research noticeably important. For example, while in 2015 Canada ranked 10 in the United Nations Development Programme (UNDP) human development index (HDI), First Nations people rank 68 (Wilson et al., 2013). The HDI is a rating of the quality of life and human potential in a population (Wilson et al., 2013). This comparison starts to form a picture of the disparity that exists between Indigenous and non-Indigenous Canadians and how Indigenous peoples are marginalized overall.

2.2.1 . Inadequate prenatal care for Indigenous families in Winnipeg. The population of Indigenous people in Manitoba is significant and among the highest of all 10 provinces, making up 14% of the population of the province (Heaman et al., 2005). Since my research is about prenatal care, I will concentrate on the prenatal care rates for these families. A study done by Heaman et al. (2005), found that 15.7% of the Indigenous women in her study received inadequate prenatal care compared to the 3.6% who were non-Indigenous. She found that a significant number of women who receive inadequate prenatal care had low income (<$20 000) and high perceived stress levels (Heaman et al., 2005). After controlling for race/ ethnicity, Heaman's (2005) study found that there were no significant predictors of inadequate prenatal care that were specific to Indigenous people, but that being Indigenous was a risk factor on its own. Heaman et al., examine this data again in a 2007 study about social inequalities in access to prenatal care, finding that the highest rates of inadequate care were in northern Manitoba and the inner city of Winnipeg, where only 8.4% of the women in the entire study lived (Heaman et al., 2005, 2007). This highlights the value of examining approaches to prenatal care that facilitate access to care for Indigenous families.

2.2.2 Barriers to access to prenatal care for Indigenous families in Winnipeg's inner city. Heaman et al., (2014) later do another study to assess the barriers, motivators and facilitators of prenatal care utilization in Winnipeg concluding that,

> Several psychosocial, attitudinal, economic and structural barriers increased the likelihood of inadequate prenatal care for women living in socioeconomically disadvantaged neighborhoods. Removing barriers to prenatal care and capitalizing on factors that motivate and facilitate women to seek prenatal care despite the challenges of their personal circumstances may help improve use of prenatal care by inner-city women" (p. 1).

The psychosocial, attitudinal, economic, and structural characteristics that Heaman uncovers depict some of the experiences that contribute to Indigenous people's marginalization in the healthcare system. These socioeconomic circumstances stem from historical abuses under colonization (Wilson et al., 2013; Di Lallo, 2014; Marsh, 2015). For example, the residential school system, forced relocation, involuntary sterilization, forced adoption, religious conversion, and enfranchisement are a few examples of government policy that have caused harm to Indigenous individuals, families, and communities (Wilson et al., 2013). It is important to include here that despite the closing of the last federally supported residential schools in in the 1990's, Indigenous children continue to be separated from their families at an alarming rate (Manitoba Legislative Review Committee, 2018; Palmeter, 2019). There is a disproportionately high percentage of Indigenous children living in the child-welfare state in Canada. Among the Canadian provinces, Manitoba has the highest rate of children in care, with almost 90 per cent of those children being Indigenous (Manitoba Legislative Review Committee, 2018). This continued separation of families mirrors the atrocities that generations Indigenous people have endured in Canada through the residential school system and the 60's scoop, perpetuating resistance to colonial systems, and serving as a deterrent to accessing prenatal care (Denison, Varcoe, & Browne, 2014; Wall-Wieler et al., 2019). In fact, such historical, continued, and intergenerational post-traumatic stress has resulted in the lack of participation by Indigenous people "in any intuitional environment, including healthcare" (Di Lallo, 2014, p. 41). This lack of trust is a barrier in access to care, and therefore it is essential that midwives are able to provide trauma-informed care and practice cultural safety when serving Indigenous families (see Theme C) if they intend to reduce barriers in access to prenatal care for the families they serve.

From September 2012 to March 2015 Heaman (Heaman, 2016; Heaman & Tjayden, 2017; Thiessen, Heaman, Mignone, Martens, & Robinson, 2016) led a research project called the *Partners in Inner-city Integrated Prenatal Care (PIIPC) Project*, which sought to address the barriers to inner city people accessing prenatal care by providing them with resource incentives

such as transportation tokens and chits, flexible scheduling, and prenatal care coordinated among providers and programs (Heaman et al., 2016b). It is of note that 35% of PIIPC participants were cared for by inner city midwives in their pregnancies (Heaman et al., 2016a). This project was successful at improving access to prenatal care, as 74.6% of PIIPC clients had adequate prenatal care versus a comparison group (7.4%) of similar socio-economic and cultural backgrounds (Heaman et al., 2016b). The PIIPC project was successful in improving equity in access to prenatal care (Heaman et al., 2016b). Heaman et al., acknowledge that at least 60% of PIIPC participants were Indigenous (Heaman et al., 2016a), but while they argue for the above noted incentives to improve access to prenatal care, they does not examine cultural interventions or a culturally safe approach to prenatal care as a means to Indigenous increase engagement in prenatal care.

2.2.3 Concluding analysis of Theme A. As an added facilitator to participation in prenatal care, my research seeks to apply the concept of cultural safety to midwifery care recipients living in the same community areas as the PIIPC Project to see if access to prenatal care is further enabled through a more Indigenous self-determining approach to healthcare, that is, a model of care shaped by feedback from the local community, specifically the recipients of that care (see Themes B and C).

A study done by Di Lallo (2014) has evaluated a culture-based prenatal care program in Wetaskiwin, Alberta, called the Aboriginal Prenatal Wellness Program (APWP). This program was designed to serve Indigenous women who were not accessing the healthcare system for prenatal care. Like the PIIPC Project, the APWP improved access to prenatal care by providing coordinated care and incentives to attend for care and combined this with training for the healthcare providers in cultural traditions and the impact of historical events on Indigenous people's lives (Di Lallo, 2014). Di Lallo (2014) quotes the 2006 Royal Commission on Aboriginal Peoples as saying, "Aboriginal women who are pregnant need culture-based prenatal outreach and support programs, designed to address their particular situation and vulnerabilities" (p. 40). Di Lallo saw a 6% drop in rates of no or limited prenatal care in the five years since the inception of the APWP, and the women expressed satisfaction with the care they received. One of the items on the APWP wish-list is to incorporate midwifery care into their team (Di Lallo, 2014). Heaman (2005, 2015a, 2015b, 2017) also recommends increased access to midwifery care for the people in her studies. Based on these recommendations, it seems necessary to fill in the

gap in the literature regarding the provision of culturally safe midwifery care to improve Indigenous women's access to and satisfaction with midwifery care (see Theme C). Since cultural-based prenatal care programs have been found to be successful, and since Indigenous midwives being available as the ideal care providers for Indigenous families in Winnipeg (NACM, 2016), this research seeks to examine cultural safety as an added facilitator to prenatal care.

The evidence presented here suggests that Indigenous families in Winnipeg's inner city benefit from facilitated access to prenatal care, and that midwives have potential to play a valuable role in caring for Indigenous families. The literature highlights two gaps. First, there is a lack of research examining the effectiveness of alternative midwifery practice models to improve access to midwifery care for Indigenous families. Second, there is limited research about the importance of cultural safety measures in reducing barriers to access to prenatal care. This research seeks to address these gaps by applying them to MCC Midwives and the community they serve, and looks to answer the following question: Does the MCC midwifery model facilitate prenatal care engagement for Indigenous families at risk of receiving inadequate prenatal care?

2.3 Theme B: Decolonizing Midwifery Care

Decolonizing healthcare means restoring the healing pathways that have been systematically withheld from Indigenous peoples. McCallum and Perry (2018) provide a historical account of how, from the 1920's to the 1960s, practices of racial segregation of Indigenous and non-Indigenous people in Manitoba and that it "[stemmed] from the belief that, people of Indigenous ancestry were racially susceptible to disease (p.80)." This lead to systematically imposed health disparities between Indigenous people and setter society (McCallum & Perry, 2018). For fear of spreading diseases to the settlers, the Canadian federal government created, "Indian hospitals," which, "offered inferior treatment and were understaffed" (McCallum & Perry, 2018). In this way, colonial ideologies in the realm of healthcare served to prevent Indigenous people from accessing good healthcare, while prioritizing the health of the settlers. McCallum and Perry conclude that,

> The final insult of colonization is that the myths of our settler society hold that ill health and early deaths of Indigenous people are their own fault, bearing no relation to the historical context of social, economic, and cultural oppression stemming from

> colonialism, white supremacy, and racism right here at home (McCallum & Perry, 2018, p. 102).

This poignant statement reveals something important – these effects come from colonial forces, not from the ways Indigenous people have responded to those forces. Therefore, when Indigenous people have the opportunity experience healthcare differently, in ways not guided by mainstream ideologies alone, they have different outcomes (Brown, Middleton, Fereday, & Pincombe, 2016; Gunn, 2014; Gurr, 2014; Marshall, Marshall, & Bartlett, 2015; Smylie et al., 2016; Tasnim et al., 2013). This is where decolonization and healthcare intersect.

The following theme (*theme B*), looks at the decolonization of midwifery care as a colonized healthcare profession. It is derived from two sub-themes: Indigenous midwifery (2.3.1) and Self-determination (2.3.2). These sub-themes come from literature that represents the current landscape of Indigenous midwifery in Canada, highlighting the right of Indigenous people to exercise self-determination within healthcare. These perspectives enable a lens through which to examine the dominant midwifery profession and analyze how it can be adapted to suit the culture of the Indigenous families in Winnipeg's inner city. This relates back to the first research question from *Theme A*, as it is intended to examine access to prenatal care for Indigenous families. This set of themes highlights the valuable work of Indigenous midwives as irreplaceable players in the provision of care for Indigenous families, and leads to the argument that contemporary approaches to midwifery services in Canada are rooted in colonial power structures, which have limited the profession and restricted Indigenous midwives from providing care to their own people and communities. The evidence suggests that in order to reach Indigenous families effectively, the midwifery model must be decolonized by the maintenance of space for self-determination among Indigenous midwives, families and communities.

2.3.1 Indigenous midwifery. The National Aboriginal Counsel of Midwives (NACM), a diverse group of approximately ninety-five Indigenous midwives, midwife Elders, and student midwives from all regions of Canada, identifies Indigenous midwives as the best maternity care providers for Indigenous communities, as "Aboriginal midwifery models honour Indigenous people, languages and cultures as well as holding birth up as a sacred event" (NACM 2016, p. 3). Contemporary Indigenous midwives base their practices on traditional medical knowledge and practices of maternal and child health and complement it with the practice of modern medicine

(Skye, 2010). Currently, there are eleven Canadian midwifery practices dedicated to providing care in Indigenous communities and approximately ninety Indigenous midwives (NACM, 2016). According to Oakley and Houd in Skye (2010), "the medicalization of childbirth was a process that systematically excluded issues of race, gender, class, and culture, and conclude that "the medicalization of the birthing process served to redefine pregnancy as an illness and the practice of midwifery as incompetent" (Skye, 2010). Along with this came the devaluing of the respected roles of Indigenous women and Indigenous midwives, who have been dishonoured and misrepresented by centuries of colonial influence and assimilation policies (Cull 2006; Shahram 2017; Skye 2010; National Inquiry into Missing and Murdered Indigenous Women and Girls 2019). This partly explains why little can be found in the literature about Indigenous midwives who were practicing in Manitoba prior to the twentieth century. There is, however, record of a Metis midwife named Jane Monkman-Cummings (Figure 2.1), who was born in 1822. She was a renowned midwife and nurse, who ran a convalescent home for patients and new mothers called *The Angel's Retreat*, and was known as the, "Florence Nightingale of the West" (Hall 2019; Westbourne-Longbourne History 1985). She was in active practice until the early 1900's and was the first Manitoba nurse awarded papers on merits of her experience (Westbourne-Longbourne History, 1985). Jane Monkman-Cummings provides evidence that midwives, and specifically, Indigenous midwives were, in fact, competent.

Figure 2.1, Jane Monkman-Cummings (1822-1908), Indigenous midwife (Hall 2019; Westbourne-Longbourne History 1985, 234)

For much of the twentieth century midwifery was unregulated in Canada, thus Indigenous midwives and non-Indigenous midwives were both forced to practice in secret or to abandon their role as midwives. This, along with policies which removed birth from Indigenous communities, led to a struggle to maintain traditional knowledge surrounding pregnancy and reproduction (Skye, 2010, Cidro, Doenmez, Phanlouvong, & Fontaine, 2018).

Indigenous midwives fought to preserve or regain their role in their communities, and for an exemption clause in Ontario (the first province to regulate midwifery) in 1991. They won the exception clause in the development of the Midwifery Act, which achieved a law that Indigenous midwives could practice midwifery freely in the province (NACM, 2016). Manitoba does not have such a clause and has ongoing issues with its midwifery education program (Thiessen et al., 2016), hence producing barriers to Indigenous people becoming midwives in the province.

While midwifery is now a more accepted as a part of the Canadian healthcare system in many regions, there is still a significant lack of midwives in general due to systematic barriers, such as the capping of hospital privileges and limits placed on funding positions for midwives (Skye, 2010), and furthermore there is an even more limited number of Indigenous midwives to provide culturally safe care to Indigenous families (NACM, 2016; Thiessen, 2016).

While the movement to regulate midwifery has spread across the country, it came primarily out the feminist homebirth advocacy of educated, white, middle-class women and their families (Burton, 2014; Kreiner, 2009), so the regulated midwifery model has been limited in meeting the needs of a diverse population due to its focus on white, middle class families. It is of note that despite these limitations, there are many midwives actively working to serve diverse populations (Burton, 2014; Foster, 2015; NACM, 2016), as are MCC Midwives. The obstacles to Indigenous people becoming midwives indicates that contemporary approaches to midwifery services in Canada are rooted in colonial power structures which have limited the profession.

2.3.2 Indigenous self-determination. Colonial power structures and systemic barriers within the healthcare system have held Indigenous midwifery back. While the number of Indigenous midwives is constricted by the barriers place in their way, Indigenous midwives are fervently working to extend themselves to Indigenous communities and are active on various committees locally, regionally, provincially, nationally, and internationally (NACM, 2016). They work to challenge assimilative ideologies and assert their Indigeneity and right to self-determination. They advocate for Indigenous midwifery, Indigenous families, and Indigenous

communities. They perform research and provide policy recommendations intended to improve the provision of midwifery services on First Nation reserves, increase the number of Indigenous midwives available to serve Indigenous communities, eliminate or minimize the limits to access to midwifery care, and encourage governments and decision-making bodies to work together to eliminate institutional barriers (NACM, 2016). These policy recommendations represent Indigenous midwifery's assertions of self-determination ‑ NACM knows what it needs. NACM emphasises that, "unless systemic issues of racism and colonization are addressed, Indigenous people will continue to experience barriers to adequate health care" (NACM, 2017, p. 9). Considering this, NACM has made suggestions of ways to work from within the healthcare system to address Indigenous people's inadequate access to care. While NACM may not be able to affect all the changes it seeks in a short time, it has made steps to help build bridges to its peoples along the way. Its recommendations include: Indigenous-led health services, initiatives to increase the number of indigenous health care providers, Indigenous patient advocates, cultural safety training for health care providers, and Indigenous-specific programs within mainstream health organizations in Indigenous communities to support Indigenous families. Indigenous midwives in Canada and abroad are making strides to assert themselves, and the work of Indigenous midwives has empowered Indigenous families, providing them with greater control over their health and wellness at the community level (Gurr, 2015, NACM, 2017).

2.3.3 Concluding analysis of theme B. Local and national research has suggested increased midwifery involvement for facilitating access to care for Indigenous women (DiLallo, 2015; Gurr, 2015; Heaman et al., 2015a). For this strategy to be most effective, midwives must practice cultural safety and adopt harm-reduction and trauma-informed approaches (See theme C). By doing these things, midwives can create space for their Indigenous clients to exercise self-determination, by respecting and supporting their right to choose what works for themselves and their families. Midwives caring for Indigenous families cannot separate Indigenous people from their lived experiences and must take into consideration the intersecting oppressions they face because of colonization and the ongoing colonial influences in their lives. Like any other midwifery consumer, Indigenous midwifery clients should not be bystanders in the care they receive. Instead, the evidence suggests that midwives caring for Indigenous families should adapt the way they practice, ensuring that they protect their clients' right to informed choice and respect their right to choose what they will do with their bodies and their families. The evidence

presented here suggests that midwifery care moves toward decolonization when Indigenous self-determination is honoured within the profession, bot in practice and politically. The evidence suggests that by ensuring this approach, the midwifery profession will be enabled to address the needs of Indigenous families in an empowering, respectful, and appropriate way. This theory will be explored and examined further in this research and applied to the midwifery profession in a way that seeks to decolonize it.

It is intended that a decolonized perspective of midwifery care will facilitate access to prenatal care for Indigenous families and improve their satisfaction with the care they receive. There are two gaps in this area of the research. First, there is a lack of research that privileges Indigenous peoples and their communities as the experts regarding their own reproductive healthcare. Second, there is a lack of research examining a decolonized perspective of midwifery care. Exploring this theme is intended to fill those gaps and answer my second research question which is: What Does a Culturally Safe Midwifery Model Look Like in Inner City Winnipeg?

