EXPLORING THE COMPLEX CONTEXT OF INDIGENOUS WOMEN'S MATERNITY EPXERIENCES IN THE OKANAGAN VALLEY, BRITISH COLUMBIA BY EXPANDING ON ABORIGINAL WOMEN'S RESPONSES TO THE CANADIAN MATERNITY EXPERIENCES SURVEY

by

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Abstract

Indigenous women's experiences during pregnancy, birth and the early months of parenthood are important to understand their strengths, gaps, needs, priorities and barriers in order to address maternal and child health disparities. Despite clear evidence on how social determinants of health influence health, there is limited research that includes the perspectives and experiences of Indigenous women. The purpose of my research was to explore Indigenous women's maternity experiences.

An interdisciplinary theoretical perspective that includes decolonized and Indigenous methodology, social determinants of health theory, critical medical anthropology, and feminist scholarship informs my research. I conducted an analysis of Indigenous women's (N=410) responses to the Canadian Maternity Experiences Survey (PHAC 2009), followed by ethnographic research with ten Indigenous mothers in the Okanagan Valley, BC. Individual in-depth interviews and participant-observations were analyzed using thematic content analysis, which is organized into proximal, intermediate and distal contexts of Indigenous women's maternity experiences.

The aim of my research was to expand upon my MES findings and to explore the complex context of Indigenous women's maternity experiences and to understand why they experience higher frequency of stressors, violence and postpartum depression. Each woman's maternity experience is shaped by her unique circumstance. My findings suggest that Indigenous women's maternity experiences are embedded within their historical, social and cultural experiences, thus illustrating the importance of addressing and alleviating social determinants of health.

My research highlights and contextualizes Indigenous women's narratives of stress, barriers and experiences of accessing maternity healthcare, the impacts of colonization, and concludes with Indigenous women's strength and resiliency as women warriors. My dissertation

contributes to expanding research on Indigenous women's maternity experiences as a way of moving forward for culturally safe and improved maternal-child health, healthcare and maternity research.

Keywords: Indigenous, maternity experiences, social determinants of health

Preface

I, Jennifer Leason am solely responsible for the research design, collection, analysis and writing of this dissertation.

All my Relations

My name is Jennifer Leason and my Saulteaux name is *Kessis Sagay-Yas Egett Kwé*: First Shining Rays of Sunlight Woman. I am of mixed Canadian ancestry and self-identify as a Saulteaux- Métis Anishinaabek Kwé. My maternal Indigenous roots are from Duck Bay, Pine Creek First Nation and Camperville, Manitoba; and my paternal Ukrainian-Norwegian roots are from Hudson Bay, Saskatchewan. I am the daughter of Patricia Valerie Marie Fagnan and Roger Allan Leason. On my maternal Indigenous side, I am the granddaughter of Cecile Eva Chartrand and George Fagnan; the great granddaughter of Elise Beauchamp and Arthur Jacque (Jimmy) Chartrand and Marie Pélagie Okanens Moosetail and Louison Fagnan. Elise Beauchamp was the daughter of Philoméne Klyne and Jean Beauchamp (son of Nancy Chartrand and Joseph Beauchamp). Arthur Jacque Chartrand was the son of Julia Brass (daughter of Julia McLeod of Pelly and George Brass) and William Gédeon Chartrand (son of Sophie Genaille and William Chartrand). Marie Pélagie Okanens Moosetail was the daughter of Isabelle Atchakwe (daughter of Mary Stevens and Jean Baptiste Atchakwe) and Francoise Moosetail of Riding Mountain: Keeseeekoowenin Band (son of Moosoahnoh Saulteaux and Kates Saulteaux).

Canadian Research Data Centre

Although the Maternity Experiences Survey data was collected and vetted by Statistics Canada, the interpretations and opinions expressed in this document do not represent the views of Statistics Canada or the Public Health Agency of Canada.

Terminology

In my dissertation I have chosen to use the term “Indigenous” as a way to respect the diversity, autonomy, self-defining and inclusive representation of Indigenous peoples in Canada

and internationally. My dissertation focus is Indigenous peoples in Canada and is inclusive of First Nation, Métis and Inuit Populations. I want to acknowledge and respect the diversity and self-identification of my sister-participants who self-identified as Cree, Syilx, Blackfoot, and Métis.

Although there is no single agreed upon definition of Indigenous (Bartlett et al. 2007), I chose this term over the Government of Canada, Constitution Act, 1982, section 35(2) term Aboriginal. The only exception I make is when I reference and cite sources that use the term Aboriginal in their data collection or publications. For example, the Public Health Agency of Canada: Canadian Maternity Experiences Survey discussed extensively in chapter three uses the term Aboriginal in its data collection.

Behavioural Research Ethics

The University of British Columbia Okanagan Behavioural Research Ethics Board granted ethics approval for this research on November 19th, 2014 (Certificate number: H14-02248).

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List of Acronyms

APS	Aboriginal Peoples Survey
BC	British Columbia
CAAN	Canadian Aboriginal AIDS Network
CCHS	Canadian Community Health Survey
CFI	Canadian Foundation for Innovation
CHRN	Canadian Homelessness Research Network
CIDA	Canadian International Development Agency
CIHR	Canadian Institute of Health Research
CMHC	Canadian Mortgage and Housing Center
CPSS	Canadian Perinatal Surveillance System
CDRC	Canadian Research and Data Centre
CTV	Canadian Television Network
EPDS	Edinburg Postnatal Depression Scale
FNC	First Nations Centre
FNIB	First Nations Inuit Health Branch
FNIHS	First Nations Inuit Health Survey
IAPH	Institute of Aboriginal Peoples' Health
INAC	Indigenous Affairs and Northern Development Canada
MCFD	Ministry of Child and Family Development
MES	Maternity Experience Survey
MNBC	Métis Nation British Columbia
MNC	Métis National Council
NAHO	National Aboriginal Health Organization
NCCH	National Collaborating Centre for Aboriginal Health
NGO	Non Government Organization
NHS	National Household Survey
NTD	Neural Tubal Defects
NWAC	Native Women's Association of Canada
OKIB	Okanagan Indian band
ONA	Okanagan Nation Alliance
PHAC	Public Health Agency of Canada
PHSA	Provincial Health Services Authority
PPD	Postpartum Depression
PRAMS	Pregnancy Risk Assessment and Monitoring System
RCAP	Royal Commission on Aboriginal Peoples
RHS	Regional Health Survey
SDH	Social Determinants of Health
STATCAN	Statistics Canada
TB	Tuberculosis
TRC	Truth and Reconciliation Commission of Canada
TCPS2	Canadian Tri-Council Policy Statement II: Research Involving Indigenous Peoples
UBCO	University of British Columbia Okanagan Campus
UN	United Nations
UN HDI	United Nations Human Development Index
WHO	World Health Organization

Glossary

Anishinaabemowin, the Ojibway language, is part of the Algonquian language group. Today the Anishinaabek people from Mikinaakominising (Turtle Island) speak various dialects of Ojibway (Ninewance 2004). Although I am not a fluent speaker and understand very little, I attempt to use some Anishinaabemowin as a way of introducing my chapters and integrating important Ojibway words and concepts within my dissertation.