2.4 Theme C: An Alternative Midwifery Model (Two-Eyed Seeing)

This theme is derived from two sub-themes: a) Cultural-safety and b) Trauma-informed care and harm-reduction. These sub-themes come from literature about practices that ease the tension between conventional and alternative approaches to healthcare involving Indigenous people. This relates back to Themes A and B, as it is intended to guide midwifery practice within the greater healthcare system to support the health and well-being of Indigenous families and supporting them in navigating the complex psycho-social dynamics they face in their lives.

2.4.1 Cultural safety. Cultural safety is defined as the application of cultural understanding for the transformation of relationships between healthcare providers and their patients such that the patient's voice takes a predominant role. The principal of cultural safety was first developed in New Zealand by Irihapeti Merenia Ramsden as a principal in midwifery and nursing practice. According to Papps and Ramsden (1996) in Greenwood, Lindsay, King, & Loewen (2017),

> The concept of cultural safety arose from the colonial context of New Zealand society. In response to the poor health status of Maori, the indigenous people of New Zealand, and their insistence that service delivery change profoundly, nursing has begun a process of self-examination and change in nursing education, prompted by Maori nurses (p. 182).

In Canada, culturally safe healthcare has been identified as a facilitator to prenatal care for Indigenous women, as well as leading to more trusting and effective relationships between

Indigenous women and their healthcare providers (Abbott et al., 2014; Brown, et al., 2016; Di Lallo, 2014; NACM , 2016; Wilson et al., 2013). Abbott et al. (2014) argue that an appropriate understanding of Indigeneity is essential to supporting Indigenous patients in a culturally safe way. Health care providers' awareness of the programs and supports available to Indigenous people can help decrease their health disadvantage (Abbott et al., 2014), but such services have been underused by Indigenous people (Marsh et al., 2015). Knowledge about Indigenous history, culture, health and health systems is essential to understanding how to approach care when serving Indigenous people (Abbott 2014, Wilson et al., 2013, Rowen 2015, Truth and Reconciliation Commission of Canada, 2015). Abbott et al. (2014) recommend that care providers receive mentorship and advice from Indigenous cultural mentors. This is relevant to this research project in that it provides knowledge which can be transferred to midwifery practice. Non-Indigenous midwives can look to Indigenous midwives as mentors and for guidance in providing culturally safe care.

2.4.2 Trauma-informed care and harm-reduction. Providing culturally safe care also involves understanding that substance use and addiction are often coping mechanisms used to deal with the pain of intergenerational trauma (Abbott et al., 2014; Torchalla et al., 2014; Wilson et al., 2013). This is known as a trauma-informed approach to healthcare and it has been shown to create a trusting healthcare environment (Torchalla et al., 2014). Marsh et al. (2015) refer to intergenerational trauma, a concept that originated from research into the experiences of Holocaust survivors and their families, as "the cumulative emotional and psychological harm experienced throughout an individual's lifespan and through subsequent generations" (p. 3). She gives other names for it, including historical trauma, cumulative trauma, and soul wound (Marsh et al., 2015).

Providing culturally safe care also involves understanding that substance use and addiction are often coping mechanisms used to deal with the pain of intergenerational trauma. Marsh et al. refer to intergenerational trauma as, "to the cumulative emotional and psychological harm experienced throughout an individual's lifespan and through subsequent generations". When providing healthcare for people experiencing such trauma, "it is also necessary to shift the focus from the individual to include environmental, social, economic and policy interventions… and from issues of drug use and reduction of drug-related harms to include issues of gendered vulnerabilities and human rights" (p. 9). Dell and Lyons and the Canadian Centre on substance

abuse define harm-reduction as, "'a health-centred approach that seeks to reduce the health and social harms associated with alcohol and drug use, without necessarily requiring that users abstain. Harm reduction is a non-judgmental response that meets users 'where they are' with regard to their substance use...' (Thomas, p. 1)… Essential to a harm reduction approach is that it offers users a choice of how they will minimize harms to themselves" (Dell et al., 2007). When serving families impacted by trauma and addictions it is important that midwives be willing to allow their clients to make their own choices about what they do with their bodies, hence facilitating self-determination (see theme B) within healthcare. Non-Indigenous midwives serving this population are required to expand their knowledge base to include an understanding of the worldviews some Indigenous people will have as a result of trauma.

2.4.3 Concluding analysis of theme C. This research will approach the issues of cultural safety, harm reduction and trauma-informed care through the perspective of Two-Eyed Seeing. Two-eyed seeing is an Indigenous theoretical perspective which was originally developed by Mi'kmaq Elder Albert Marshal as a means of incorporating the strengths of Western and Indigenous knowledges to generate a deeper perspective (Iwama et al., 2009; Marshall et al., 2015; Martin, 2012). This approach makes way for healthcare providers to maintain two perspectives at once, both embracing the contribution of the holistic Indigenous view of health (Includes spiritual, emotional, physical & intellectual well being of the individual and community) within the modern healthcare system to create greater health (Marshall et al., 2015; Martin, 2012). As applied to this research, this theory holds that one would expect the implementation and integration of cultural safety measures to have a meaningful and positive influence on the experiences MCC Midwives' Indigenous clients because the whole person, family and community would be addressed in their experience of midwifery care, hence benefitting their health in a holistic manner. Two-Eyed Seeing has been used to examine the research literature about addictions to, "build an overall understanding of culture as an intervention in healing Indigenous people from addictions" (Rowan et al., 2015). Evidence has found Two-Eyed Seeing to be an effective approach to providing culturally safe, trauma-informed addictions treatment (Marsh et al., 2015). This theoretical perspective will be used in this paper as a tool for creating a decolonizing lens though which to look at the midwifery profession, and to sensitize midwifery politics to the needs of Indigenous families. It is expected that by understanding more about the difficulties influencing Indigenous peoples' lives, through

practicing Two-Eyed Seeing, midwives may be aided in decolonizing their practice in such a way that they are enabled to address the needs of Indigenous families in more empowering, respectful, and appropriate ways.

There are two gaps in the literature. First, there is a lack of research focusing on the integration of Indigenous and Western worldviews in healthcare provision to improve Indigenous individuals' interactions within the healthcare system in general. Second, there is no research which applies the theory of Two-Eyed Seeing to the provision of culturally safe prenatal care. Stewart (2009) argues that Indigenous health research must come from Indigenous values and philosophies and that Indigenous ways of knowing can form new understandings in health research related to Indigenous peoples. I seek to exemplify this concept with my research on client experiences of the MCC Midwifery model of care. Exploring this set of themes in this way is intended to fill those gaps by valuing the worldviews and experiences of MCC's Indigenous clients as guideposts, and answer the third research question which is: How can healthcare providers working with Indigenous people engage Two-Eyed Seeing on the path to cultural safety?

2.5 Summary of literature review

MCC Midwives strive toward culturally safe practice in response to the complex health and psycho-social needs of the Indigenous families of inner-city Winnipeg (see Appendix A; Mount Carmel Clinic Midwives, 2015). Implementation of culturally safe practice has been shown to create more trusting and effective relationships between Indigenous people and their healthcare providers (Abbott et al., 2014; Di Lallo, 2014; Wilson et al., 2013). This research will explore the experiences of local Indigenous families who have received prenatal care from MCC Midwives, and it will also compare MCC midwives' rates of prenatal care to those of the PIIPC Project, as well as other local prenatal care statistics. Two-Eyed Seeing will be employed as a theoretical tool for deconstructing the colonial worldview which dominates the healthcare system and causes inequity in access to healthcare for Indigenous families. Using a Two-Eyed Seeing approach, MCC midwives are enabled to further tailor their model of care in a way that is more appropriate for local Indigenous clients. NACM represents an organization that is engaging in Two-Eyed Seeing, as they are applying an Indigenous worldview to the existing Western healthcare system. The knowledge of Indigenous midwives is beneficial in this way also, as non-Indigenous midwives serving Indigenous populations can look to NACM for guidance - as a

cultural mentor - on how to support the families in their care from an Indigenous midwifery point of view.

This literature review highlights six gaps which will be explored through examining three research questions. The literature review of theme A finds a lack of research examining the effectiveness of alternative midwifery practice models to improve access to midwifery care for Indigenous families, as well as limited research about the importance of cultural safety in reducing barriers to access to prenatal care. These gaps are explored by building an understanding of how MCC midwives provide accessible prenatal care and seeks for find out if the MCC midwifery model encourages Indigenous families to participate in prenatal care. The literature reviewed in theme B shows that there is a lack of research that privileges Indigenous people and their communities as the experts regarding their own reproductive healthcare, and a lack of research examining a decolonized perspective of midwifery care. These gaps will be addressed by examining a the MCC midwifery model to understand the parameters which define whether it is a culturally safe model of care and if culturally safe prenatal care makes midwifery care more accessible and appropriate for the indigenous families MCC midwives serve. The final two gaps in the literature review are found in theme C which finds that there is a lack of research focusing on the integration of Indigenous and Western worldviews in healthcare provision and no research which applies the theory of Two-Eyed Seeing to the provision of prenatal care. These gaps will be addressed by applying a Two-Eyed Seeing lens to the reported prenatal care experiences of MCC midwifery clients to gain insight into what qualities the clients consider supportive versus qualities they consider obstructive.

Chapter 3: Research Design, Methods and Approach

3.1 Research Framework

3.1.1 Multi-paradigmatic worldview. This research project is multi-paradigmatic, integrating pragmatic and Indigenous paradigms. Held (2019) argues, a "multiparadigmatic space is coproduced by Western and Indigenous scholars with the aspiration of true and full decolonization, understood as a mutual endeavor with an unpredictable outcome" (p.2). Using multiple paradigms came about after discovering that there was an intersection where the two paradigms engaged each in a practical way, such that effective data collection could occur using multiple methods, in a process which places great value on Indigenous and decolonial perspectives. Held (2019) refers to this as "decolonizing research," meaning that while the research process is based on a Western paradigm, it is grounded in an Indigenous paradigm which continuously considers and validates Indigenous worldviews and knowledge throughout the research process.

On one hand, this research uses a pragmatic paradigm, in that it is problem centered, real world oriented, pluralistic and it considers the consequences of the research (Creswell & Poth, 2018). Rather than being anecdotal or theoretical, it places an emphasis on a specific real-world problem and its solutions. According to Cresswell & Poth (2018), "For the mixed methods researcher, pragmatism opens the door to multiple methods, different worldviews, and different assumptions, as well as different forms of data collection and analysis" (p. 11). This description fits well with the fact that an Indigenous paradigm is integrated into the pragmatic paradigm to provide the best understanding of the research problem, since the research problem is one which concerns Indigenous people.

On the other hand, Indigenous research paradigms are essential to conducting meaningful research involving Indigenous peoples because they ensure that the research is grounded in Indigenous worldviews. According to Cora Weber-Pillwax (2001), "Indigenous research requires a context that is consciously considered and purposefully incorporated into the research by the researcher" (p.166). Therefore, an Indigenous research paradigm will inform this research (Chilisa, 2012; Weber-Pillwax, 2001; Wilson, 2008). As a non-Indigenous researcher, using Indigenous research methodologies, (as is the case with this research project) one must be cognizant of both Indigenous worldviews and of Euro-Western worldviews (Herising, 2005). Those performing Indigenous research need to have the ability to critically examine Western

research methods, while also developing methods that will work within Indigenous paradigms (Herising, 2005).

The purpose of this multi-paradigmatic approach to this research project is intended to create a transformative potential (Herising, 2005) for both Indigenous recipients of midwifery care – who inform the research on what is working well and what needs improvement, and for the midwives and other healthcare providers to better understand the needs of the Indigenous people in their care. In this research project, the Indigenous paradigm encompasses each element of the research, so that Indigenous knowledge, worldviews and ways of knowing were considered throughout the research process. This is done to maintain what Wilson (2008) refers to as "relational accountability" (p. 97), meaning "that the methodology needs to be based in a community context (be relational) and has to demonstrate respect, reciprocity and responsibility (be accountable as it is put into action)" (Wilson, 2008, p.97). This is what this research project intends to do.

3.1.3 Indigenous cultural mentors. According to (Abbott et al., 2014), "Despite the complexities of what is necessarily lifelong learning around cultural competence, cultural educators and mentors can help [healthcare providers] avoid communication pitfalls and provide more culturally competent care" (p. 58). For this reason, and Elder and two midwife members of the NACM were approached, requesting their guidance and participation in this research as Indigenous cultural mentors to the researcher.

3.1.3.1 Consulting with an Elder. I talked with a local Cree Elder, Lorraine Cameron Munro regarding about my research throughout the process. Lorraine is a retired nurse, which made her an especially good fit for this project. She agreed to be a mentor and I gave her tobacco in exchange. We maintained a friendly relationship as the research progressed, checking in with each other periodically throughout the research and writing process.

3.1.3.2 Consulting with Indigenous midwives. Two Indigenous midwives were invited to participate in the study. After the preliminary analysis of the interviews was complete, they were asked to review the analysis and provide their feedback, which was then incorporated into the final analysis.

3.1.4 The client-midwife relationship. I find myself in two roles – that of the researcher and that of a midwife working at the clinic being researched. I am aware of the concern that this could be a conflict of interest.

Midwife means, 'with-woman.' When considering the appropriateness of the seeming midwife-researcher dichotomy, it is necessary to maintain that midwifery philosophy is grounded in a partnership model between clients and their midwives (Thompson, 2004). This relationship is one based on a power-sharing dynamic. Thompson breaks this power-sharing model into three parts. First, she describes a power-dynamic that is harmful. She calls this "power-over" (p. 71), which is exploitative and manipulative. Next, she describes "power-for" (p. 81) and "power-with" models (p. 82). She calls these nutritive (or nurturing, protective and promoting growth) and integrative (or promoting mutual participation, power-shifting/ sharing) respectively. This is how midwives begin to manifest the types of relationships they will have with their clients from their earliest days of training. It is this element of midwifery care that makes it particularly unique among the medical professions.

As a person so deeply involved in this research process, I have a responsibility to maintain a heightened sense of accountability to my clients when interacting with them as a researcher and in representing them and the work of my midwife colleagues and I in the research. I have a responsibility to protect them in continuity with my role as a midwife, yet in a new way for all parties. I feel deeply reflective of being a non-Indigenous researcher doing research about a group of vulnerable Indigenous families, which is why I chose to ground this research in an Indigenous research paradigm, hoping that I can approach the research in a manner which serves them in a good way. While being an outsider as a researcher is valued in a conventional approach to research, it does not necessarily fit with Indigenous research paradigm, which actually promotes the building relationships and the sharing of stories as a part of the research process (Assembly of First Nations., 2007; Chilisa, 2012; Smith, 2012; Wilson, 2008). Indigenous research, "moves away from conceiving the researched as participants to seeing them as co-researchers… [such that] an ethical framework emerges that emphasizes accountable responsibilities of researchers and respectful relationships between the researchers and the researched" (Chilisa & Tsheko, 2014, p. 223) In this way an Indigenous research paradigm and midwifery philosophy are closely aligned.

I understood that in my position, I risked presenting a biased interpretation of the results and that I could feel pressured to report favorably about the results. It is for this reason that I choose to approach this project as a participatory research process (Wilson et al., 2013), where critique was welcome and exposure of the weaknesses and limitations of the MCC Midwifery

model is encouraged. While the research may demonstrate that the MCC Midwifery model is effective in some ways, the model can most certainly be improved.

It was very important that I not ask leading questions when interviewing participants and I had to be mindful of not phrasing the questions to illicit a favorable response. For example, rather than asking, “Did your midwives treat you with respect?” I asked, “How did your midwives treat you?” to allow the participants to come up with their own adjectives to describe their experiences.

I do not see the conclusion of this research as the final word of the value of MCC Midwives and the level of satisfaction of their clients, but rather as a place to grow from. The MCC Midwifery model evolved to be the way it is in response to the needs of the families that they serve, but up until this point, the clients have never given them the opportunity to provide direct, meaningful feedback. This research project is a step toward improving the relationship between MCC Midwives and the families they serve by listening to their stories and continuing to adapt our practice to reflect their values and visions of how their care can be enhanced. This approach intends to centre the participants as producers of knowledge rather than minimizing them as subjects within the research (Chilisa, 2012; Wilson et al., 2013; Wilson, 2008). It respects the lived experiences of the people involved, and the lived experiences of their communities.

3.3 Data Analysis Approach

3.3.1 Data collection methods

This research design consists of multiple methids (Leech & Onwuegbuzie, 2009). It focuses primarily on the qualitative data of interviews, but also applies statistical analysis concurrently to add clarity and to determine MCC midwives prenatal care rates. Data collection methods included a systematic literature review, eleven semi-structured interviews, and compiling statistics from Mount Carmel Clinic Midwives’ caseload from January through December, 2018. It is a case study of midwifery care in Winnipeg’s inner city. Since previous research in Winnipeg and Manitoba is mostly about rates of inadequate prenatal care, and since that the lowest rates of prenatal care in the province are in the same inner city community where the majority of MCC midwifery clients live (Heaman & Manitoba Centre for Health Policy., 2013), it is logical to follow up on that data by examining culturally safe midwifery care as an added and unexamined facilitator to access to prenatal care in the community. This research is

intended to focus on Indigenous families' experiences of the prenatal care model that MCC midwives provide. It consists of interviews with eleven Indigenous families. This approach serves to highlight the knowledge and strengths found in the perspectives that these families hold. Rather then focusing on their deficiencies, as is often the case (Tait Neufeld & Cidro, 2017), this research will seek to challenge the dominant narrative to shed light on what is present underneath the statistical surface, to tell a deeper story.