Bezhig	One
Niizh	Two
Niswe	Three
Niiwin	Four
Naanan	Five
Nggodwaaswi	Six
Niizhwaaswi	Seven
Gwayahkooshkaywin	Balance
Kitche Manitou	Creator
Kessis Sagay-Yas Egett Kwé	First Shining Rays of Sunlight Woman
Kwé	Woman
Midewiwin	Spiritual society of the Anishinaabek
Miigwetch	Thank you
Mino Bimadizawin	The Good Life
Nennook-agi	Humming bird

I acknowledge the Okanagan/Sqilxw/Syilx peoples and their traditional territory and use the following Nsyilxcən terms.

Lim Limt	Thank you
Inkumupulux	Head of the Lake (Lake Okanagan)

Acknowledgements

In keeping with tradition I would like to begin with thanks. Thank you Kitche Manitou: Creator for the breath of life. Thank you to my mother (and all the mothers before me) for the gift of water and bringing me into this world; I miss you. Thank you dad, Roger Leason, for your ongoing love and support and encouragement to "get 'er done." Thank you to my sister, Jacki Leason-Wilson, for always standing beside me through thick and thin. You have been my biggest support and my best friend. I would not be where I am today without you. I would especially like to thank my children Lucas and Lucy (Jackson) who endured the last seven years while I was in graduate school. I cannot help but feel guilty that I have spent your entire childhood glued to my computer screen, distracted in the depths of books and journal articles, away at conferences and trying to balance being a mom while teaching, reading and writing. Thank you for your patience as I said, "just one more page;" "just one more chapter;" "just one more email." Although some days were difficult, your smiles, laughter, sticky hand hugs and power kisses kept me grounded and gave me strength to continue in times when I wanted to quit. Thank you for your everlasting love and patience, belief in me, and for showing me the meaning of love, hope and balance.

I would like to acknowledge and thank the Okanagan, Sqilxw, Syilx traditional territory. Thank you to the Inkumupulux community for your loving kindness and supporting me to raise my children while I am so far from home and family. Lim limpt.

Thank you to my committee for supporting me and providing guidance during my MA and Ph.D. journey. I would especially like to thank my supervisor, Dr. Naomi McPherson, who has been an exceptional teacher, mentor and friend. I could not have finished this degree without your love, encouragement and guidance. I am forever grateful. Thank you Peter, for being my brother and for volunteering your time. It is a rare quality for someone to give without asking for anything in return, which is a true testament to your loving kindness. Thank you Patti, for your

guidance and expertise in women's and maternal health. Thank you for connecting me to the Women and Children's Hospital, and for giving me a place to bunk while I conduced my research at the RDC in Vancouver.

I would not be where I am today without the generosity of funding institutions, grants and scholarships. Thank you to the Canadian Institute of Health Research: Institute of Aboriginal Peoples Health (IAPH) for the 3-year doctoral research award (Code: 201110DQU-265973-215964). Thank you to the British Columbia Network Environment for Aboriginal Health Research (NEAHR), Kloshe Tillicum, for supporting my first two years of my MA. I could not have completed my doctoral studies without your generous funding of scholarships and the support of the Indigenous health research community and National Gathering of Graduate Students (NGGS). Also, thank you to INDSPIRE, BC Association of Friendship Centers, BC Women and Children's Hospital, the BC Provincial Health Services Authority, and Métis Nation British Columbia for their generous scholarships, which helped alleviate the financial stress associated with graduate studies.

Thank you to the University of British Columbia Okanagan, Aboriginal Programs and Services, College of Graduate Studies, Community Culture and Global Studies, UBCO faculty, especially Dr. Gregory Younging, and Supporting Aboriginal Graduate Enhancement (SAGE). I would like to thank the staff at the UBC Vancouver Statistics Canada Research Data Centre for their support, especially Lee Grenon, Cheryl Fu and Denis Ma for their statistical expertise.

I would especially like to thank my "Sisters" for sharing your stories, lives, homes, families, histories and maternity experiences with me. I am further inspired by your stories to continue to learn, grown, understand and advance the importance of Indigenous women and peoples' health.

Thank you to all the Mothers of the Nations. May Creator and Sky Woman support you as you raise your children; our future. Miigwetch!

Dedication

For my mother Patricia Valerie Marie Fagnan-Leason

(19 September 1953 − 21 May 2013)

Nennook-agi (Hummingbird)

Two weeks before you died you came to my window while I was studying. I looked up several times and saw a beautiful golden green hummingbird with a bright fuchsia chest. How strange I thought; it's too early in May for them to be in the Okanagan already. So I researched online for 'Humming Bird Medicine' and wrote a note to myself that I have posted beside my desk. I believe you came to say good-bye and that this was your final message.

> Hummingbirds are messengers. They are a symbol of love, joy and beauty. They teach us that we can look back on our past, never to dwell but to keep moving forward. Hummingbirds migrate over 2000 miles, teaching us resiliency and to be persistent in pursuit of our dreams. Their energy teaches us that we can overcome the impossible and be strengthened by life's challenges. Hummingbirds open the heart, bring peace and return the natural balance (Gimel 2009).

For all the warrior men and women who continue to fight for a better future: just keep going.

Chapter 1 (Bezhig): Introduction

1.1 Prologue

I would like to begin with the story of Sky Woman. I begin with this story as a way of demonstrating what women (and cultures) can offer in terms of concrete ways to read/re-read our current situations in the world (Dillard 2008:278) when working in the area of Indigenous maternal child health.

> When Sky Woman was pregnant, she fell from the sky carrying seeds of creation (the three sisters of corn, bean and squash, and the medicines of tobacco and strawberry) and after lying on top of the turtle; she created [Mother] earth (Sunseri 2008:23-24).

As a conception story, Sky Woman illustrates an Indigenous gendered ontology, gendered bodies and gender roles (McPherson 2007: 128). Sky Woman demonstrates Indigenous women's power and the roles they play as women and mothers of the nation (Laronde 2005; Lavell-Harvard and Anderson 2014). Traditionally, Indigenous women commanded the highest respect in their communities as water carriers and the givers of life. They were considered sacred (Anderson 2000:73) and powerful beings because they "birth the whole world" (Bear 1990: 133). Conception, pregnancy, birth and mothering are beautiful and powerful ceremonies and there is a need to reawaken our women (and society) to the power that is inherent in that transformative process, which birth (and life) should be (Cook 1989). By promoting *mino-bimaadiziwin*, the 'good life' (Simpson 2006:26; Rheault 1998) to the birthing, raising and nurturing of the next generation (Bédard 2006:74), we can restore *gwayahkooshkaywin:* 'balance.'

Although my dissertation represents a formalized way of researching and understanding Indigenous women's maternity experiences in the Okanagan Valley and Canada, my journey was initiated and largely influenced by my own observations and experiences, including the

stories shared by my mother, sister, aunts, cousins, grandmothers, friends and community. Their struggles, strength and resistance, persistence, love and compassion have inspired and shaped my interest in Indigenous maternal and child health and maternity experiences. My sister's story is one that has particularly influenced me.

In the mid 1990s, my sister Jacki was diagnosed with Polycystic Ovarian Disease (PCOS), a hormonal disorder that affects 6 to 10 per cent of Canadian women and is linked to insulin resistance, which may increase chances of infertility and miscarriage (Canadian Women's Health Network 2015; Cocksedge et al. 2008; Diabetes Week 2015:151). As a result of her PCOS, my sister suffered five miscarriages since 1991, then a tubal pregnancy resulting in a miscarriage in 2011. As her sister and someone who loves her dearly, it was difficult to watch Jacki struggle and cope with multiple losses when all she ever wanted in life was to be a mother. After twenty years of strict diet and exercise, fertility treatments and multiple surgeries, Jacki and Ron conceived a baby girl. Jacki was diagnosed with gestational diabetes mellitus in her first trimester and placed on bed rest for her third trimester. On 15 July 2010 she gave birth to my niece, Morgan. In her words: "She is our miracle baby." As her sister I was privileged to Jacki's most intimate thoughts, emotions, struggles and experiences throughout her miscarriages and birth. Our stories and kitchen table conversations, late night phone calls, poker games and vent sessions were avenues to share and validate our lived experiences as sisters, Indigenous women and new mothers. There is comfort and camaraderie in sharing our stories and experiences.

Unfortunately, like Sky Woman who fell through a dark hole, not all stories are brought to light and some have been shadowed in the darkness of silence. As the pages of my dissertation unfold, I explore how the historical exclusion and misrepresentation of Indigenous women's experiences and their voices have created spaces of dialogue and debate on contemporary

Indigenous maternal and child health experiences and outcomes. My dissertation is a small space for Indigenous women's voices and the diversity of their maternity experiences and perspectives can be heard. A space "where there was once silence there is now a chorus of voices, a multiplicity of perspectives, (and) anything but a unified stance" (Kelm and Townsend 2006:17). By no means does my dissertation capture the full complexity of Indigenous women's maternity experiences, nor does it do justice to those experiences. Rather, this document represents an exploration. My findings are a small piece of the larger puzzle that, I suspect, I will spend my entire life and career trying to understand.

Like Sky Woman who carries the seeds of creation, I hope that by shedding light on the social and cultural context of Indigenous women's maternity experiences, small seeds of meaningful change will be planted to address Indigenous women's maternal child health disparities and inequities, as well as transform Indigenous women's maternity experiences and health research.

1.1.1 Coming Home

Globally, there are an estimated 370 million Indigenous peoples living in more than 70 countries, with more than 5000 languages and cultures (International Work Group for Indigenous Affairs 2016). Unfortunately, as is the case in Canada, Indigenous peoples' health is comparatively poorer than the health of their non-Indigenous counterparts in countries all over the world (Gracey and King 2009; King 2012; WHO 2014). The United Nations Human Development Index (UN HDI), which measures educational attainment, average annual income and life expectancy, ranks Canada as 9th overall within the world (UN HDI 2014). However, Perry Bellgarde, the Grand Chief of the Assembly of First Nations states that if Canada were judged on the economic and social wellbeing of its Aboriginal peoples alone, Canada would place 63rd out of 174 countries (Maclean's 2015). Indeed, McHardy and O'Sullivan (2004)

found that Indigenous communities represented 65 of the 100 unhealthiest communities in Canada.

Life expectancy is perhaps the most important measure of health and asks the fundamental question: how long can the typical person expect to live? Internationally, Indigenous peoples have a lower life expectancy than their non-Indigenous counterparts. For Indigenous peoples in Australia, there is 20.6-year life expectancy gap for males and 19.9 years for female Indigenous populations.[1] In New Zealand[2] the life expectancy gap is 7.3 years for Indigenous males and 7.9 years for females. In the United States, the life expectancy gap is 6.7 years for males and 5.3 years for females.[3] Canada is no better, with a life expectancy gap is 7.4 for males and 5.4 years for females (Bramley et al. 2005).

In addition to life expectancy gaps, there are also gaps in Indigenous maternal and child health. Maternal and child health is the health of a woman during pregnancy and birthing and the postpartum period, which encompasses family planning, preconception, as well as prenatal and postnatal care (WHO 2015). Maternal child health is important, not only to the health and wellbeing of mothers and their infants, but is also an important public health priority to create and support healthy individuals, families, communities and nations now and into the future.