3.3.2 Research questions. Each of the research objectives will be answered with an associated data collection approach and purpose. Below are each of the research questions and their respective data collection approaches.

3.3.1 Analysis of interviews. The analysis of the interviews focuses on the perspectives of eleven Indigenous families who had prenatal care with MCC midwives. Their views on the MCC midwifery prenatal care model are evaluated responses from eleven audio recorded 30 to 60-minute interviews. One of the eleven chose not to be audio recorded, so the interview was recorded manually.

The first step was planning for the interview questions. The questions were based on the three research objectives of this project which arose from the preceding literature review (Chapter 2). Twenty-nine interview questions were finalized.

To assess the needs of the families in the area, most of whom are Indigenous, former and current clients of MCC Midwives were invited as participants in the study. Posters were posted at the MCC Midwifery clinic and a sign-up sheet was available to interested participants. Three speakers were recruited when I visited The Mothering Project (MIK) to let them know about the recruitment. The others were recruited from the midwifery clinic. Fifteen people signed up to me interviewed, buy only eleven speakers could be contacted for an interview. Those meeting the following criteria were accepted for interviews:

- Former or current Indigenous MCC Midwifery clients
- Any age, with parental consent if under 18 years of age
- Availability
- Agree to be interviewed

Participants had the option of being interviewed at MCC or elsewhere. Eight chose to do their interview at MCC and three chose to do it at home. The purpose of providing choice of

interview location, as well as other choices speakers were given, was to ensure that the speakers had flexibility and power.

After the interviews were performed, they were transcribed, and then a thematic analysis of each interview was performed manually and using the computer software, *Nvivo 12*. More than thirty themes were found among the interview transcripts. These were then grouped into similar and other related themes, which were finalized into seven major themes, each with several associated subthemes. Next these themes and subthemes were put into spreadsheet charts, which were manually analysed to find what the speakers had to say about the major themes and subthemes. These themes will be examined in this document. The analysis primarily looks for similar and divergent perspectives, highlighting the strongest of these, and looking at where the speakers agreed and disagreed regarding different aspects of their experiences of prenatal care with MCC Midwives. Other salient points are examined in contrast to each other, to provide context, and show added, important, and related information that arose from the interviews.

Even though they are limited, negative sentiments and areas of divergence should be given heightened attention. Considering the interviewer was one of the speakers' midwives, the negative sentiments expressed by fewer people, may be more significant than they appear, as the speakers may have held back on expressing such things to the person who was their care provider, and may be again. Also, given the small number of participants, negative sentiments and areas of divergence may have been more substantial if there were additional participants.

The participants are referred to as speakers from here on in this paper in order to elevate them from the position of subjects of research to storytellers, hence honoring them for their insight as local Indigenous people, who are knowledgeable about themselves and the MCC midwifery model of care (Chilisa, 2012; Wilson et al., 2013; Wilson, 2008).

3.3.2 Analysis of midwifery caseload data. This is the quantitative portion of the research. MCC midwives maintain a data tracking spread sheet of their yearly caseload based on data retrieved from the *Manitoba midwifery Discharge summary form*, which "contains summary information for all Manitoba women receiving prenatal, intrapartum, and/or postpartum care from a midwife. Information on demographics, maternal outcomes, birth outcomes, consultations, transfer of care and transport are provided from discharge summary forms completed by the primary midwife for each client upon discharge from care and submitted to Manitoba Health" (MCHP, 2014). This data is held by the MCHP, but could not be accessed for

this study, so the MCC midwives' caseload data tracking spreadsheet was used instead and should contain the same data as well as other demographic data about CFS involvement among other things. The midwifery data used in this research project is from a one-year period, from January 1, 2018 to December 31, 2018.

The purpose of this analysis is to look at MCC Midwifery clients' Indigenous status, priority populations status, and prenatal care rates in comparison to related statistics in the *PIIPC Final Report*: *Evaluation of the partners in inner city integrated prenatal care (PIIPC) project* which looks at the same rates in the same and similar population over a four-year period of funded and coordinated interventions (Heaman et al., 2017). Child and Family Services (CFS) involvement and rates of newborn apprehension will be highlighted as well since CFS arose as a strong theme in the interviews.

3.4 Validity and reliability

Upon completion of the initial analysis of the interviews, two Indigenous midwives were consulted to clarify themes present in the interviews. Their feedback helped to create validity in the form of peer debriefing (Creswell & Poth, 2018).

Member checking was performed using two methods (Brit et al., 2016). Participants were given both a copy of their interview transcript as well as a copy of the preliminary analysis of the interviews to verify that they agreed.

Methodological triangulation of the literature review, along with the interviews, and quantitative midwifery statistics were be performed to strengthen the analysis (Chilisa, 2012; Cluett & Bluff, 2006; Creswell & Poth, 2018).

3.5 Ethics

3.5.1 Informed consent. Informed consent forms were read over with and explained to each participant in accessible language. Upon acceptance of participation, the participants' signatures were obtained the informed consent form. It was made clear that the participants that they could choose not to answer any of the questions and that they can withdraw from the study at any time.

3.5.2 Privacy and confidentiality. Privacy and confidentiality have been upheld. Recordings of sessions and any research notes are securely contained in a safe location and will only be accessible to the researcher. No names or identifying information was attached to any recordings or notes. Names on informed consent forms are securely kept in a different location.

Published documents will not use real names and numerical codes were assigned to each participant for use when referring to a specific individual's interview transcript.

3.5.3 Ethics approval

Ethics approval was obtained from the University of Winnipeg research ethics board (REB) (University of Winnipeg, 2017), as well as WRHA REB, via University of Manitoba. Approval was also granted from WRHA Midwifery Services and Mount Carmel clinic.

Chapter 4: Facilitating Prenatal Care for Indigenous Families at Risk of Receiving Inadequate Prenatal Care in Inner City Winnipeg

4.1 Introduction

This chapter seeks to answer the first research questions: *Does the MCC midwifery model facilitate prenatal care engagement for Indigenous families at risk of receiving inadequate prenatal care?* MCC midwives have tailored the way they practiced, in response to their interactions with their clients and developed an alternative midwifery care model, sensitive to the unique needs of the Indigenous families of Winnipeg's inner city, and focuses on facilitating access to prenatal care.

This chapter provides an analysis of the ways MCC midwives have adapted the way they practice in order to improve access to prenatal care for their clients. Section 4.2 and 4.3 examine how the MCC Midwifery practice model is structured to improve access to care for local families. Section 4.4 examines the ways in which the MCC midwifery model attempts to reduce barriers in access to and use of prenatal care. Section 4.5 is a statistical analysis of rates of prenatal care with MCC midwives versus PIIPC project prenatal care rates, in comparison to prenatal care rates in Winnipeg prior to any organized interventions to improve access to prenatal care in Winnipeg's inner city. Section 4.6 provides a brief conclusion.

4.2 Interdisciplinary Prenatal Care

MCC Midwives provide a unique model of interdisciplinary prenatal care, that takes a holistic approach to care and strives toward culturally safe practice to address the complex health and psycho-social needs of the inner city and Indigenous families they serve.

4.2.1 Sharing care with an obstetrician. MCC midwives share care of many of their clients with an obstetrician. The obstetrician, who is called Dr. A in this paper, started attending the MCC midwifery clinic in 2013 to provide convenient access to specialist care for clients in need of an obstetric consultation. Eventually MCC midwives and Dr. A started sharing care of clients prenatally to facilitate access to care to people who came to MCC midwives seeking prenatal care when the capacity of the midwives' practice group was full for attending births and providing postpartum care. In such cases, the midwives provide prenatal care and care was transferred to Dr. A's practice group for the birth of their babies. MCC midwifery clients see Dr. A for a variety of other reasons prenatally as well. Concerns mentioned by the speakers include,

high risk pregnancies, hepatitis C, gestational diabetes, fetal concerns, mental health concerns, addictions, family planning, and other gynecological concerns.

In 2018, MCC midwives had a total caseload of 154 clients. Ninety of those clients received a complete course of midwifery care, which includes prenatal, intrapartum, and postpartum care. Forty-nine of those clients were shared care with Dr. A prenatally but did not receive midwifery care during the intrapartum or postpartum periods. Fifteen clients left midwifery care before birth, for reasons such as miscarriages, changing care providers, or moving away from the city.

4.2.2 MCC Midwifery client views on the interdisciplinary prenatal care model. Nine of the speakers talked about having a consult or transfer of care to Dr. A. One of them met her in the postpartum period. The speakers expressed positive sentiments about their experiences of Dr. A. They felt it was a good experience, and that having her attend MCC was convenient. They thought Dr. A took her time, was non judgemental, friendly, and made them feel better. Below are some of the positive experiences the speakers reported:

> Speaker 3: Ever since I found out I was pregnant my daughter thought she was also pregnant, and said she was pregnant too, and she was only 2 years old at the time. So… after I was done listening to my baby. My daughter was so like, 'Wow, I want to listen to my baby.' So, Dr. [A] put her on the table here and told her that she was going to listen to her baby. And then she put the little thing there and then Dr. A started going, 'Boom boom boom boom boom boom,' and she was like, 'Do you hear your baby?'
> And she was like, 'Yes!' And that was the cutest ever.

> Speaker 20: The first time [I met her was to remove an IUD and] I was scared because I never had to undergo surgery. But then the second time, with the tubal [pregnancy], I felt ok because it was Dr. [A]. She even left me a note saying, 'Don' worry, I took care of you'. She left a note for me for when I woke up… Cuz, I was crying. I was really upset. And Dr. [A] said, 'It's ok. I'll take good care of you. You'll be fine.' I was really scared, but once I got up and I seen the note, it made me feel better.

> Speaker 15: She's friendly. She answered questions that I needed answered.

One speaker felt frustrated with the fact the doctor only attends MCC once every other week and she thought Dr. A should attend more often. Two of the speakers did not have a consult or transfer of care to Dr. A.

The speakers approved of Dr. A attending MCC. It is good that Dr. A comes to MCC because there are no obstetricians in the Point Douglas. This is significant because it means that

all pregnant people living in the north end are referred to obstetricians outside of their community in the second or third trimester of pregnancy, even if people are seeing a general practitioner or nurse practitioner for care initially. Rather than clients having to venture away from the inner city to meet with consultants, they have the convenience of seeing Dr. A locally, at MCC.

4.3 Continuity of Care

According to the College of Midwives of Manitoba (CMM), *Standard on Continuity of Care* (2017) a on-call midwifery group must consist of no more than five midwives. The standard states,

> The provision of continuity of care is a goal that has inherent value for both clients and midwives and is a means to support excellent outcomes, meaningful relationships, informed choice, choice of birthplace, and normal birth… A 2013 Cochrane review concluded that clients who receive continuity of care are less likely to request an epidural; less likely to have an episiotomy, instrumental delivery, preterm delivery; and less likely to experience a fetal loss or neonatal death (p.1).

There are currently five midwives practicing out of MCC. MCC midwifery clients meet between one and five midwives during the prenatal period depending on how they access care.

One reason MCC midwives refer clients to Dr. A is when the midwifery caseload has reached the capacity to provide intrapartum and postpartum care, meaning that at a certain point, the midwives are unable to attend any more births than what is already on their roster. In such cases, the midwives continue to provide prenatal care for clients whose births they can not attend and must transfer their clients care to Dr. A for the birth and postpartum care. To reduce the number of clients needing to be referred away from midwifery care to Dr. A, for low risk obstetrical care in labour and delivery, MCC might benefit from having additional midwives on staff to meet the demand. There would be pros and cons to this, as discussed next, in 4.3.1.

4.3.1. MCC midwives' client's views on the number of midwives at MCC. Various thoughts emerged from discussion about how the speakers felt about the number of midwives they met at MCC. Six of the speakers were not asked about the number of midwives they met. Four of the speakers expressed being open to receiving care from any and all the midwives at MCC. Three of the speakers felt that having access to multiple midwives was helpful because of the increased likelihood that somebody would be available to meet with them when they needed it. They said the following things about this:

> Speaker 1: There was actually five [midwives] in total, but I only remember three… it was good because there is always someone there.

> Speaker 15: It's better than having just one because if one's too busy it's easy to go to another one, so it's good to have multiple.

> Speaker 16: It's just perfect here… there's always a [midwife available].

Contrary to the speakers, above, one of the speakers felt she was not open to meeting all of the midwives because she felt it was too many people. She suggested that a team of three would be ideal. Another speaker felt that it was difficult to gain trust when meeting so many different midwives. She said,

> Speaker 19: I have a deep history of trust issues and that's why it took time for me. The path that we were on meant me seeing a different person each time, so for trust building it was a little hard for me. That's why it took a little bit of time… But after being there, in the second and third trimesters… I became more comfortable at sharing things. It was about building trust.

There is insufficient evidence to suggest whether the number of midwives at MCC is appropriate or not. Not enough people were asked whether they were open to seeing all the midwives. The available results are evenly mixed, so the analysis must give both the similar and divergent themes equal consideration and more research is needed about this. It might be useful to have two separate pods of 3-4 midwives at MCC to provide both greater access to care and improved continuity of care.

4.4 Reducing Barriers to Prenatal Care

This section examines the ways in which the MCC midwifery model attempts to reduce barriers in access to and use of prenatal care. The following resources were reported by the speakers as ways the midwives help to reducing barriers to access to prenatal care for MCC midwifery clients.

4.4.1. Bus tokens and taxi slips. Previous research found that lack of access to transportation was a barrier for Indigenous families and families with adequate prenatal care accessing care in Winnipeg (Heaman et al., 2005; 2014) MCC midwives provide two bus tokens or taxi slips to their clients when they give them out to help people with transportation to get to and from their appointment. If a client has a support person who attends appointments with them, that person is also given two, as needed, to get to and from appointments with the pregnant person. The intent behind this is to ensure both access to care and the support of loved ones in

their pregnancy journey. The speakers referred to three uses for bus tokens and taxi slips. These were, to get to and from prenatal appointments with at the MCC midwifery clinic, to get to fetal assessments, and to get to the hospital in labour.

The speakers had several things to say about bus tokens and taxi slips. Nine of the eleven speakers used bus token or taxi slips to access prenatal care services. The main idea was that taking the bus, or a taxi was easier than walking. The speakers noted the following challenges to walking: Complications of pregnancy, winter weather conditions, and having small children in tow. Next, while only expressed by two of the speakers, is poignant given the subject of inadequate prenatal care and the associated risks. The two speakers, who were both people experiencing high-risk pregnancies, said that they would have missed at least some of their fetal assessment ultrasound appointments, had they not had bus tokens or taxi slips to get there.

> Speaker 3: [I got] taxi slips because I couldn't walk. I was too big. Cuz I had gestational diabetes. There was a lot of problems with my pregnancy… probably would have never went to my appointments [if I did not have the taxi slips].
>
> Speaker 16: Yeah. They paid for me, like right at the end, because I had high blood pressure, I had to go for fetal assessments every week. That was awesome… I probably wouldn't have went [without taxi slips]. I probably would have been like, ah whatever, [But] actually, I went every time. [I had] one fetal assessment every month, then one every two weeks, and then one every week at the end.

Finally, the speakers expressed positive sentiments about bus tokens and taxi slips made by the speakers. Some of the same positive responses were made by multiple people, including, that they were awesome, a huge support, helpful, relieved financial stress, and made it easier to get to and from appointments. They said,

> Speaker 2: It's was really good, I guess, because I really needed it. It was a huge support.
>
> Speaker 7: It took a lot of stress off when [Baby's name] was born and I called for a taxi slip because I didn't want to go in the cold and I didn't want to miss my appointment, and they just did it right away. Just got everything going, And I went in, a couple times I needed a bus token for the same reason, and it was very efficient, and it saved a lot of money. And it makes you want to go back, right? Like, "Ok. they gave me a bus ticket." Because they give you a ticket to get home and back next time, so it works like a reminder. I'd find in in my purse and be like, "Oh yeah, my bus token - I have an appointment this week."

The areas of divergence regarding bus tokens and taxi slips among the speakers is minor. One speaker was not asked about them in their interview. One speaker was a well-resourced

person who had a vehicle and did not need bus tokens or taxi slips. One person who did access bus tokens and taxi slips prenatally said that she would have accessed the care she needed regardless of whether she had them.

> Speaker 15: It helps with transportation [but] I still have to make my appointments [even without bus token or taxi slips because] ... it's for the baby's health.

Most of the speakers utilized bus tokens and/ or taxi slips while accessing prenatal care with MCC midwives. The speakers appreciated the practicality of receiving bus tokens and/ or taxi slips, which encouraged them to attend for prenatal care because it made it easier for them to get there and to return home, especially in poor weather conditions or with small children in tow. This is consistent with previous research, which found that transportation incentives helped at-risk, inner city and Indigenous women to attend for prenatal care in Winnipeg and elsewhere (Di Lallo, 2014; Heaman MI et al., 2014; J. Smylie & Phillips-Beck, 2019). The divergent themes show small deviations but are significant because they point to the fact that some of MCC midwifery clients have different needs than others.

4.4.2 Flexible Access to Care

The interviews show that the speakers approved of the way MCC midwives approach scheduling. The main sentiment, expressed by six of the eleven speakers, was that it was easy to schedule appointments with the midwives. Second, they expressed positive sentiments. Speakers considered scheduling appointments with the midwives, flexible, fast, helpful, good, nice, and accommodating. Regarding the flexibility of scheduling, Speaker 1 said,

> Speaker 1: They work with your schedule and they didn't say, "No you got to come on this day or you're not gonna to come till next time." It’s very flexible.

Two of the ways MCC midwives provide flexibility in scheduling is to have drop-in prenatal care as described in section 4.4.2.1 and to make rescheduling missed appointments easy and free of judgement as described in 4.4.2.2. Finally, the speakers describe their experiences of the midwives’ on-call availability.

4.4.2.1 Drop-in and unscheduled visits. MCC midwives have an open-door policy. Clients are encouraged to attend, as needed, when the clinic is open. They can call to request a same day appointment, or they are welcome to just drop in. MCC midwives also have a scheduled drop-in clinic every Monday afternoon to create a structure that encourages clients to

attend for unscheduled visits on a certain day of the week, even though they are welcome any day that the midwives have their clinic running.

Three perspectives emerged among the speakers regarding drop in and unscheduled visits. Eight of the speakers reported attending for an unscheduled appointment with the midwives. Four of those people discussed how it was not a long wait when the midwives fit these unscheduled visits into the clinic schedule for the day. Three of the speakers expressed other positive sentiments about attending for unscheduled visits, including: It made them feel better, it was accommodating, it was good, and it was nice. They said,

> Speaker 1: It made me feel better after that they told me everything was fine.
>
> Speaker 19: Well, it was actually kind of funny. [I showed up when I didn't have an appointment and] … they were really understanding… There was one time where I did it, and they had they time, so they just ended up seeing me, so, [they were] really a accommodating.

The only area of divergence among the speakers regarding drop-in and unscheduled visits is that two of them never attended without having an unscheduled appointment. One of the speakers was not asked about unscheduled appointments.

Most of the speakers reported attending for prenatal care when they did not have a scheduled appointment and they described having positive experiences when they did so. When the speakers attended for unscheduled visits, they felt that there was a reasonable wait time. Again, not all the speakers had the same needs, but those who needed it, did feel that they benefitted from the accessibility of the MCC midwifery prenatal care scheduling model.

4.4.2.2 Accommodating for missed appointments. It is not uncommon for MCC midwives' clients to miss scheduled appointments. The midwives approach the issue by providing flexible access to prenatal care, rather than penalizing or shaming people when they do not attend their appointments, thus being person-centered. Person-centered care is one of the fundamental standards of midwifery care. According to the College of midwives of Ontario (CMO) *Professional Standards* guideline (2018),

> Person-centred care is focused on the client and their life context. Person-centred care recognizes the central role the client has in their own health care, and responds to their unique needs, values, and preferences. Working with individuals in partnership, person-centred care offers high-quality care provided with compassion, respect, and trust (p. 6).

This is standard of care means that midwives are philosophically enabled to provide the care their clients need as defined by their clients.

The speakers were asked about their experiences of missing prenatal appointments with the midwives. All eleven of the speakers reported missing prenatal care appointments with the midwives. Two of them stated that they missed many appointments. Four of the speakers talked about how easy it was to rebook missed appointments. Speaker 20 explained,

> Speaker 20: It was always easy. I would just phone in and it was super-fast.

The speakers used positive sentiments to describe how the midwives responded to them missing appointments. They said that the midwives were generally easy going about missed appointments. They said,

> Speaker 11: It's no big deal. Just life.

> Speaker 7: It was good because I didn't really keep a lot of my appointments because things came up with my three-year-old. Towards the end they didn't even as me to reschedule, they would just call me and tell me when my appointment could be, like when their next available time was, and I thought that was really helpful. Instead of being like, "Oh shoot! I missed it. Ok. I have to remind myself to call tomorrow between this time and this time to rebook." She would just call and be like, "Oh we've rebooked you in. Hopefully you're available either at this time or this time." [I was] like, "Oh yes I will be…" It was really nice that they kind of do that for you.

> Speaker19: Well, they were really accommodating. They didn't ask like, 21 questions or say, "Why weren't you here?" Or anything like that. They'd be like, " It's okay, I understand." I'd call and say, " I'm on my way or I'm gonna be a little bit late. I overslept…" They were understanding.

> Speaker 20: They still made me feel like it was ok. They weren't mad. They just called to reschedule. Still cheerful. And then it was good.

The only area of divergence revealed by the speakers was that one speaker reported that when she missed her appointment with the midwives, the nurse from another program at MCC called, *The Mothering Project/ Manito Ikwe Kagiikwe (MIK)*, saw her for prenatal care in lieu of that appointment instead. She said,

> Speaker 1: I might have missed some but with [the nurse at *The Mothering Project*] over there [within MCC]. It was very convenient. She like, even with the doctors she'll sneak us in. It's very helpful and... I love all the staff here.

Speakers described four ways that they rebooked missed appointments. They described a variety of ways that they arranged for a follow up appointment once their appointment was missed. Since all the speakers reported missing scheduled appointments, it can be concluded that missing prenatal appointments is a typical part of the course of prenatal care for MCC midwifery clients. The usual course of prenatal care for pregnant people starts around 12 weeks, and includes an appointment once every 4-6 weeks until 28 weeks gestation, then every 2 weeks until 36 weeks gestation, and finally, once per week until delivery of the baby (SOGC, 1998). This adds up to at least 10 prenatal care visits over a nine-month period, which is quite a few appointments for a person to make space for in their life, particularly if they are experiencing barriers which impede their ability to access care, such as lack of transportation or childcare for their other children, to name just a few. Those with higher-risk pregnancies are expected to attend even more appointments than those with normal pregnancies.

When describing their experiences of missing appointments with the midwives, the speakers expressed positive sentiments about how the midwives responded to their absence, and they did not find rebooking to be problematic, as there was a flexible variety of options available for doing so.

4.4.2.3 On-call availability. The speakers were asked questions about the on-call availability of MCC midwives, as this is a unique aspect of midwifery care, where the midwives are on call and available by phone for questions and concerns, 24 hours a day, every day (CMO, 2018). On-call availability was viewed with positive sentiments. The speakers considered the midwives' on-call availability informative, convenient, calming, comforting and reassuring. They said they thought it was easy and that they liked it. The speakers said the following things:

> Speaker 3: She was really informational on what I was going through because I didn't know why I was having pains in my stomach. So she calmed me down and then I came in the next morning and we listened to the baby's heartbeat.

> Speaker 7: One of my issues when I was pregnant, and I used the pager [was when] coughing up blood and I didn't know what to do. So, I called her and said, "I'm coughing up blood." And they kind of talked me through it … and then they met me at the hospital and made sure everything was alright. So, the pager works phenomenally.

> Speaker 15: The pager's easy to get a hold of the midwives. And if a midwife doesn't know what to do, they'll either send you to the emergency or you can… come see them the next day.

> Speaker 16: They'd just like, reassure me that I was okay, [and they would say], "If this happens then go to the doctor."

> Speaker 19: It's comforting to know that I can call, whatever time day or night.

The divergent theme here is that one speaker did not like waiting for the midwives to call her back when she paged them, and she would prefer if they answered right away when called. This indicates that the midwives should consider using their cell phones, rather than their pagers, if they wish to address their clients' desire for immediate contact.

4.5 Improved Rates of Prenatal Care

Adequacy of prenatal care has been defined in several ways. While there are more sophisticated formulas that can be used to calculate rates of prenatal care, such as the Revised-Graduated Prenatal Care Utilization Index (R-GINDEX), but this was not possible, as access the Manitoba Population Research Data Repository which holds the data needed to use the formula could not be made available for the research project (Manitoba Centre for Health Policy, 2015). Instead, for this study, adequate prenatal is defined as six or more prenatal care visits, with anything less considered to be inadequate prenatal care, as in Hiebert (2001). Using 6 or more prenatal care visits as the definition of adequate prenatal care, 98 of 139 clients, or 70.5% of MCC midwifery clients received adequate prenatal care.

The table below shows data about the number of prenatal care visits MCC midwifery clients had in 2018 compared to the participants of the PIIPC project (Heaman et al., 2017). These data are shown in contrast to data from a case-control done by Heaman et al., in 2014, which examined barriers to prenatal care in women who gave birth in Winnipeg hospitals between 2007 and 2010 – prior to any focused interventions to reduce rates of inadequate prenatal care in Winnipeg. MCC Midwives have more clients with ten or more prenatal visits than those involved in the PIIPC project, with 46% of families receiving receiving 10 or more prenatal care visits in their pregnancies. This percentage is nearly double the rate of participants with 10 or more visits than the PIIPC project which saw 25.3% of participants receiving 10 or more prenatal visits. This data shows the facilitating access and reducing barriers to prenatal care improves rates of access to care.

Number of prenatal care visits at MCC midwifery (2018)			
Characteristic	**Women with inadequate prenatal care in the previous "Barriers" study* N=202 n (%)**	**Women in the PIIPC project** N=198 n (%)**	**MCC midwives' clients Jan through Dec 2018*** N= 139 n (%)**
Number of prenatal care visits			
None or unknown	42 (20.8)	2 (1.0)	1 (<1)
1-3 visits	110 (54.5)	31 (15.7)	25 (18)
4-9 visits	50 (24.8)	115 (58.1)	48 (35)
10+	0	50 (25.3)	**64 (46)**

*The retrospective comparison group consisted of women with inadequate prenatal care (cases) in the study, "Barriers, motivators and facilitators related to prenatal care utilization among inner-city women in Winnipeg, Canada: A case-control study"; findings are based on self-report data from completion of a structured questionnaire (Heaman et al., 2014).
** Based on data from review of health records of women in the PIIPC project.
*** Based on MCC midwives caseload Jan – Dec/ 2018.

Table 4.1 Number of prenatal care visits at MCC midwifery (2018). Adapted from: "Comparison of 202 women with inadequate prenatal care (cases) who participated in the "Barriers to prenatal care" study (2007-2010), and 198 women enrolled in the PIIPC project (2012-2015) whose health records were reviewed" (Heaman et al., 2017).

The above data indicates that MCC midwives prenatal care model is at least as effective as the PIIPC interventions at facilitating adequate prenatal care. MCC midwives also have significantly more clients attending for 10 or more prenatal care visits. The primary additional intervention imposed by MCC midwives, since the PIIPC project, is the increased incorporation of cultural safety measures, including a harm reduction approach to all aspects of care, and trauma informed care. MCC midwifery has also remained a consistent community resource focused on reaching local Indigenous families for the past nine years.

4.6 Chapter Summary

The speakers approved of the Interdisciplinary model of prenatal care at MCC. They found having access to an obstetrician in the community convenient and it ensured that they were able to attend for consultations when needed, and it gave them access to a prenatal care provider locally, when the midwives had a full caseload and were not able to accommodate them by attending their births.

The speakers had mixed feelings about the seeing five different midwives during their pregnancies. Most of the speakers felt that having more midwives improved their ability to access care when they needed it. However, some of the speakers reported that having five midwives to get to know made it more difficult to build trusting relationships with each of the midwives.

The speakers described bus tokens and taxi slips as important resources for helping them get to and from prenatal care appointments. The also felt that the flexibility of the MCC midwifery model of care, specifically drop in appointments, unscheduled prenatal care visits, and the midwives' on-call availability reduced barriers in their access to prenatal care.

MCC midwives' model of care improves access to prenatal care for Indigenous families in Winnipeg's inner city. MCC midwives' model of care is successful at facilitating improved rates of prenatal care and is successful in reaching priority populations, especially Indigenous families, to provide that care. According to Tait (2013),

> From an ethical policy perspective, the focus of government policies and the practices they generate must be first and foremost to ensure that individuals, families and groups are not left worse off than prior to a government policy impacting upon their life. Furthermore, the impact of living a life determined by multiple government policies should not be a story of individual and family devastation, and government policies should not be the most significant determinant of health for any group of people (p. 1).

For this reason, MCC midwives should never be removed from the inner city unless it replaced by another, easily accessible, culturally safe, or Indigenous-led program, such as those described by Smylie & Phillips-Beck (2019). The PIIPC project created the foundation of the MCC midwifery practice model, which grew stronger through the relationships built between the midwives, their clients, and the community. The Winnipeg Regional Health Authority (WRHA), whom employs MCC midwives must continue to support this important practice model, as to remove it as a resource would be detrimental to the community, in that it would place local families in a position of renewed barriers in access to prenatal care. Furthermore, it might be beneficial to increase the number of midwives dedicated to serving Indigenous families and the inner city community, who specifically focus on improving access to care for a greater number of vulnerable and marginalized families, as well as to increase the number of families who receive the full scope of midwifery care in the intrapartum and postpartum periods, without needing to have their care transferred to Dr. A when experiencing low-risk pregnancies.

Chapter 5: Envisioning a Culturally Safe Midwifery Model in a Local Context

5.1 Introduction

This chapter examines the second research question: *What does a culturally safe midwifery model look like in inner city Winnipeg?* While the MCC midwifery model offers effective logistical improvements in access to prenatal care in the inner city, such as flexible access to care and bus tokens and taxi slips, it also strives provide culturally safe care based on the views of the Indigenous families that they serve.

This chapter explores the lived experiences of Indigenous families in the local context of Winnipeg's inner city, and how their socio-demographic positioning leads them to face unique challenges in their lives. Section 5.2 situates the families as inner-city residents, exploring some of the challenges their communities face. Section 5.3 examines the role the child welfare system plays in the lives of MCC midwifery clients. Section 5.4 looks at how MCC midwifery clients view the midwives' sensitivity to the socio-demographic characteristics of their community. Section 5.5 explores cultural safety measures the midwives could incorporate into their practice to make it more reflective of the Indigenous people they serve. Finally, the chapter concludes by defining culturally safety as it applies to the MCC midwifery model of care.

5.2 Point Douglas

Nine of the eleven speakers interviewed live in Point Douglas. One of the speakers lived in Point Douglas in the past but had recently moved to the West End. One speaker lived in Winnipeg previously, but now lives outside of the city. The speakers were invited to talk about Point Douglas in order to provide an understanding how the local population experiences their community, and to gain insight into the local culture. Several similar perspectives emerged among the speakers. While people from the outside perceive Point Douglas as a dangerous place filled with poverty and crime, the speakers, as residents of the community, see it in a more dynamic and nuanced way. They expressed a mixture of positive and negative sentiments.

The speakers expressed several positive sentiments about Point Douglas. They consider Point Douglas to be a quiet, peaceful, comforting, and welcoming community that is family oriented and generous. The main opinion, which was expressed by three of the speakers, was an appreciation that everything in Point Douglas is near to other resources, family, and MCC. Speaker 19 referred to MCC as, "The heart of the north end." The speakers also expressed

several negative sentiments about Point Douglas. They used the words, *rough* and *ghetto* to describe the community.

These reflections on the qualities of the Point Douglas community sets the tone for understanding the subsequent themes that will be discussed in this chapter.

5.2.1 Priority populations. In 2018, MCC midwives had 154 clients, 123 or 80% of whom were Indigenous. As well, 88% of their clients are what the Winnipeg Regional Health authority (WRHA) calls, *priority of populations*, or “communities who currently do not receive adequate perinatal health care and are socio-economically disadvantaged clients” (WRHA, 2018, p. 34). Between 2003 and 2010 almost 50% of midwifery clients in Manitoba fell into this category. Thiessen al., explain that,

> In an effort to support the development of midwifery services in the province, Manitoba Health developed the *Standard for the Provision of Funded Midwifery Care in Manitoba (2002),* which included goals to integrate midwifery into the regional health care system, to increase access to primary care for women, and to target priority populations designated as adolescent (< 20 years), Aboriginal, immigrant, socially isolated, and poor women (Thiessen, Heaman, Mignone, Martens, & Robinson, 2014, p. 708).

Thiessen’s statistics are consistent with what the MCC midwifery priority population caseload was prior to the initiation of the PIIPC project in 2012. In the first year of the PIIPC project there is a sharp increase in priority populations numbers, with them rising to 70% of the MCC midwifery caseload in the first year, and to 80% by the completion of the PIIPC project (Heaman et al., 2017). Three years after the PIIPC project ended, the MCC midwifery caseload shows a continued increasing trajectory in access to prenatal care for priority populations in inner city Winnipeg. See figure 5.1.