There is a need to focus on Indigenous and Tribal peoples' health (Anderson et al. 2016), including Indigenous maternal child health disparities. Australian Indigenous and Torres Strait Islander women are between two to five times more likely to die in childbirth than non-Indigenous women (Bar-Zeev et al. 2013). Indigenous women are two to three times more likely to have higher preterm delivery rates, a low birth weight infant, and higher perinatal mortality rates (Blair 1996; De Costa and Child 1996; Buckskin et al. 2013). In New Zealand, the Māori suffer disparities in maternal child health as well. According to the 2013/2014 New Zealand Health Survey, infant death rates for Māori (5.7 per 1000 live births) and, for Pacific peoples

(6.9 per 1000 live births) were 1.4 and 1.7 times higher than European or Other ethnic group (4.1 per 1000 live births). Higher infant death rates were largely attributed to socioeconomic position, whereby 45 per cent of Māori women resided in the most socioeconomically deprived areas (Ministry of Health Manatu Hauora 2015). In the United States (USA), the maternal mortality ratio for American Indian/Alaska Native women is four times higher than the general population (Amnesty International 2011, Baldwin et al. 2008). Further discussion on Indigenous maternal child health in Canada is included in the following chapter.

My exposure and passion for international Indigenous maternal child health and the rights of Indigenous peoples began in 2006 when I was an intern with the Young Leaders Program through Ghost River Rediscovery, a program funded by the Canadian International Development Agency (CIDA). I was placed with Ekjut, a non-government organization (NGO) that aims to reduce maternal and child mortality rates in marginalized populations, including the Adivasi Indigenous communities of Ho, Santhal, Oraon, Juang, Munda and Bhuyian in Jharkahand and Orissa, India. According to India's National Family Health Survey (NFHS) and the Indian Sample Registration System (SRS), an estimated 2.5 million children under the age of five died in India between 1998-1999 (Claeson et al. 2000) and the national level estimate for maternal mortality was 520 maternal deaths per 100,000 births (Sing et al. 2011). EKJUT's mandate is to reduce maternal and child mortality, as directed by the United Nations Millennium Development Goals, specifically MDG3 to promote gender equality and empowerment of women, MDG4 to reduce child mortality, and MDG5 to improve maternal health. As a result of their appreciative inquiry and community based participatory action research, Ekjut reduced infant and maternal mortality by 35 per cent from 2005-2010 (Tripathy et al. 2010) and were awarded the 2011 Lancet's clinical trial of the year and the 2015 India Public Health Champion, World Health Organization (WHO).

During the last month of my internship with Ekjut, there was a tuberculosis (TB) outbreak in Cross Lake, Manitoba, that reached international media attention (CTV News 2008). According to Health Canada, between the years 2002 and 2006, TB rates were eight to 10 times higher for Aboriginal people compared to the overall Canadian rates. Tuberculosis rates were 29 times higher for Aboriginal people on and off reserve and TB cases were as high as 156 cases per 100,000 in Nunavut (Health Canada 2012). The report attributed higher rates of TB in Canada's Indigenous population to poverty, specifically the lack of affordable, adequate and safe housing.

Dr. Nirmala Nair, a co-founding member of Ekjut, asked me how one of the richest countries in the world could still face Third World conditions. She inquired about the health status of "my people" and asked why Indigenous peoples' health fared worse than the non-Indigenous population. I remember struggling to answer her questions, not only because the answers were complex, but also I simply did not know. As a Canadian, I am proud of the values that promote universal health care and equitable access to health. The Canada Health Act (1985) legislates publicly funded health care and the primary objective is to "protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers" (Canada Health Act 1985). However, systematic differences, inequitable access and barriers continue to create health disparities between Indigenous and non-Indigenous populations in Canada.

The words "my people" resonated with me and in that moment I knew I needed to return home to pursue a goal where everyone (including Indigenous peoples and women) should have a fair opportunity to attain their full health potential and, more importantly, that no one should be disadvantaged from achieving this potential, if it can be avoided (Whitehead 1991, 1992; WHO 1986a). Despite dramatic improvements in health care and technology, Indigenous

women "continue to feel isolated, impoverished and [to] experience inadequate nutrition during pregnancy (Royal Commission on Aboriginal People 1996:132). Upon completing my internship in India, I returned home to learn about Indigenous maternal child health in Canada. What unfolded in the following seven years was transformational.

1.1.2 Midewiwin: Dissertation Aim and Outline

Midewiwin, a spiritual society of the Anishinaabek, describes the seven stages of the life cycle:

> These stages include infancy (the good life); childhood (the spirit life); youth (the fast life); young adulthood (the wondering/wandering life); middle adulthood (planning/planting life); mature adulthood (doing life); and elder years (Elder life). As with other teachings, in this model the individual progresses from being the recipient of care and teachings, to seeking and fulfilling one's purpose, to becoming the teacher (Anderson 2011:9).

My doctoral research is organized into seven chapters, which mirror Anishinaabek seven stages of life. At the infancy of my graduate journey, it was the "good life" and birth into academia. I formed attachment to my graduate committee, who were my family, made friends among my graduate cohort, learned the language of the institution, and took my first steps in researching Indigenous heath. I continued my child-like inquisition into maternal child health disparities and why disparities continue to be produced and sustained over time (Richmond and Ross 2009:405). What I found was that, health disparities are not only the result of individual health behaviours and choices, but are also the result of social determinants of health, a topic I discuss in my literature review in chapter one.

The next phase of my doctoral journey was my childhood within academia or "spirit life." Like a child, I was drawn to stories, especially Indigenous women's narratives about their lived experiences. Unlike the Disney princesses I was obsessed with as a child, the heroines and protagonists of my academic childhood fixed upon generations of Indigenous women writers

and authors who continue to resist oppression, reclaim Indigenous mothering practices and restore the balance of inequity and injustice. The stories gave spirit and voice to the disheartening statistical disparities and social determinants and inspired me to contribute to this collective narrative of Canadian Indigenous women. Indigenous women's experiences are more than just numbers. By weaving together statistics and story, my literature review in chapter one prepared me to embark on the next stage of my journey, the "wondering and wandering life."

My wondering and wandering life led me to the Canadian Maternity Experiences Survey, hereafter MES (PHAC 2009). The MES was initiated by the Canadian Perinatal Surveillance System (CPSS) and conducted by Statistics Canada (Stat Can) and the Public Health Agency of Canada (PHAC). The MES was intended to provide representative, pan-Canadian data of women's experiences, practices and perceptions during pregnancy, birth and early postpartum months. As the leading agency of public health information and research in Canada, which informs policy and maternal child health programming, the MES was to serve as evidence-based research aimed at improving maternity care and infant health. The MES identified recent immigrant, young (age 16-19), and Aboriginal women to be higher risk of adverse pregnancy outcomes and that specific results from each population would be produced through focused publications (PHAC 2008: 11). These subsequent publications were never produced and I was left wondering just what, according to the MES… are Indigenous women's maternity experiences?

Over the months 2012 to 2013, I disaggregated Indigenous women's (N=410) responses to the MES (PHAC 2009) and conducted an analysis that highlighted Indigenous women's maternity experiences, which I discuss in chapter three. My analysis underlines a number of essential findings. However for purposes of my dissertation, I focus on three key findings. First, Indigenous women's experiences of higher rates of maternal stress are associated with

emotional, relationship, financial and traumatic stressors. The second key finding was the higher frequency of maternal violence experienced by Indigenous women. And the third key finding is the higher frequency of postpartum depression.

My MES analysis was a description of the Aboriginal women's maternity experiences, but I was also interested in understanding ***why*** Aboriginal women experience higher rates and frequency of stress, violence and postpartum depression. This led to the second phase of my research and the aim of doctoral research: to contextualize Aboriginal women's maternity experiences by engaging women in a conversation. Through experiential focused ethnography, I wanted to gain an understanding into the barriers they face as Indigenous women and mothers, and identify the strengths, gaps, needs and priorities that are important to them. Therefore, the aim of my research was to expand upon my MES findings and explore the complex interrelated determinants that contextualize Indigenous women's maternity experiences.

This next phase of my research represented the "planning and planting life" stage of my dissertation. In order to understand the complex interrelated determinants and context of Indigenous women's maternity experiences, my research utilizes an interdisciplinary lens. I use an interdisciplinary framework called *Gwayahkooshkaywin,* a Saulteaux-Ojibway word for 'balance,' modeled after Albert Marshall's Two-Eyed Seeing (Marshal 2008) that incorporates decolonized and Indigenous methodology, social determinants of health theory, critical medical anthropology, and feminist scholarship to research the complex and interrelated determinants (and layers) of Indigenous women's experiences. The next leg of my doctoral journey was "doing life". I collected and analyzed my ethnographic data to contextualize Indigenous women's maternity experiences. Chapter two includes an explanation of my research methods, including my MES analysis, experiential focused ethnography through one-on-one in-depth interviews with ten Indigenous birth mothers in the Okanagan Valley, who are introduced in

chapter four. This chapter aims to give an overview of who they are and their circumstances at the time of our interviews.

The context of Indigenous women's maternity experiences is unique and complex. After completing my analysis, I chose to organize my interview findings into proximal, intermediate and distal contexts. Like a stone thrown in water, the ripples that emanate from the centre represent multiple interrelated determinants and layers that contribute to women's overall experience. Chapter five is an examination of the first layer of proximal determinants that directly affect Indigenous mother's daily-lived experiences, including higher rates of stress and postpartum depression. These include education, employment, income, food security and access to safe and affordable housing. I include Indigenous women's maternity narratives of stress related to parenting, relationships and violence, as well as social support and strategies for coping with stress.

In chapter six I discuss the next two layers that contextualize Indigenous women's maternity experiences, including intermediate and distal determinants. The intermediate determinants include cultural safety in health care and barriers to accessing maternal healthcare, including Indigenous women's fear of child apprehension, and how those fears surface when women access maternity health care services. I then discuss the external layer of Indigenous women's experiences that are related to distal determinants, including colonialism, racism, social exclusion and self-determination. I include data from my interviews on Indigenous women's experiences of residential school and foster care. Chapter six includes Indigenous women's strength-based narratives of self-determination, resiliency and strength as means to create a better future for themselves and their children. Chapter six concludes with Indigenous women's narratives as women warriors who continue to resist, reclaim, restore, revitalize and reconnect with Indigenous mothering, identity, family and community.

In chapter seven the dissertation comes full circle and ends with the "Elder life." The chapter includes a discussion of my research findings, research limitations, and contributions to the literature and concludes with future research directions. My research highlights the unique and complex experiences and barriers faced by Indigenous women and mothers, and identifies the strengths, gaps and needs that are important to them. My findings suggest that Indigenous women's unique and complex maternity experiences are embedded within their historical, social and cultural experiences, thus illustrating the importance of addressing and alleviating social determinants of health in order to answer the "fundamental epidemiological question—why these people in this place at this time?" (Agar 2003:3). My intent is that my research should contribute to expanding research on Indigenous women's maternity experiences as a way of moving forward for culturally safe and improved maternal-child health and healthcare. The dissertation concludes with an epilogue, including a discussion of my personal reflections, growth and transformation.

1.2 Literature Review

The Indigenous peoples in Canada represent many rich and diverse histories, cultures, and languages. They reside in various geographies throughout Canada and have varying social, political and economic institutions, governances and organizations. There are 1,400,685 Aboriginal people representing 4.3 per cent of the total Canadian population (NHS 2011). "Aboriginal" peoples of Canada are defined in the *Constitution Act*, 1982, section 35 (2) as including the Indian, Inuit and Métis and refers to a person reporting being Aboriginal, that is, First Nations, Métis or Inuk (Inuit) and/or being a Registered or Treaty Indian (that is, registered under the *Indian Act* of Canada) and/or being a member of a First Nation or Indian band. Currently there are 851,560 people of First Nations descent (60.8 per cent of total Aboriginal population: 637,660 registered and 213,900 non-registered; 324,780 Aboriginal people live on-

reserve); 451,795 Métis (32.3 per cent of total Aboriginal population), and 59,445 Inuit (4.2 per cent of total Aboriginal population) (NHS 2011).

Indigenous peoples are the fastest growing segment of the Canadian population. According to the 2011 Canadian National Household Survey (NHS 2011) between 2006 and 2011, the Indigenous population increased 20.1 per cent, compared to 5.2 per cent for the general population. This increase may be due to a higher fertility rate (First Nation women's fertility rate is 2.9 children; 2.2 children for Métis women and 3.4 children for Inuit women, compared to 1.5 children for the overall Canadian population) as well as other changes such as an increase in self-identification. Compared to the median age of 39.8 for the general Canadian population, the Indigenous population is young. For First Nations people with registered Indian status and living on reserve the median age was 24 years of age and 27 years of age for those living off reserve; 31 years of age for Métis peoples, and 23 years of age for Inuit peoples (NHS 2011).