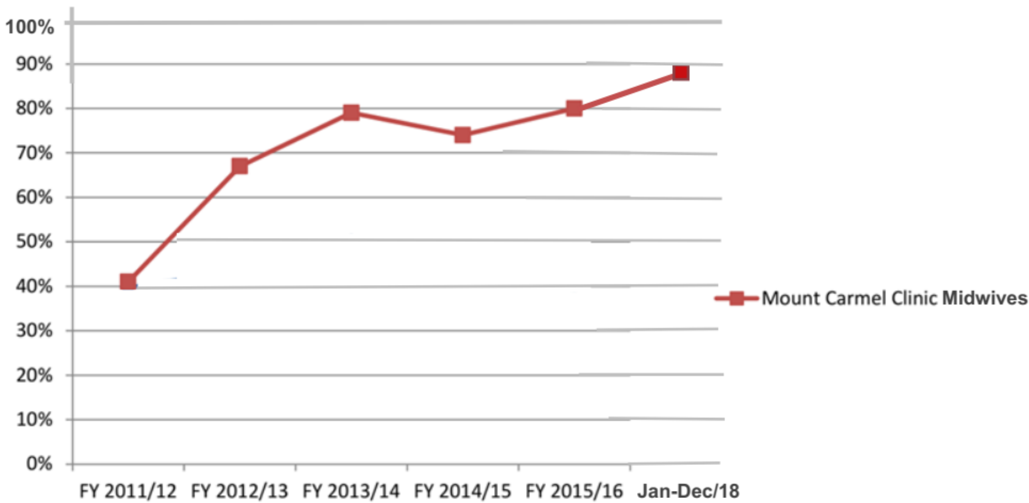

Figure 5.1. Priority populations. Adapted from "Proportion of midwifery clients at Mount Carmel Clinic who were from priority populations (FY = fiscal year) in Heaman et al., 2017, p. 21.

It is not surprising that with a focused effort the MCC midwifery caseload would be made up of an increasing number of priority populations, since the Point Douglas and Downtown communities experience greater socio-demographic disparities when compared to the rest of Winnipeg. For this reason, much of the community fits the priority populations demographic that the WRHA is trying to reach. Point Douglas and Downtown have higher than average rates of adolescent pregnancy, immigrant and visible minority populations, and higher levels of poverty than other areas of Winnipeg (Centre for Healthcare Innovation (CHI) & WRHA, 2015). The adolescent pregnancy rate of Winnipeg proper is 15.5%, whereas Point Douglas and Downtown have significantly higher rates of adolescent pregnancy, at 38.9% and 30.3%, respectively (CHI &WRHA, 2015). This positions MCC midwives to be easily and locally available to pregnant adolescents and to reduce the specific risks associated with inadequate prenatal care in adolescents (Debiec, Paul, Mitchell, & Hitti, 2010; Fleming et al., 2015; Heaman & Manitoba Centre for Health Policy., 2013). Another socio-demographic disparity experienced by people living in the Point Douglas and Downtown community areas is low household income. While Winnipeg proper has an average low income rate of 16.4%, Point Douglas and Downtown have significantly higher rates of low household income, at 33.3% and 32.4%, respectively (CHI & WRHA, 2015). Again, MCC midwives are conveniently positioned to provide care within the

community, to improve access to prenatal care for families facing barriers associated with insufficient financial resources, such as transportation costs (Heaman et al., 2014, 2015).

5.2.1.1 Indigeneity. Not only does Winnipeg's inner city have a high Indigenous population compared to other communities in Winnipeg, Point Douglas has the largest urban population of Indigenous people in Canada (CHI & WRHA, 2015; Paskievich, 2017).

While the final PIIPC report does not discuss Indigeneity, other data available from Heaman (2018), shows that at least 61% of PIIPC clients were Indigenous and 31% of PIIPC clients were of unknown racial/ ethnic background as it was not recorded in the studied health records used for the study. It is likely that there were significantly more Indigenous clients in the PIIPC project than what is known, based on the previous research, which found 85% of women with inadequate prenatal care at Women's Hospital in Winnipeg were Indigenous and also mostly lived in Point Douglas and Downtown (Heaman et al., 2014). These numbers point to the significance of MCC midwives approaching their care model with sensitivity to the fact that the marginalized positioning of their clients is due to colonization and the systemic oppression of Indigenous peoples in Canada, and that it is necessary that MCC midwives be committed to learning about this oppression so as not to perpetuate it in their work as midwives who work mostly with Indigenous families (Smylie & Phillips-Beck, 2019).

5.2.2 Problematic substance use. The speakers talked about problematic substance use in Point Douglas. Seven of the eleven speakers had a history of problematic substance use or current addictions, including both drugs and/ or alcohol. Three speakers reported no history of problematic substance use. When asked how they felt about discussing their experiences of substance use with the midwives, five of the speakers expressed positive sentiments about disclosing and discussing these issues. The positive sentiments included, being comfortable with the midwives and wanting the midwives to know about their substance use for the health of their pregnancies. One of these speakers stated that, while reluctant at first, she shared this information with the midwives because she trusted the services provided by the MCC at large. No speakers expressed any negative sentiments about discussing substance use with the midwives.

> Speaker 16: [The midwives are] not judgmental or like, look at you differently here. I wasn't judged. That's what I liked, cuz I was on methadone when I came here [and] they didn't judge me.

Three of the speakers talked about being worried about their babies due to using drugs while pregnant. One of them said,

> Speaker 15: When I found out I was pregnant I was all like, on drugs. So we were scared about FAS… and that kind of thing.

Two of the speakers said that their baby's dad was not in their life due to problematic substance use. One of them said,

> Speaker 1: At first, I felt a little iffy about it. But… I used to come here when I was small… So it would seem like it was an all right place to [talk about it so nothing bad] happens to the baby. They need to know what's going on with you. So, I just opened.

No divergent perspectives of problematic substance use emerged from the interviews.

Based on what the speakers said about problematic substance use, a conclusion can be drawn that a history of problematic substance use, is common among MCC midwifery clients. MCC Midwives should continue to approach substance use with a harm reduction philosophy that is person-centered.

5.2.3 Trauma in pregnancy. The speakers were asked about experiences of trauma. Rather than recounting life experiences of trauma, all the speakers directed the conversation toward traumas they experienced during their pregnancies. Several similar topics arose regarding trauma in pregnancy.

Four of the speakers discussed the stress of having mental health concerns during pregnancy as traumatic. Their mental health concerns included, depression, anxiety, job stress, and general pregnancy blues. Three of the speakers considered conflict with their baby's dad to be traumatic for them. One person said,

> Speaker 1: Me and her dad fought lots when I was pregnant. Cuz he was like, a solvent user... And he didn't like, do it around me… but when he would [come] home… on it, or coming off it and I guess he'd be aggressive and mean.

Three of the speakers expressed that worrying about their babies was traumatic. They said,

> Speaker 3: My last [pregnancy was] because of gestational diabetes. I had to get a whole bunch of blood work done and tests for them keep an eye on my baby.

> Speaker 19: I [was] just like freaking out about all these things. I'm worried about how I'm going to get things done for her [and] I was so afraid of losing her while I was pregnant with her… And I was really clumsy when I was pregnant… and I tripped going up the stairs, and… when I tripped, I fell into the railing and got really freaked out and I went to the hospital to make sure she was okay. So, that was the only real trauma.

Two of the speakers expressed that the fear of Child and Family Services (CFS), Manitoba's child welfare agency, was traumatic. One person said,

> Speaker 7: Having lots of CFS involvement [was traumatic]. [CFS] trying to get involved and coming up with assumptions. They made it sound like I was going to get [older child's name] taken away. It was awful. Yeah, because of me and [my partner's relationship problems].

Most of the speakers reported experiencing trauma in pregnancy while in the care of MCC midwives. MCC midwives should be aware that their clients may be feeling stressed about the impact of their life circumstances on their pregnancies and that the clients may be experiencing these things as traumatic. Their clients might like them to check in about stressors and offer supports to help their clients navigate through such traumas.

5.3 Child and Family Services

Child and family services (CFS) emerged from the interviews as a significant theme, and it is not surprising, given the high rates of child apprehension in Manitoba. Manitoba has the highest rate of children in care among all the provinces and territories in Canada (Manitoba Legislative Review Committee, 2018). There is an overrepresentation of Indigenous children in care in Manitoba, with 90% of children in care being Indigenous (Manitoba Legislative Review Committee, 2018). Over a quarter, or 25.5% of MCC midwifery clients have their babies apprehended at birth, and almost 48% of MCC midwifery clients have prenatal CFS involvement or birth alerts.

5.3.1 CFS Involvement and newborn apprehension. The high rates of CFS involvement and newborn apprehension in Manitoba are alarming, adding up to being more than 9 000, or the equivalent of two entire school divisions of Indigenous children in CFS care in Manitoba (Cora Morgan in Palmeter, 2019). The most recent provincial statistic is that on average 400 newborns are apprehended per year in Manitoba, this is the equivalent of "40 babies, or a classroom of children, that are taken every month" (Coral Morgan in Palmeter, 2019, 21:15). This means that approximately 6% of Manitoba's apprehended Indigenous newborns are born into the care of MCC midwives! At least 36% of MCC midwifery clients who have prenatal CFS involvement have their babies apprehended as newborns, and this number is likely significantly more, as the number of clients who have their babies apprehended when their care is transferred to Dr. A is unknown. This indicates that having prenatal CFS involvement puts families at significant risk of newborn apprehension. It suggests an urgent need for MCC

midwives to have dedicated support available for their clients who have CFS involvement, as MCC midwives alone have had very little impact on rates of newborn apprehension.

5.3.2 How MCC midwifery clients experience CFS. Several similar views emerged about CFS. Four of the eleven speakers had current CFS involvement and four of the speakers had previous CFS involvement. Two of the speakers with previous CFS involvement had their files closed. Two of the speakers with previous CFS involvement had only had temporary involvement - one when the speaker's child was injured, and one who was visited by CFS unexpectedly at home, for no known reason.

There were three other similar subjects that emerged. First, the speakers talked about CFS apprehending children and newborns. One speaker talked about her baby being apprehended at birth. One speaker talked about CFS threatening to apprehend her older child when she was pregnant. One speaker told a story about how one of her relatives had their baby apprehended at birth.

Next, two of the speakers described feeling like they were being scrutinized, and like they had to prove themselves to CFS. One of these two speakers did not have CFS involvement but was afraid of CFS and felt like she needed to prepare for their involvement, so that she could protect herself if they did come into her life.

Finally, the third topic to emerge was about suffering. Three of the speakers talked about the pain they felt in relation to CFS. One of the speakers talked about the conflict she experienced with her CFS worker, and how the pain of it led her to use drugs two times during that pregnancy. One of the speakers described her interactions with CFS as, "awful," and explained that she felt like she was under attack by them. The third speaker was the same person mentioned, above, who did not have CFS involvement during her pregnancy, but felt concerned about them. This speaker believes that the stress from her fear of CFS lead to her to experience severe postpartum depression.

There were two areas of divergence. Of the eleven speakers, only two had had no CFS involvement. One speaker declined to discuss the subject of CFS. These two things indicate that CFS involvement is prevalent at MCC and that it is a sensitive subject that some families would rather not discuss.

The speakers had other reflections on CFS, ranging from thoughts on why CFS gets involved with families, to considerations CFS should make when assessing families, such as

understanding poverty, recognizing that everyone has bad days, and an awareness of the harm and trauma caused by CFS interfering in people's lives. The speakers had many things to say about this subject, including:

> Speaker 1: Honestly, I was going to run with [baby when CFS was apprehending her from the hospital]. As I was walking her to the car with my [CFS] social worker. I was telling [baby's dad], I'm like, "What is she going to do? Chase me? I don't think so". He's like, "No babe, just put her in that car". Cuz it would've made things worse.
>
> Speaker 1: I honestly think if CFS would have sent her home with me [instead of apprehending baby] when they were supposed to after the hospital, I probably would have been more sober.
>
> Speaker 7: CFS makes assumptions about people… They don't know me. They get a glimpse of be on a bad day, and that's fine. People are allowed to have bad days.
>
> Speaker 11: CFS should acknowledge that some mothers are just struggling because they're poor.

Two of the speakers expressed concerns about the relationship between CFS and healthcare providers. One speaker was afraid MCC midwives would report her to CFS due to her history of addictions. She said,

> Speaker 19: Actually, with midwifery… one of my biggest concerns… was being flagged for something [to CFS], cuz I was just coming out of addiction and I was trying to get sober because I'm pregnant. I kept telling them over all the trimesters, that my concern is something happening and my baby getting apprehended. And it's still a concern, like, them showing up at my doorstep… So, I'm doing everything in my power to make sure that I'm on the ball and everything's taken care of with her. So CFS, if they do try to get involved, which they're already trying to, they have no concerns with her. She's mine. I'm keeping her. I carried her for 9 months, so I'm going to take care of her.

Another speaker voiced the belief that public health nurses worked in concert with CFS. She said,

> Speaker 7: And it's scary because CFS relies on the public health nurses.

The speakers had many insights about the role of CFS in their lives and in their communities. That they fear being reported to CFS by their healthcare providers is particularly concerning, as healthcare providers are under no obligation to report pregnant people to CFS unless the pregnant person in under the age of majority. Furthermore, a recent study by Wall-Wieler et al., (2019) found that Manitoban mothers with a history of having a child taken into custody by CFS are at higher risk of having inadequate or no prenatal care in a subsequent

pregnancy compared with mothers with no history of involvement with CFS. Again, this points to a dire need of a dedicated person to provide MCC midwifery clients with support to navigate CFS, not only for families with CFS involvement, but also specifically for Indigenous families experiencing CFS-related trauma, even if they do not have CFS involved in their lives presently.

5.3.3 Letters of support. During the first interview, Speaker 1 suggested that the midwives write letters of support to CFS for their clients. To investigate this idea further, in consecutive interviews, speakers were asked what they thought about the idea. Five of the speakers were not asked about the midwives writing a letter to CFS. The other six speakers gave feedback and expressed their approval of the midwives providing this supportive measure with prior client consent. They made the following suggestions:

> Speaker 1: Maybe the midwives could write support letters and make a consent form for clients to sign stating that they approve of [the midwives writing letters of support for their clients].
>
> Speaker 3: Maybe make little notes that clients can give to their CFS workers stating that they are getting prenatal care, and to let them know that they are doing good in their pregnancy and being sober, if they are... It would probably help with the mothers getting and keeping their babies their care.
>
> Speaker 7: It was a very upward battle and trying to get all the support letters and trying to find everybody to say that things were happening, so it would be de-stressing if the midwives could write a letter in advance and [told their clients], "We want them to know that you are trying."
>
> Speaker 16: Midwives could advocate for moms, advocate for them to take their babies home, advocate for them to mother [their children].

CFS involvement is pervasive among MCC midwives' Indigenous clients and it is problematic. Clients would like the midwives to help them with CFS, but besides writing a letter of support, they do not know how else the midwives can help them. As previously mentioned, MCC midwives need help supporting their clients to navigate the child-welfare system, as well as their traumas associated with the prevalence of CFS involvement in Indigenous families and communities. MCC midwives have had very little impact on the apprehension of the Indigenous newborns in their care, which is sadly not surprising, as according to Indigenous artist and activist Jaye Simpson in a CBC special edition of *The Current*, "It's my firm belief that the foster care system is working the way it's designed, as a machine to destroy indigeneity" (Tremonti, 2018, 43:50). This notion is reiterated by others on this program, including Canada's Indigenous

services minister, Jane Philpot, who says, “The system is [not] broken, the system is doing what it's been designed to do. We have to disrupt that system” (Tremonti, 2018, 58:21). The issue of Indigenous child-welfare is so pervasive and complex in Manitoba that, aside from advocating for their clients, MCC midwives can do little more than serve as witnesses of their clients' experiences with the system. Providing letters of support, as recommended by the speakers is at least a small action the midwives can take to advocate for their clients. It is essential that this issue be addressed at MCC.

5.4 How MCC Midwifery Clients View the Midwives' Sensitivity to the Socio-Demographic Qualities of Their Community

Speakers were asked questions about MCC midwives' sensitivity to community demographics to get a client-based assessment of the midwives' approach to cultural safety.

Several similar perspectives arose from the interviews about MCC midwives' sensitivity to the local community demographics. Six of the speakers thought the midwives were sensitive to local community demographics. They felt this was the case because MCC is in the Point Douglas, so community demographics are visible, and that because the midwives talk to their clients about their life circumstances, they are aware of what local people are going through. The speakers also expressed positive sentiments about how the midwives relate to their Indigenous clients. They said that they experienced the midwives as non-judgemental, stating:

> Speaker 3: They didn't act surprised or like judgmental or anything like that. It was a good experience, so I don't have like a problem opening up to them with any of my problems.

> Speaker 16: They're not judgmental or like, look at you differently here. I wasn't judged. That's what I liked, cuz I was on methadone when I came here that's what I liked, was that they didn't judge me.

The speakers felt that the midwives were understanding, and they did not act surprised about things the speakers shared with them. One said,

> Speaker 15: They listen. [They] don't just, you know, have [their] own say. They listen to what we're struggling with…. [They] are understanding.