Given the diversity, young and growing Indigenous demographics, maternal and child health should be a Canadian priority. In the next section I review the current state of Indigenous women's reproductive health, as well as maternal and child health in Canada.

1.2.1 Indigenous Women and Maternal Child Health Disparities

The social and economic marginalization of Indigenous women has negative consequences on their health (Dodgson and Struthers 2005; Reading 2012:33). It has resulted in a life expectancy gap between three to ten years less for Indigenous women, compared to non-Indigenous women in Canada (Health Canada 2009). Circulatory disease is the leading cause of death, followed by external causes (accidents and suicide), cancers and digestive diseases (Health Canada 2003). Health disparities are also observed in Indigenous women's reproductive health including higher rates of sexually transmitted infection (STI), reproductive tract

infections, high-risk pregnancy and sexual violence (Stout, Kipling and Stout 2001). The incidence of cervical cancer is between 1.8 to 3.6 times higher than non-Indigenous women (Young et al. 2000) and Indigenous women have higher rates of death from cervical cancer (Health Canada 2000). Poor reproductive health outcomes are the result of lower participation rates in health screening (Black 2009: 157), inadequate access and structural barriers, barriers related to remote community access, lack of public information and awareness, and issues of comfort with healthcare providers (Yee et al. 2011).

The maternal and infant mortality rate in Canada is among the lowest in the world. The infant mortality rate (IMR) in Canada is 5.1 infant deaths per 1,000 live births (CPHA 2004). According to Statistics Canada, data quality, concepts and methodology, the definitions for early neonatal death is the death of a child under one week of age (0-6 days), infant death or Infant Mortality Rates (IMR) is the death of a child under one year, neonatal death is death of child under four weeks old (0-27 days), perinatal death is the death of a child under one week (0-6 days) and stillbirth (fetal death) is the death of a fetus of 28 or more weeks of gestation (Stat Can 2012).

Unfortunately, Indigenous women are at higher risk for adverse pregnancy and infant health outcomes (Edouard et al. 1991; Shah et al. 2011) but exact rates are unknown because there is a lack of inclusive, disaggregated, accurate and reliable national information specifically for First Nations, Inuit, and Métis populations (Smylie and Anderson 2006; Smylie et al. 2010:144; Green 2007). There are major gaps in Indigenous peoples' health indicators and performance measures to inform Indigenous community or regional health planning (Anderson and Smylie 2009:99). The gaps in perinatal health outcomes for First Nation, Métis and Inuit mothers and infants are the result of the lack of ethnic identifiers in registration systems, clinical

and hospital databases, as well as challenges in cross-linking datasets, jurisdictional complexity, lack of capacity and culturally specific health indicators (Smylie 2010).

The IMR research available for status First Nations women living on and off reserve, and for Inuit, range from 1.7 to over 4 times higher than Canadian rates (Smylie 2012; Smylie et al. 2010: 146). In British Columbia, longitudinal research from 1981 to 2000 indicates that IMR are 2.3 times higher for First Nations infants in rural areas and 2.1 times higher for First Nation infants in urban areas, with Sudden Infant Death Syndrome (SIDS) being the leading cause of death (Luo et al. 2004). Higher IMR within Indigenous populations has been attributed to maternal risk factors such as previous preterm birth, two or more previous spontaneous abortions, low weight gain during pregnancy due to nutritional limitations, smoking while pregnant, inadequate prenatal care and high levels of perceived stress for Indigenous women (Heaman et al. 2005). In addition to IMR, Inuit and First Nations populations have higher stillbirth rates, with an estimated stillbirth and perinatal mortality at 2.0 to 2.5 times the Canadian average (Chalmers and Wen 2004). The higher rates of stillbirth are attributed to poor fetal growth, placental disorders and congenital anomalies, and were often the result of diabetic and hypertensive complications among Inuit and First Nations populations in Québec (Gilbert et al. 2015). In a recent study conducted in Québec from 1996 to 2010, Chen et al. (2015) found that perinatal and infant mortality rates were 1.47 and 1.8 times higher for First Nations, and 2.37 and 4.46 times higher for Inuit compared to non-Aboriginal births, and post neonatal mortality among First Nations was 3.71 times higher and 8.98 times higher for Inuit infants. These pockets of data illustrate First Nation and Inuit IMR and perinatal mortality rates. However, there is no Métis specific data. In addition, the pockets of research in British Columbia, Saskatchewan and Québec are not inclusive of all Indigenous populations and further population health data is needed across the country.

In addition to higher rates of adverse maternal and child health outcomes, Indigenous women also have higher rates of gestational diabetes mellitus (GDM). According to the Canadian Diabetes Association (2005-2009), GDM occurs in two to four per cent of pregnant women. (Dyck et al. 2010; Oster et al. 2014; Riese and Grant 2006) and range from 8 per cent to 18 per cent (Liu et al. 2012). Researchers found that Indigenous GDM rates range between 9 per cent and 13 percent for First Nation women in Saskatchewan, Manitoba, Quebec and Ontario (Aljohani et al. 2008: 133). This finding is consistent with Dyck et al. (2002), who found that among a sample of 2,006 women in the Saskatoon Health District, 11.5 per cent of Indigenous women had GDM compared to 3.5 per cent of the general population. In a study conducted in Ontario by Liu et al. (2012), Indigenous women had higher rates of GDM at 10.3 per cent compared to 6 per cent of the general population. GDM in Indigenous populations is important to address risk associated with adverse pregnancy outcomes and child health. Osgood et al. (2011) suggest that the strongest risk factor for Type 2 diabetes mellitus among children and adolescents was maternal diabetes. Given the current state of diabetes in Indigenous communities in Canada (Dyck et al. 2012; Iwasaki et al 2005; Oster et al. 2011; Young et al. 2000), GDM remains an important public health concern.

While the available epidemiological research and statistics describe Indigenous maternal child health disparities, causal factors and proposed solutions remain a challenge. Public health initiatives have largely focused on health behaviors (Kleinschmidt et al. 1995), are critiqued for not reaching high-risk populations (Greaves et al. 2003), and for the lack of culturally appropriate approaches that are inclusive and understanding of social context (Bottoroff 2007). Health research and public health interventions are critiqued for excluding Indigenous peoples' experiences and perceptions of health (Adelson 2005; Bartlett et al. 2007), including broader determinants of health and wellbeing such as income and employment, and the impacts of

racism and colonialism (King and Gracey 2009).

Recent research emphasizes that the primary factors shaping the health of Canadians are not medical treatments or lifestyle choices and behaviours but rather, the living conditions into which people are born, grow, live, work and age. These conditions are known as social determinates of health (Blane et al. 1996; Marmot 1996; Epp 1986; Lalonde 1974; Marmot 2005, 2007; Marmot et al. 2008; PHAC 2011; Raphael 2004; Tarlov 1996; Townsend et al. 1988; WHO 2008). Differences in health are not the sole result of genetic and biological factors, of choices made or of chance, but also differences observed across gender, age, racial, ethnic, social class, sexual orientation, socioeconomic status, dis/ability, geographical location and other circumstances (Braveman 2006:167). Differences in health are also the result of unequal access to key socioeconomic and environmental factors that influence health, such as income, education, employment and social supports (Health Disparities Task Group 2004). These factors are often the result of government decisions, policy, laws and regulations including distribution of money, power and resources at global, national and local levels (Marmot 2010). In the next section, I discuss how living conditions, that is, the social determinants of health impact Indigenous women in Canada.

1.2.2 Social Determinants of Indigenous Maternal and Child Health in Canada

There is a growing body of literature on Social Determinants of Health. However, there is a need for a more holistic and inclusive approach to Indigenous peoples' health determinants (Nesdole et al. 2014:209). Stemming from the SDH literature is a growing body of research aimed to address Indigenous peoples' social determinants of health (Canadian Council of Social Determinants of Health 2013; de Leeuw and Greenwood 2011; Greenwood et al. 2015; Hutchinson 2006; NCCAH 2009; Shah 2004; Wilson and Rosenberg 2002) that is inclusive of Indigenous peoples' specific circumstances and underlying causes related to colonization,

globalization, migration, loss of language, disruptions to cultural continuity, and disconnection from land (King and Gracey 2009: 76; King et al. 2009).

The context of Indigenous women's maternity experiences is unique and complex and I chose to organize my interview findings into proximal, intermediate and distal contexts. Like a stone thrown in water, the ripples that emanate from the center represent multiple interrelated determinants and layers that contribute to women's overall experience (Figure 1.1). Proximal determinants are the first layer of immediate daily conditions that impact health and well-being. These include health behaviors, education, employment and income, food security, and physical environments, including safe and affordable housing. Intermediate determinants of health include health care systems, educational systems, community infrastructure, resources and capacities, environmental stewardship and cultural continuity. Distal determinants include colonialism, racism and social exclusion, and self-determination (Loppie-Reading and Wien 2013). In the next three sections, I discuss the role proximal, intermediate, and distal determinants influence and affect Indigenous maternal and child health.

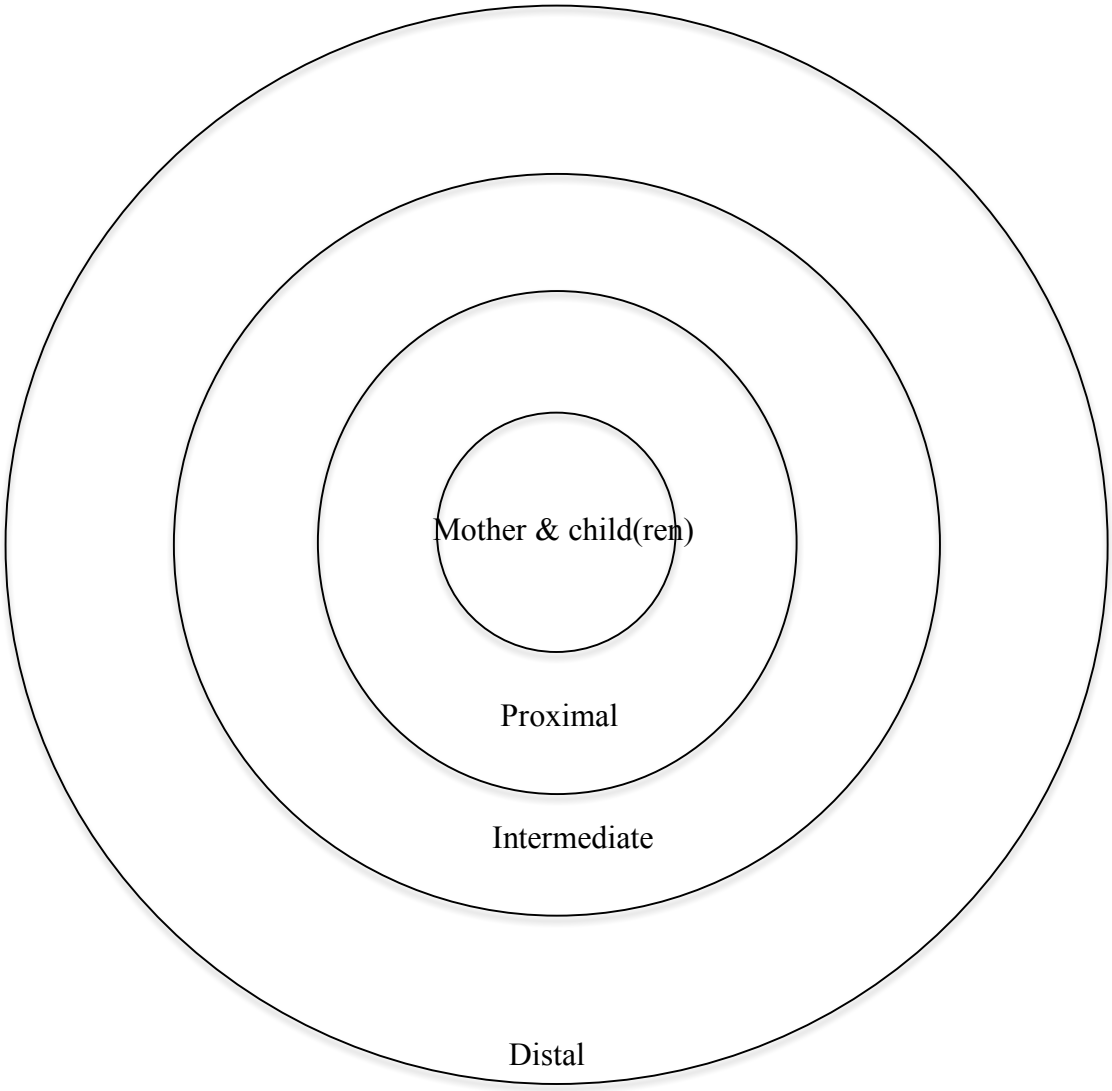

Illustration 1.1. Proximal, Intermediate and Distal Determinants of Indigenous Women's Maternity Experiences