The fact that the speakers feel that the midwives are understanding, rather than judgemental is significant, as Indigenous parents are judged in the maternity care setting (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019). According to Smylie, judgemental treatment amounts to racism. She says,

> Racism has a huge role, both attitudinal and systemic racism and colonial violence. So, in my experience, 25 years providing primary care, including maternity care to diverse First Nations, Inuit, and Métis families in diverse urban, and rural, and remote settings, I find that First Nations, Inuit, and Métis parents get constantly mis-judged (p. 366).

Racist prenatal care is not culturally safe prenatal care. So, the speakers' comments are reassuring that MCC midwives are no perpetuating attitudinal racism toward their Indigenous clients.

Two of the speakers were not asked about the midwives' sensitivity to community demographics. One speaker felt that the midwives had some understanding of the community demographics but had felt stereotyped as a teen mother early in her first pregnancy with MCC midwives. This speaker expressed having had all positive experiences with MCC midwives during her second course of prenatal care with them. One speaker said that the midwives could not understand what it was like, or how bad life can be for people living in the inner city. They expressed concern for what their children will experience growing up in the community. One speaker said,

> Speaker 4: The midwives don't get how bad it is. I don't want my kids to have the same experiences that I had.

This comment indicates that the midwives can not fully understand the lived experiences of their clients. The midwives can, however, be sensitive to the socio-demographic circumstances of their clients and exercise an understanding that clients are doing what they have to do to get by in life, whatever that looks like for them (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019).

5.5 Cultural Safety

When asked about cultural safety at the MCC midwifery clinic, the speakers reflected on measures the midwives could incorporate into their practice to make it more reflective of the Indigenous people they serve. These measures include access to smudging or sage, the mothers having a sharing circle together, incorporating the seven sacred teachings into the clinic environment, posting bulletin board material which reflects Indigenous culture, making the clinic space more home-like, creating a poster or a pamphlet to let Indigenous people know what services MCC midwives can provide for them, and the midwives need to be aware that they have to earn the trust of their Indigenous clients (table 5.1).

Cultural safety measures suggested by speakers
- Access to smudging or sage - Have a sharing circle with the mothers - Incorporate seven sacred teachings - Have cultural stuff on the bulletin board - Make the clinic more homey - Make pamphlets or posters saying that MCC midwives serve Indigenous people and explain and what they do - Give Indigenous clients time to learn that they can trust the midwives

Table 5.1. Cultural safety measures suggested by speakers

When asked, most of the speakers had not heard of the term, cultural safety. This indicates that academic terminology is not necessarily useful to everyday people. Despite this, the speakers interpreted the definition of cultural safety in their own ways and came up with many suggestions on how the midwives can make Indigenous people feel more comfortable in the clinic environment, and how to make the clinic more reflective of the Indigenous people who attend the clinic.

The problem that arises from this analysis of cultural safety is determining whether the MCC midwifery model is, in fact, culturally safe. Before examining this problem further in the conclusion of this chapter, it is imperative to discuss Indigenous midwifery as a culturally safe midwifery model.

5.5.1 Indigenous midwifery. The National Aboriginal Council of Midwives (NACM) identifies Indigenous midwifery care as the best practice for maternal health care in Indigenous communities across Canada (NACM, 2016). NACM equates the poor maternal-newborn outcomes in Indigenous populations with the decline of Indigenous midwifery and access to culturally-safe care (NACM, 2016). Contemporary Indigenous midwives in Canada base their practices on traditional knowledge of medicine and practices of maternal and child health, and complements it with the practice of modern medicine (Skye, 2010). NACM lists the top two barriers for families to accessing Indigenous midwifery care as, “families growing up disconnected from their culture… [and] knowledge about traditional birthing practices, and Indigenous midwifery services not being available in their communities” (NACM, 2017, 9). It is for these reasons that the speakers were asked about their thoughts on Indigenous midwifery.

Ten of the eleven speakers were asked if they would be interested in having an Indigenous midwife if they could. Six of them said they would be interested in having an

Indigenous midwife. Four of the speakers had neutral responses. One was not sure, three were indifferent, and one expressed that they would have high expectations of an Indigenous midwife.

5.5.1.1 Things speakers think would be good about Indigenous midwives. The Speakers were asked about Indigenous midwifery and what they thought would be good about Indigenous midwives. They said they thought it would be cool. One speaker said,

> Speaker 16: [Having an Indigenous midwife] would be cool… [because] they know what we've been through.

The speakers thought that Indigenous midwives would be relatable because Indigenous midwives would understand their lived experience on a deeper level. The speakers thought Indigenous midwives would bring Indigenous teachings and culture to prenatal care and Indigenous midwives would be able to share knowledge about traditional medicines. The lack of Indigenous midwives was recognized. The speakers felt it would be nice to see more Indigenous healthcare providers, acknowledging that Indigenous healthcare providers would face different struggles than non-Indigenous healthcare providers. One speaker said,

> Speaker 20: You don't see much Indigenous people doing anything, really, so [to] see them, like being a doctor or whatever, I would be proud because they must have came a long way to come to where they are.

These insights reveal that the clients have an interest in Indigenous midwifery. Having Indigenous midwives at MCC would help fill the gap of MCC midwives being unable to fully relate to the lived experiences of their clients and would allow for the integration of traditional knowledge around pregnancy and parenting.

5.6 Chapter Summary: The Continuum of Cultural Safety

To determine whether the MCC midwifery model is culturally safe, it is necessary to examine the defining characteristics of cultural safety more thoroughly. Rather than understanding cultural safety as a static state of being, it should instead be viewed as a process or continuum (Brascoupé & Waters, 2009; Yeung, 2016). According to Brascoupé & Waters (2009),

> On the negative end of the continuum, where cultural destructiveness and cultural incapacity lie, we can see the roots of colonization, … [where] the paternalistic legislative and policy stance, and discriminatory attitudes towards Aboriginal people meant that too often western policy deliberately or inadvertently ignored or actively destroyed the languages, cultures and traditions of Aboriginal peoples… On the positive side of the continuum, beginning with ‘cultural pre-competence’ and [moving

> toward a sensitivity and a] growing awareness and recognition of the cultures of Aboriginal people… When cultural safety is reached on the continuum, the result is a transformation of the relationship between the provider and Aboriginal peoples, where their needs and voice take a predominant role (p. 5).

In other words, when moving through the continuum of cultural safety, there is a paradigm shift between the care provider and the healthcare recipient, such that there is a transfer of power such that the care provider is no longer exercising power over the healthcare recipient. The first step away from cultural pre-competence is cultural awareness. This is when a care provider recognizes their own cultural behaviours and how they differ from other people (Brascoupé & Waters, 2009; Wilson et al., 2013). Through this awareness, the power dynamic between the care provider and those in their care can begin to shift. Next, in the phase of cultural competence, care providers can develop the skills that are necessary to ensure quality care for their Indigenous clients. This includes ensuring that, at both systemic and individual levels, processes are in place to promote culturally competent healthcare practices by identifying what is important to the healthcare recipients in relation to their healthcare (Birch et al., 2009). It is not enough for a care provider to be informed of the injustices of the past, instead, to be culturally safe care providers, they must take actions to prevent the perpetuation of harmful behaviours by allowing the needs of those in their care to be a top priority (Brascoupé & Waters, 2009; Wilson et al., 2013).

Based on what the speakers have said, it is fair to consider the MCC midwifery model to relatively culturally safe. However, while the MCC midwifery model does consciously move toward culturally safety in an ever-evolving process, which enables trusting and respectful relationships between the midwives and their clients, as well as facilitating access to prenatal care, there are elements lacking from mainstream prenatal care models which would make them more culturally safe, such as having an Elder or others with traditional knowledge surrounding pregnancy, birth and parenting, as well as access to cultural resources such as smudging and ceremony. Since, "the ultimate goal of promoting this empowerment is to return complete control of health care systems and provision of health care to Indigenous communities," (Yeung, 2016) MCC midwives should not work in isolation from Indigenous birth workers, such as Indigenous midwives and Indigenous doulas, as these Knowledge Keepers are the only ones can provide MCC midwifery clients with access to healing traditional knowledge, as well as relate to their lived experience (NACM, 2017; National Aboriginal Health Organization (NAHO), 2004;

Smylie et al., 2016). Furthermore, to be more fully culturally safe, the MCC midwifery model must also include Indigenous-led supports to help their clients navigate CFS and the traumas caused by the impact of the child welfare system and ongoing assimilative policies in their families and communities (Manitoba Legislative Review Committee, 2018). It is elements such as these that would support Indigenous self-determination (Cidro et al., 2018; Ireland, Montgomery-Andersen, & Geraghty, 2019; Smylie et al., 2016; Yeung, 2016), and decolonize the midwifery model, such that new models of community-based, interdisciplinary maternity care can emerge to reach a greater number of Indigenous families, in even more empowering, respectful, and appropriate ways.

Chapter 6: Engaging Two-Eyed Seeing on the Path to Cultural Safety

6.1 Introduction

This final chapter explores the question: *What lessons can healthcare providers learn about cultural safety by applying Two-Eyed Seeing to their relationships with Indigenous healthcare recipients?* Cultural safety is an example of Indigenous theory that is becoming increasingly more well-known in the mainstream medical world. One way that healthcare practitioners can strengthen in their ability to apply cultural safety to their work is to practice Two-Eyed Seeing to their interactions with Indigenous patients and clients (Greenwood et al., 2017). This final chapter will explore how a Two-Eyed Seeing perspective can be used in medical practice to integrate the perspectives of Indigenous healthcare recipients to have a meaningful and positive influence on the they way they experience healthcare. Section 6.2 looks at Two-Eyed Seeing and how it will be applied to this chapter. Section 6.3 examines some experiences the speakers have had with healthcare providers and the impact of those interactions on their experiences of that care. Section 6.4 examines interactions the speakers have had with the midwives, how their positive interactions with the midwives could translate to other disciplines to improve the way others work with Indigenous healthcare recipients, and how the MCC midwifery model could be improved to provide a greater degree of cultural safety. Section 6.5 explores the messages the speakers have for healthcare providers working with Indigenous people. Section 6.6 examines how the MCC midwifery model engages with Truth and Reconciliation Commission's (TRC) calls to action to honour it and better serve Indigenous families receiving prenatal care in inner city Winnipeg. Finally, section 6.7 reflects on the lessons learned in this research project and makes recommendations for areas of future research.

6.2 Two-Eyed Seeing and reflective practice

Two-Eyed Seeing is a Indigenous theoretical perspective which incorporates western and Indigenous knowledge to generate a deeper perspective (Marshall et al., 2015; Martin, 2012; Iwama, 2009). By applying a Two-Eyed Seeing lens, one is enabled to see multiple perspectives at once (Marshall et al., 2015; Martin, 2012). In this research, the main source of Indigenous knowledge are the Indigenous healthcare recipients themselves, who bring a worldview that is not otherwise accessible. Their perspectives are important because western perspectives are bound to contain biases and assumptions that are prone to reinforcing paternalistic and colonial relationships between Indigenous and non-Indigenous communities (Roy & Campbell, 2014).

Reflective practice is an element of, two eyed seeing, which Marshall, Marshall and Bartlett (2012) have expressed as lessons learned. According to Hovey et al., these lessons, which help guide Two-Eyed Seeing, involve “a dynamic, changing, interactive, and relational process which generates new ideas, understandings, and information… It allows the exploration of lessons learned and working together to enhance the health of Indigenous peoples through a practical sharing of knowledge to improve human situations” (Hovey, Delormier, McComber, Lévesque, & Martin, 2017, p. 1278). In keeping with the concept of reflective practice, this chapter looks at lessons learned through examination of what the speakers say about their experiences of interacting with healthcare providers, including MCC midwives. Specifically, it looks at what they say about the role of relationships in their interactions with healthcare providers.

6.2.1 Relationships. The overarching theme of this research project is relationships. The speakers repeatedly talk about how the different elements of their relationships with midwives and other healthcare providers impact their experiences of the care they receive.

The MCC Midwifery model involves multiple relationships. MCC midwives have interpersonal relationships with their clients, and their clients’ support people and families. The midwives also have relationships with their professional colleagues and each other. The interprofessional relationships form a web of support for both the midwives and their clients. For the midwives, community resources and professional colleagues enable the midwives to provide more comprehensive care to their clients, by referring them to services that aim to meet their needs.

MCC midwifery clients also have relationships with the same people as the midwives, although the clients experience these relationships from the position of a healthcare recipient instead. Without the clients, there would be no need for the services. This should be taken into consideration before choosing to treat Indigenous healthcare recipients in a disrespectful manner.

Throughout the interview process, the speakers talk about their appreciation for their relationships with MCC midwives. In section 4.3.1, they describe how they appreciate that there is a group of midwives to support them because there is a greater number of people available to provide them with care as they need it, and all of those people know their clients’ stories, and they all take the time to get to know the clients and build a relationship with them. In section 5.3.3, the speakers expressed how their relationships with the midwives should make letters of

support from the midwives to CFS credible personal references and supporting evidence that families should stay together, and their babies should not apprehended at birth. The speakers also expressed that their relationships with the midwives made them feel comfortable and open to talking to the midwives about their experiences of trauma (section 5.2.3) and problematic substance use (section 5.2.2).The midwife-client relationship is the foundation of the MCC midwifery model of care, and they ways the midwives relate with their clients is the key to making this model effective. According to Cidro et al., (2018), "The basis for support for First Nations women who birth is a positive relationship. According to research with First Nations communities in [British Columbia], the positive and stressful aspects of relationships with care providers were underpinned by respect, understanding of cultural context and connection with communities" (p. 2). The speakers value their interactions with MCC midwives for the fact that they lead to a relationship. Comparing her relationship with MCC midwives to other healthcare providers, Speaker 11 says,

> There is no comparison. There is absolutely no comparison. That's actually one reason why I haven't found another family doctor because you don't get that one on one personal kind of … what's the word I'm looking for? It's not a bond, but you know, that relationship… You know, I walk in and all of you guys know me. ... Which is wonderful. I don't I don't feel there's that relationship with other medical professionals… If I have a problem, I'm not going to be afraid to tell you guys. No matter what it is.

In section 6.3, 6.4 and 6.5 will examine the speaker's views on the role of relationships in their interactions with healthcare providers to generate a deeper understanding of what MCC midwifery clients value in their interactions, as well as what types of interactions makes them unhappy or deter them from care, and provides reflective analysis on how their views can be applied in practice to improve the relationships between healthcare providers and Indigenous healthcare recipients.

6.3 Interactions with Healthcare Providers

Several similar topics arose from discussion about the speakers' experiences of their interactions with healthcare providers. The speakers expressed many negative sentiments. Four of the eleven speakers found their interactions to be impersonal. Two of them said they did not like having to repeatedly retell their history to healthcare providers who did not know them, and two of them did not like not knowing the person who will deliver their baby. Speaker 11 said,

> Speaker 11: I don't want to walk into a place and have to tell you all over again what my problems are.

Three speakers commented that doctor's appointments were very short. They felt that the short appointments prevented relationship building and made it difficult to know exactly what was going on with their health. Three of the speakers felt judged by healthcare providers. One of them expressed thinking they were judged due to racial discrimination. Two of the speakers expressed feeling uncomfortable when interacting with healthcare providers. Other negative sentiments expressed by the speakers include, harsh attitudes, closed off and uncaring demeanors, lack of eye contact, and assumptions that Indigenous patients are drug seeking. They said,

> Speaker 15: Say if I need like pain killers, because I have boxer fracture, so it hurts in the middle of the winter because I have two pins in there. So you go there for pain killers and right away they judge you and think you're addicted to opiates. And it's only because of the colour of your skin.

> Speaker 2: They don't really explain what was wrong with me... They just, they'll only give you a prescription for Tylenol or something. In and out, that's it.

> Speaker 12: I notice the doctors I've seen have been closed and not really present when you need them… It's really awkward... It makes it uncomfortable.

These types of negative experiences with healthcare providers place Indigenous healthcare recipients in a vulnerable position. According to Yeung (2016), such negative experiences such, "have become prominent reasons for the delay or omission of seeking timely care. Health care institutions that do not practice culturally safe care ultimately alienate Indigenous peoples from seeking needed health services, thus perpetuating poorer health outcomes" (p.1). Speaker 3 recounts an experience she had with an insensitive healthcare provider that led her to not seek prenatal care for three consecutive pregnancies:

> Speaker 3: I had this one experience on Sargent at a walk-in clinic when I was pregnant with my second oldest who is going to be eighteen… When I told the doctor that I think I'm pregnant and that I was using alcohol… he just said, 'You shouldn't be drinking if you knew that, if you thought you're pregnant.' You know like, 'mothers don't do that

> kind of stuff.' And I was like, 'Holy. You're mean.' So that made me feel uncomfortable. I never went back, so I never ever got prenatal care for my three older ones.

In this case, it was a judgemental attitude which led this pregnant person to feel so uncomfortable that she avoided prenatal care for many years, until she took a chance on MCC midwives in her fourth pregnancy.

While the speakers reported several negative encounters with healthcare providers, three of the speakers did talk about positive interactions they had. One speaker expressed appreciation for the MIK nurse, who helps clients get in to see a doctor at MCC if they miss their appointments. One speaker appreciated that a Dr. A gave them a prescription for antidepressants to try out while waiting for an appointment with clinical health psychology to address her mental health concerns. One of the speakers had a meaningful interaction with an Indigenous physician at MCC.

Most of the speakers reported negative sentiments about their interactions with healthcare providers and this is problematic because it puts them at risk of not perusing the care that could help them. Healthcare providers who alienate their patients as described above, should understand that they are, in fact, perpetuating a history of distrust among Indigenous healthcare recipients and the healthcare system. Instead a respectful, non-judgmental approach would be more useful if they wish to work more effectively with Indigenous people.

6.4 Midwifery Care as a Positive Healthcare Interaction

The speakers talked about the qualities of MCC midwives often in comparison to other healthcare providers. They described the attitudes of the midwives using positive sentiments. Five of the speakers said the midwives were nice. Four remarked that the midwives had a positive attitude. Three said they were welcoming. They said,

> Speaker 7: They were always positive. And always welcoming. Sometimes when I would say new things they would be like, "Really? Wow. OK." But they were always willing to do the research so they could get on board with me, so it was nice.

> Speaker 15: [They] are just always friendly… always smiles. I've never seen [them] mad.

Three said they were bubbly. Speaker 19 said,

> Speaker 19: I'd say they were pretty bubbly and cheerful. And they're really supportive. I did kind of go out of left field with questions that people didn't know how to answer, but they answered them to the best of their abilities. It's comforting.

Three called the midwives trustworthy. Three of the speakers felt the midwives were comforting.

> Speaker 11: [The midwives] always calm my mind.

Four of the speakers described the midwives as supportive. They said,

> Speaker 7: I feel like [midwife's name] was a big help because she was there through both of my pregnancies. And [midwife's name] brings a lot of energy, even if you call her in the middle of the night. It doesn't matter… [She] was almost like a nice grounding tool in both my pregnancies.

> Speaker 20: I don't think I would have had it any other way… I even tell people, when I have friends that are pregnant, "You should have a midwife. They're good. They make you feel comfortable."

The speakers also expressed many other positive sentiments about the midwives' attitudes, including that the midwives were respectful, non judgemental, helpful, laid back, caring, patient, calm, excellent, and grounding. These sentiments provide evidence that the MCC midwifery model is reflects the values of culturally safe practice, as balance of power has shifted, such that the speakers feel safe and respected in their interactions with the midwives.

While the midwives are well received overall, one of the speakers felt pressured by them. This should be taken seriously by the midwives for two reasons. First, it is against midwifery philosophy to pressure their clients to do anything, as informed choice fundamental standard of practice for midwives in Canada. The Collage of Midwives of Manitoba (CMM) *Standard on Informed Choice* states,

> The interactive process of informed choice involves the promotion of shared responsibility between the midwife and the woman and her family… The midwife is responsible for facilitating the ongoing exchange of current knowledge in a nonurgent, non-authoritarian and co-operative manner, including sharing what is known and unknown about procedures, tests, and medications … [However,] the childbearing woman is recognized as the primary decision-maker (CMM, 1998. p1).

Second, making clients feel pressured interferes with trust building (Abbott et al., 2014) and strains the client-midwife relationship, which is a critical element of cultural safety and the MCC midwifery model.

Speakers also described the midwives' attitudes toward the support people that they brought to their prenatal care visits with the midwives. Five of the speakers brought their children. Seven of the speakers brought their partners. The speakers expressed positive

sentiments about how their support people were received by midwives. They expressed the following sentiments,

> Speaker 11: [My partner is] an extension of me and he was treated as such.

> Speaker 20: [The midwives treated my family] just like family.

Since all the speakers reported bringing support people to their appointments with the midwives, these relationships are clearly important to the speakers. This highlights the importance of midwives having good relationships with their clients. The midwives should continue to endeavor to make their client's support people feel comfortable and welcome as they too become an element of the midwife-client relationship.

6.4.1 Providing Support. The speakers talked about the ways in which the midwives supported them. The speakers said that the midwives helped them through everything, sat down and conversed with them, were available to talk if something was bothering them, made sure they were okay, helped get them in to parenting programs, referred them to Dr. A (see chapter 4), took a harm reduction approach, advocated for them with CFS, wrote them a sick note, provided pamphlets, and were willing to do research. Three of the speakers talked about how they formed a relationship with the midwives. Two of those said that the midwives were like family.

> Speaker 1: The midwives at Mount Carmel Clinic are more like family than if you go somewhere else where your just there for your appointment… You sit down and [have a] one-to-one talk. Like, if something's bugging us… we can talk [their] ear off forever.

> Speaker 20: [The midwives treated me] just like family. Like they've known me for a while. Which is good.

The speakers hold their relationships with the midwives in high regard and value the relationships they build with the midwives over time. Speaker 19 said, "With the midwives there is a relationship built over nine months." The theme of relationships repeatedly emerges from the interviews. The midwives provide their clients with supportive care, and they provide that support in a manner that earns the trust of the families in their care. Maintaining good relationships is a part of the midwifery model of care after all, as practicing person-centered is a foundational standard of midwifery care (College of Midwives of Ontario, 2018), so the clients should and do expect to be treated respectfully and kindly by the midwives. This appears to create a positive perception of midwifery care among the speakers.

6.4.2 Taking enough time. This section shows what speakers said they like the about the time they spent in appointments with the midwives. They felt that the midwives made sure they were alright, explained things, answered their questions, and were thorough. They also like that the midwives would listen to them and were available to talk, even if it was not pregnancy related.

The speakers revealed three similar views about time. Seven of the eleven speakers felt that the midwives took enough time in appointments. Three of the speakers liked that their appointments were longer than appointments with other care providers. Two of the speakers expressed enjoyment with being able to sit down and have a casual conversation with the midwives. They said,

> Speaker 1: The midwives at Mount Carmel Clinic are more like family than if you go somewhere else because they're just there for your appointment and they don't want to hear about your history or they don't want to sit down and we can this 1 to 1 talk like if something's bugging us, or. They just want you for your appointment and boom that's it. "Here come back at this time". So here at least we can talk your guys' ear off forever.

> Speaker 16: It wasn't like super quick or anything, like some places.

> Speaker 19: Midwifery care is more hands on, and you sit there and have a conversation. You can sit there and have a coffee, which I've done with one of the midwives… She sat there with baby and we talked for a little bit while I drank my coffee. So, I mean, there's time to sit down and relax and interact with the provider, rather than just in and out.

These sentiments are similar to those expressed by Indigenous healthcare participants elsewhere in the literature (Abbott et al., 2014; Di Lallo, 2014; Wilson et al., 2013).

The literature argues that by allowing for adequate time for an appointments contributes to building rapport and therapeutic relationships, which in turn may contribute to better health outcomes for Indigenous families (Abbott et al., 2014; Wilson et al., 2013). According to Wilson et al., (2013) healthcare providers working with Indigenous patients should,

> Schedule longer appointment times. Investing more time from the beginning helps establish more effective and respectful rapport. Health professionals should be aware that the health narrative begins with the context and ends with the individual. This is rooted in… the value of humility, and it requires professionals to be skilled in active listening… Recognize that when patients are not listened to, it is a continuation of the oppression.

This recommendation is in consistent with the MCC midwifery model, and based on the what the speakers have said, allowing more time for appointments is meaningful to them as well.

Two of the speakers, expressed divergent sentiments about the longer appointments the midwives provide. One said that she sometimes did not have the time to sit around and chat. She said,

> Speaker 3: Sometimes I was in a rush and I couldn't sit around but I had to answer a whole bunch of questions. I was like, in a rush and they kept asking questions and making sure that I was alright. I was like, "Yes, I'm alright. " And, "OK I'll do that. Yes, I will. I'll be here that day. Don't worry."

The other said that she prefers to keep her privacy and not share too much information about her personal life with the midwives, or other people in general.

> Speaker 12: I don't really like being open about my own circumstances. But I think that there might be people that do need to talk to somebody. So, I feel like it's a good thing that you guys do try to get information from people.

Overall, the speakers were satisfied with the amount of time the midwives took in appointments and enjoyed the experiences they had. Healthcare providers should provide their clients with an opportunity to converse so that they feel listened to, but they must be aware that people may not always have time to spend in appointments. They should also be sensitive to their clients' need for privacy, with an understanding that some clients are not interested in having too personal a relationship. While there is much literature on the value of making sufficient time available to Indigenous healthcare recipients as a means of providing culturally safe healthcare, the literature on cultural safety does not delve into ideas about Indigenous healthcare recipients' needs and preferences for privacy, indicating that more research is needed to better understand how to navigate these boundaries.

6.4.3 Room for improvement.

While the speakers mainly expressed positive sentiments about the care they received from the midwives, they were asked about how they thought MCC midwives could improve or add to their services. The positive sentiments included that the midwives did a lot, were helpful, and that they are doing a good job already. They said,

> Speaker 1: They helped me in all the ways… They helped me through everything.
>
> Speaker 2: They mostly do everything.
>
> Speaker 3: They did a lot.
>
> Speaker 4: They were excellent.

Speaker 11: [They] are already helping; [they] are on track.

Speaker 12: I'm pretty sure [they] had everything covered.

Speaker 15: [They] do a pretty good job.

These positive sentiments validate that the MCC midwifery model is effective at meeting the needs of the families that it serves. However, two of the speakers expressed negative sentiments and recommended ways that the midwives could improve their interactions with clients. One speaker felt pressured by a midwife when discussing what the speaker should be eating to help control her gestational diabetes (GDM). The speaker suggested that midwives beware of their tone when discussing these things with their clients. Another speaker felt pressured about abortion and adoption options as a pregnant teen in her first pregnancy and she warned the midwives to beware of stereotyping people from the inner city.

> Speaker 1: One midwife was kind of… up in my face when I [had] gestational diabetes… "Can't eat this, can't drink that. You gotta do this, you gotta do that…" [It made me feel] pressured. [It would have been better] if she would have told me a different, nicer way.

> Speaker 7: I had one comment about the adoption and abortion options... I told them that that wasn't an option and it was not what I wanted and then a couple visits later it got brought up again… I felt like I was getting pushed or like, trying to be convinced or something like that… I feel like that was kind of a stereotyping of where I was [a teen mom and] because I'm in the North End… I wondered why they brought it up again… and if they're suggesting that more than once it's kind of like, "Am I a good mom. Do they not see me fit? They know what fit is." So, it could get a little discouraging.

These negative sentiments indicate that there is room for improvement in the MCC midwifery model of care. Highlighting such sentiments is important because it creates an opportunity to better understand the needs of MCC midwifery clients. Greenwood et al., (2017) talk about the 1996 *Royal Commission on Aboriginal Peoples (RCAP)*, which, "Among other recommendations… encouraged mainstream health services and organizations to undertake a systematic assessment of their practices to see how they [could] improve their connections with Aboriginal peoples" (p. 181). This is precisely the purpose of this research project.

Greenwood et al., argue that RCAP represents a pivotal turning point with respect to the dominant understanding of the effect historical abuses in Indigenous peoples in Canada. They explain,

"RCAP paved the way for the *Indian Residential Schools Settlement Agreement (IRSSA)* in 2006. The largest class action settlement in Canadian history, the IRSSA recognized the damage and abuse of the federal Indian residential school system, and called upon the federal government to compensate survivors and support their healing. In response to the IRSSA, the federal government also delivered a public apology for the abuses and traumas inflicted upon Aboriginal children in residential schools, and in 2008 formed the [*Truth can Reconciliation commission of Canada] (TRC)* to document the experiences of residential school survivors and their families" (p. 181).

The TRC will be discussed further in this chapter in section 6.6., using the calls to action as a tool for creating a deeper understanding of what healthcare providers and policy makers can do to promote better healthcare experiences for the Indigenous people that they serve.

The speakers made suggestions for additional supports the midwives could provide, including, giving clients an ultrasound photo, writing a letter of support letter to CFS, providing hygiene resources for clients (such as shampoo conditioner, razers, body wash), providing support outside of clinical care, providing resources involving Indigenous culture, providing community education about MCC midwives, and creating access to information about MCC midwives on the internet and social media (table 6.1).

Room for improvement: Suggestions of additional supports
- Ultrasound photo - Support letter/ ongoing support with CFS - Hygiene resources for clients (shampoo conditioner, razers, body wash) - Provide support on the outside - go out for lunch with clients - Provide examples of traditional medicines - Smudge with clients - Incorporate seven sacred teachings - Make pamphlets explaining what the midwives do - Make a poster explaining what midwives do - Put info about MCC Midwives on social media and MCC web site - Let people know what you do

Table 6.1. Room for improvement: Suggestions of additional supports

Certain recommendations that the speakers have, such as, incorporating the seven sacred teachings, sharing knowledge about traditional medicines, and leading a smudge with MCC midwifery clients, suggest that there would be value in having an Indigenous midwife, doula or support worker at MCC to provide midwifery clients with cultural support. Abbott et al., (2014) Cidro et al., (2018), and Smylie & Phillips-Beck (2019) provide examples of how Indigenous healthcare workers benefit Indigenous healthcare recipients. These Indigenous professionals

could work cooperatively with non-Indigenous care providers to provide patients with culturally safe care that includes Indigenous team member so that Indigenous healthcare recipients can have care providers who can relate to their lived experience and provide access to additional Indigenous knowledge and resources

The speakers were happy with the care they received, overall. The midwives should try to implement the changes suggested by the speakers in table 6.1. By engaging in reflective practice in this way, MCC midwives can use the advice of the speakers to create an even more culturally safe model of care.

6.5 Suggestions for healthcare providers

The speakers were asked if they had any suggestions for healthcare providers working with Indigenous people. In response, they asked not to be judged for being Indigenous or for having an addiction. They asked healthcare providers to put themselves in their patients' shoes, and to try to understand where they are coming from, and what led them to be in the circumstances they are in. They asked healthcare providers to try to improve their relationships with Indigenous people. They said,

> Speaker 1: Don't judge us we're all humans. Sure, we have an addiction. Just don't label us as an addict or something. We're here. We have a child growing us and we want help. Sure, we're addicts but everybody has secrets or problems. And people, well, in my experience, I got judged, well not really judged but I got lots of rolling eyes and whatever at other, past doctors' places, because of being an addict. But still I made to an appointment.
>
> Speaker 11: Just treat us like other regular people. Like, I mean I know most of the time I get, 'You're native? You're metis?' Yes. I'm white [passing], but that doesn't mean anything. It's still my heritage. It's my bloodline. And those that do look native shouldn't be treated differently, much like any other race.
>
> Speaker 12: Probably to just improve their relationships with Indigenous people. That's all.
>
> Speaker 16: Maybe not be so, I don't know, maybe put yourself in our shoes. And just think of all the stuff that we went through. Think of why we're living in poverty and all that kind of stuff.

The speakers expressed ways that healthcare providers could make their interactions more culturally safe. They want to experience healthcare providers as non-judgemental. Non-judgemental care is respectful care and respectful care is a necessity of cultural safety (Abbott et

al., 2014; Brascoupé & Waters, 2009). Brascoupé & Waters (2009) explain that cultural safety is about more than just “alluding to the identity of every person as an individual and as a member of a cultural community,” and that, “The first step in the healing process is to establish safety and trust with clients [because] safety can restore power and control… and foster responsibility for self and a feeling of belonging” (p. 31), rather than the alienation that comes along with judgemental attitudes. In this way, cultural safety is also about personal safety for Indigenous healthcare recipients.

The overall point of view here, is that healthcare providers could improve their relationships with Indigenous people by simply treating them with more kindness.

6.6 Honoring the Truth and Reconciliation Commission’s (TRC) calls to action and the National Inquiry into Missing and Murdered Indigenous Women and Girls (MMIWG) calls to justice

In 2016, the Winnipeg regional Health Authority (WRHA), released a statement in response to the Truth and Reconciliation Commissions (TRC) calls to action. It reads:

> Truth and Reconciliation Commission - Calls to Action RESOLVED that the WRHA Board hereby approves that the [WRHA] commit to responding to the health-related Calls to Action (Numbers 18-24), through the provision of high quality, culturally safe health care that is free of racism for Indigenous people… as recommended by the First Nations, Metis and Inuit Health Committee [of the WRHA] (Winnipeg Regional Health Authority, 2016).

MCC midwives along with the WRHA have an opportunity to honour this commitment to the TRC calls to action by looking at them through a Two-Eyed Seeing lens, by going beyond addressing the recommendations superficially, and instead, to take meaningful action to move “towards reconciliation and healing of the dysfunction and harms of colonization” (Greenwood et al., 2017, p. 181). Calls to action number 18-24 are the healthcare-related calls to action. As Smylie, (2015) explains that “the seven TRC recommendations specific to health, nested within the larger set of recommendations, comprise a comprehensive blueprint for lasting and tangible change” (p. 263). The following analysis will examine how MCC midwives are taking action to follow this blueprint and honour the TRC call to action, as shown by the evidence presented in this and the previous two chapters.

6.6.1 Call to action number 18. Call to action number 18 “calls for acknowledgment of the historical and political roots of health inequities” (Greenwood et al., 2017, p. 181). This is a

foundational call to action as it necessitates an understanding that health disparities experienced by Indigenous people are directly attributed to government policies of cultural genocide (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019; Smylie, 2015). By recognizing this call to action, MCC midwives acknowledge that the residential school system, government policies of forced assimilation, and the range of other processes and events that undermined Indigenous cultures and societies were wrong. This, in turn, produces a footing to defend their clients' rights to self-determination, health, and well-being.

6.6.2 Call to action number 19. Call to action number 19 "calls for measurable goals to identify and close the gap in health outcomes" (Greenwood et al., 2017, p. 181). The MCC midwifery model aims to do this with regards to prenatal care. It is not enough to identify that people living in the community area are at risk of receiving inadequate prenatal care when it is clear that the community members who are most at risk are the Indigenous families, as evidenced by the fact that 80% of MCC midwives clients are Indigenous. This research project is motivated primarily by this fact.

6.6.3 Call to action number 20. Call to action number 20 "calls for resolution of jurisdictional disputes and recognition of distinct health needs of Métis, Inuit, and off-reserve First Nation peoples" (Greenwood et al., 2017, p. 181). By acknowledging that the inner-city Indigenous families face unique challenges, the MCC midwifery model is positioned to address their clients needs in a way that is specific to the needs of the local community.

6.6.4 Calls to action number 21 and 22. Call to action number 21 "calls for sustainable funding for Aboriginal healing centres" (Greenwood et al., 2017, p. 181). Call to action number 22 "calls for recognition of the value of Aboriginal healing practices" (Greenwood et al., 2017, p. 181). By advocating for their Indigenous clients' and Indigenous colleagues' right to access to traditional medicine and the maintenance of their traditional health practices, such as Indigenous midwives, as well as doulas and cultural support workers who can provide culturally appropriate practical help, emotional support and ceremony (National Aboriginal Health Organization (NAHO), 2004), the MCC midwifery model honours this call to actions.

6.6.5 Calls to action number 23 and 24. The final two recommendations in this section - calls to action numbers 23 and 24 – "speak directly to some of the principles of cultural safety... Specifically, number #23 calls upon the government to 'increase the number of Aboriginal professionals working in the health-care field, [ensure] the retention of Aboriginal health-care

providers in Aboriginal communities, [and provide] cultural competency training for all health-care professionals'" (Greenwood et al., 2017, p. 181). MCC midwives honour these calls to action by providing evidence-based culturally safe care, by engaging in reflective practice such that their approach to culturally safe care is an evolving process, and by building relationships with Indigenous healthcare organizations in the community.

6.6.6 Seeing beyond calls to action 18-24. What is missing from the WRHA TRC statement is an acknowledgement of the fact that the TRC report is fundamentally a story of child welfare and that the current health and well-being of Indigenous people is inextricably linked to historically rooted and ongoing assimilative policies. This is made clear by the fact that the first five calls to action are related to child welfare (Truth and Reconciliation Commission of Canada, 2015).

While the child welfare calls to action do not apply to the MCC midwifery model in the same ways that the healthcare calls to action do, their relevance can not be overlooked, given the high rates of CFS involvement and newborn apprehension MCC midwifery clients experience, and the overwhelming distress it causes their families and community. The apprehension of children from the care of their families is historically and presently associated with devastating outcomes for the mother and the child, including but not limited to, trauma (Atwool, 2019), problematic substance use (Canfield et al., 2017), suicide (Wall-Wieler, et al, 2018a, Wall-Wieler, et al., 2018b) maternal mortality (Wall-Wieler, et al., 2018c), and far-reaching intergenerational effects (Manitoba Legislative Review Committee, 2018; National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019a; Truth and Reconciliation Commission of Canada, 2015, Wall-Wieler, et al., 2018c). The apprehension of a child by child welfare agencies is shown to have similar effects on maternal metal health as if her child had died (Wall-Wieler et al., 2017). Finally, pregnant people with a history of child apprehension are also more likely to have inadequate prenatal care (Wall-Wieler et al., 2019). It is for these reasons, that the child welfare calls to action in the TRC report are, in fact, important health-related recommendations, despite maybe not appearing so on the surface.

On 31 January, 2020 Manitoba's Families Minister, Heather Stefanson announced that as of April 1, 2020 the CFS practice of birth alerts program will end (Bergen, 2020). The birth alerts she is talking about are are documents sent to hospitals by CFS, which flag pregnant people who are due to give birth. Birth alerts direct hospital staff to call CFS when a person with

a birth alert gives birth, at which time a CFS social worker will attend the hospital to determine the parent's fitness to parent their baby. This assessment leads to parenting plans and often, to the apprehension of the newborn at birth, into the charge of CFS. To replace the birth alert system, Stefanson said, "The goal is to work with mothers before the baby is born and provide her with supports to keep the baby safe with his mother, instead of the antagonistic practice of what often ends in the apprehension of a newborn, and working backwards within the system of those supports to return the child to his or her family" (Ridgen, 2020, para 6). To date, MCC midwives have not been approached to participate in such an endeavour, despite the number of families in their care who have prenatal CFS involvement.

Unfortunately, Manitoba has since announced that it had decided to suspend this commitment, citing the Covid-19 pandemic as the reason (Canadian Press, 2020).

6.6.6.1 Child welfare and the MMIWG calls to justice.

In response to the news that the birth alerts are set to continue in Manitoba until after the Covid-19 pandemic is contained, Grand Chief Arlen Dumas of the Assembly of Manitoba Chiefs said,

> We realize that [COVID-19] is a critical reality for all Manitobans; however, our First Nations mothers and newborns babies have endured decades of unfair treatment and human rights violations. Their lives should not be discounted in light of [COVID-19]… The changes needed are within the Child and Family Services system and should not have vast impacts on the health care system. We call on the Manitoba government to be honourable to their commitment (Canadian Press, 2020, para 12 & 13).

The commitment Dumas speaks of is rooted father back than Manitoba's January 2020 announcement. The MMIWG report outlines the ongoing and historical context of that which makes child welfare legislation problematic (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019a, 2019a). It concludes that, "The Canadian state has used child welfare laws and agencies as a tool to oppress, displace, disrupt, and destroy Indigenous families, communities, and Nations… [and that] it is a tool in the genocide of Indigenous Peoples" (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019a, 355).

In terms of what healthcare providers can do to honour the MMIWG calls to justice in relation to CFS, they can engage in the training outlined in call to Justice 12.12, including, learning about the "history of the child welfare system in the oppression and genocide of

Indigenous Peoples, [getting] anti-racism and anti-bias training,]and developing an understanding of] local culture and language training" (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019b, 195). They can also support the families in their care, by advocating for them with CFS as noted in call to justice 12.4, that is, in a way that promotes Indigenous self-determination and argues against CFS apprehending babies on the basis of poverty and cultural bias.

With the present birth alert system, MCC midwives have been unsuccessful in reducing rates of newborn apprehensions, even though they are well positioned to be a hub of support for families involved with the child welfare system. This indicates that their clients are in urgent need of additional dedicated support, close to where they live and ideally at the MCC midwifery clinic, to support them in navigating the child welfare system.

6.7 Conclusion: Lessons Learned

One of the greatest lessons learned here is that the MCC midwifery model not only improves rates of prenatal care for Indigenous families in Winnipeg's inner-city, it does so with the humility to learn from and respond to the needs of their clients. They model cultural safety in midwifery care as a fluid and evolving process based on respecting the lived experiences of their clients and honoring the trust-relationship, respectfully and with kindness. This could not be confirmed without engaging in meaningful consultation with the speakers who were interviewed for this research project as representatives of the Indigenous MCC midwifery clientele. Their insights generate evidence of the benefit of access to culturally safe midwifery care for Indigenous families in Winnipeg's inner city.

This research project is but one step in an evolving approach to culturally safe care. Ongoing community engagement is necessary for keeping the MCC midwifery model grounded in a local worldview. As Greenwood et al., (2017) explain,

> We believe that the needed transformations in the healthcare system will not come from Western concepts or Indigenous concepts alone, but will require embracing both in the spirit of Two-Eyed Seeing. This means that non-Indigenous health organizations, systems, and service providers must create space—ethical space—for Indigenous knowledge that is specific, local, and relevant to the communities being served to shape the delivery of health services to those communities… or far too long, Western thought worlds have dominated, repressed, and sought to eliminate Indigenous ones; thus, it is the former that will have to learn from the latter how to enter into respectful relationships (p. 186).

In this way, relationship-building becomes an act of ongoing reconciliation where Indigenous and non-Indigenous members of the inner-city community work together to create something that empowers inner city families to be healthy and safe.

Below, figure 6.1 has been created to help visualize how the MCC midwifery model has incorporated evidence from the literature about cultural safety, prenatal care, and other relevant data with what the speakers have said about the challenges they have faced accessing healthcare and their proposed solutions. It is based on this chapter, as well as chapters two, four and five.

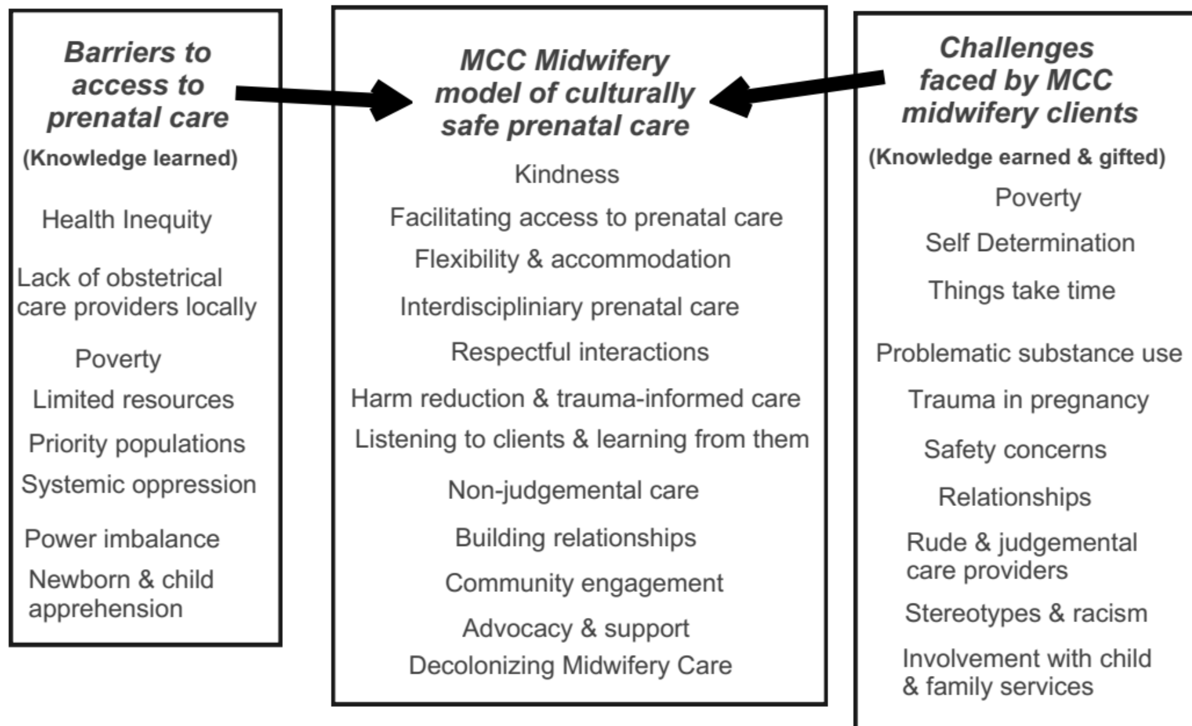

Figure 6.1 Two-Eyed Seeing: Envisioning a culturally safe midwifery model

The box on the left shows the barriers in access to prenatal care that were discussed in in the literature. These barriers are expressed as "knowledge learned" (Institute of Health Economics (IHE), 2011, 3) to show that they were learned from western sources. The box on the right describes the challenges that speakers reported to have faced in accessing prenatal care. These challenges are expressed as "knowledge earned and gifted" (IHE, 2011, 3) to show that they are insights generously offered by the speakers. The centre box, which has arrows pointing to it from the other two boxes are the main elements of the MCC midwifery model of culturally

safe prenatal care and they are derived from looking at the problem of barriers and facilitators to access to prenatal care from a Two-Eyed Seeing perspective.

The MCC midwifery model of prenatal care sets a tone for continued engagement with the midwives, as MCC midwives provide more than just prenatal care. They also provide care in labour and birth as well as primary care of the birther and newborn for six weeks postpartum. On top of this, MCC midwives remain available to non-pregnant clients to provide well-person care, including pregnancy tests, birth control, sexually transmitted and blood born infections testing, cervical screening, and harm-reduction supplies, as well as being available when clients stop by just to visit.

6.7.1 Recommended Areas of Future Research

6.7.1.1 The impact of the scope of midwifery care. Since MCC midwives provide more than just prenatal care, also caring for many their clients during labour and birth, as well as being the primary healthcare provider for the mom and baby for six weeks postpartum. The impact of their scope should be measured, especially due to its potential to support families so that their babies are not apprehended.

6.7.1.2 MCC midwives are uniquely situated to support their clients to avoid newborn apprehension. Since the midwives have been unsuccessful in reducing rates of newborn apprehensions, their clients are in urgent need of professional support, close to where they live and ideally within the midwifery clinic, to help them navigate the child welfare system and prevent their babies from being apprehended unnecessarily.

6.7.1.3 Well client care. MCC Midwives provide more well-person care than most other local midwives. This is partially due to the funding model which quantifies midwifery work by counting courses of care, which only includes prenatal, antepartum, and postpartum care and not well-person care, despite if being in the scope of midwifery care. MCC midwives do not turn away people who present for things like sexually transmitted and blood borne infections, pregnancy tests, and cervical screening. This work should be measured and the impact of ease of access to these services should be assessed. This research should also quantify how much work MCC midwives do in this area and the associated cost effectiveness, as well as client satisfaction.

6.7.1.4 Number of midwives. Since MCC midwives' model of prenatal care effectively increases rates of prenatal care, research should be done to assess the appropriate number of

midwives who should be providing care at MCC and directly dedicated to serving inner city families.

6.7.1.5 Indigenous birth workers are needed. MCC should have Indigenous midwives to provide their clients with the unique things that only an Indigenous midwife can provide (NACM, 2017, National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019a). While access to Indigenous midwifery is very limited in Winnipeg, there is a growing movement toward Indigenous-led initiatives to train Indigenous birth workers to provide support to Indigenous families before, during and after the birthing process. These initiatives are intended to bridge the gap left by the interruption of traditional birthing practices in Indigenous communities to "provide a pathway back to retrieving women centered knowledge around women's bodies, infant care and parenting that promote resiliency in Indigenous families" (Cidro et al., 2018).

While Indigenous doulas are not discussed in this paper, they are introduced here due to a growing movement supporting their important role of restoring sacred knowledge and to highlight their work, which is becoming increasingly more accessible to Indigenous families and gaining credibility (Cidro et al., 2018; NAHO, 2004; National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019; Smylie, 2014; J. Smylie & Phillips-Beck, 2019; Wiijii'idiwag Ikwewag, 2019; Winnipeg Boldness Project, 2017; Zaagi'idiwin, 2019). Future research should examine how MCC midwives and Indigenous doulas can work together to provide more holistic and appropriate care to Indigenous families in the inner city.

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Appendix A

Mount Carmel Clinic Midwives: Vision, Mission, Principals and Objectives

VISION STATEMENT

Feel Safe. Feel Heard. Feel Cared For.

MISSION STATEMENT

Promoting better outcomes for you, your baby and your family through accessible, flexible and personal prenatal, birth and postpartum care.

PRINCIPLES

We provide care that is equitable, accessible, flexible, non-judgmental, nurturing, accepting, respectful and safe. We provide client centered education. We are mindful of our own privileged position in the relationships with our clients. We acknowledge the harmful effects of colonization and policies such as residential schools on the health and well being of Indigenous women, their families, and their communities. We are working towards culturally safe practice. We use harm reduction and trauma informed approaches to care. We trust our clients to make the best possible choices for themselves and their babies. We are committed to interdisciplinary care provision, trusting our colleagues, while advocating for our clients. We engage in reflective practice to pursue innovative programs, quality midwifery care, and caring for each other.

OBJECTIVES

Connect families and ourselves to resources relevant to the local Indigenous community.

Advocate for Indigenous representation in midwifery and the Indigenous reproductive justice movement.

Help families to access resources and supports regarding poverty, Child and Family Services and justice.

Connect women to resources regarding addictions treatment and other related supports.

Participate in interdisciplinary case management.

Deliver midwifery care to an appropriate number of women with an appropriate number of midwives.

Offer choices in intrapartum care, including epidurals.

Engage in reflective practice to pursue innovative programs, quality midwifery care and practitioner sustainable self-care

Promote the midwifery profession.

(Mount Carmel Clinic Midwives, 2015)