1.2.2.1 Proximal Determinants

Proximal determinants are the first layer of immediate conditions that have a direct impact on health. These include health behaviors, education, employment and income, food security, and physical environments, including safe and affordable housing (Reading and Wein 2013). It is difficult to communicate the complexity and diversity of Indigenous people's lives, specifically women's quality of life. It is even more difficult to communicate the embodied inequalities of Indigenous people's lower socioeconomic status (Adelson 2005) and adverse social determinants of health, including poverty (Burbank 2011). Although there is no set definition of poverty in Canada, the low-income threshold in Canada is $41,568 for a family of four (Stat Can 2015). Statistics illustrate that more than 36 per cent of Aboriginal women, compared to 17 per cent of non-Aboriginal women, live in poverty (CWF 2005), and that poverty affects 52 per cent of Indigenous children (Anderson 2003). According to Statistics Canada (2001) 21.9 per cent of Aboriginal households had incomes below the low-income cut offs, compared to 12.4 per cent of non-Aboriginal households. Poverty can be described as absolute or relative. Absolute poverty describes deprivation; a situation where a person can't afford basic needs such as adequate food, shelter, clothing, and transportation. Relative poverty describes inequality, a situation where a person is noticeably worse off than most people in his or her community. Poverty is an important determinant of health because it is linked to social exclusion (Galabuzi 2004), which results in increased anxiety, insecurity, low self-esteem, and feelings of hopelessness (Iwasaki et al. 2006, 2005; Kirmayer et al. 2000).

Poverty is directly related to education, employment and income. According to the 2012 Aboriginal Peoples Survey (APS), Aboriginal people and specifically, Indigenous women, have lower education attainment. Approximately 72 per cent of First Nations people living off reserve, 42 per cent Inuit and 77 per cent Métis aged 18 to 44,had a high school diploma or

equivalent, compared to 89 per cent of the non-Aboriginal population. For Aboriginal women, 39 per cent of First Nation, 27 per cent of Métis and 53 per cent of Inuit women aged 25 or over had *not* graduated from high school (APS 2012). Of those who did not graduate, 34 per cent of First Nation women indicated that pregnancy or taking care of children was the main reason for not completing their education (Stat Can 2003). Higher rates of Aboriginal women's poverty may also be attributed to higher unemployment rates. Approximately 13.5 per cent of Aboriginal women are unemployed, compared to 6.4 per cent of the non-Aboriginal counterparts and the average income for Aboriginal women was $15,654 (Stat Can 2006).

Education impacts employment, employment impacts income, and income influences access to food, clothing and shelter. This pathway illustrates how Aboriginal peoples are disproportionately affected by poor housing and living conditions (RCAP 1996). According to Stat Can (2008), 15 per cent of First Nation, 3 percent of Métis and 31 per cent of Inuit people, compared to 3 per cent of the Canadian population live in crowded dwellings. In addition, 28 percent of First Nation, 14 per cent of Métis and 28 per cent of Inuit, compared to 7 per cent of the non-Aboriginal population live in dwellings in need of major repair. Access to safe, adequate and affordable housing is an important SDH because issues such as overcrowding are associated with asthma and allergies (Morris et al.1990; Berghout et al. 2005), increased risk of transmitting infectious disease, lower respiratory tract infections, and higher rates of injury and family tension.

Indigenous women's experiences related to proximal determinants of health such as education, employment and income, food security, and physical environments are important to understanding the context of their lived experiences and the barriers they may face. While proximal determinants focus on the individual and immediate environment in which people live, there is also a need to "study up" (Nader 1972) and redirect our "attention away from those

individuals and groups who are mistakenly held to be responsible for their condition, toward a range of broader upstream political and economic forces" (McKinlay 1985:2). Rather than focus on solely on individual behaviors and immediate or proximal social contexts, there is a need to examine and address midstream (intermediate) and upstream (distal) contexts and interventions (Johner et al. 2006:156). In the next section I review the literature on Indigenous women's maternity experiences with intermediate determinants of health including their experiences with Canadian health care systems, community resources and infrastructure and discuss resources, capacities and cultural continuity.

1.2.2.2 Intermediate Determinants

As discussed above, Indigenous women have unique and empirically different maternal child health outcomes and socio-economic barriers associated with social determinants of health. Indigenous women also have varying needs and access to healthcare services and supports (Young et al. 2000). Indigenous women face barriers when accessing mainstream health care (Tait 2003), including maternal, reproductive and prenatal health care services in urban areas and on reserve (Benoit et al. 2003; Stout and Harp 2009). Indigenous mothers face unique barriers including healthcare providers perceptions of Indigenous women (Van Herk et al. 2011:58), discrimination when accessing mainstream healthcare (Browne and Fiske 2007), including fear of accessing healthcare when child apprehension from government officials (aka Social Services) is being threatened (Cull 2006; Denison et al. 2013:1105). Additional barriers include gaps in sustainable funding resulting in program cessation, staff turnover and human resource shortages (Stout, Kipling and Stout 2001). Human resource shortages result in a lack of access to medical personnel such as doctors, nurses, nurse practitioners and midwives. There is a lack of culturally appropriate supports, information and resources (Browne et al. 2000), as well as Indigenous women's varying levels of power, choice and control over their maternal

health and maternity experiences (Varcoe et al. 2013).

Indigenous women who reside in rural and remote reserve communities are uniquely impacted by obstetric evacuation policies and practices. According to Health Canada's evacuation policy and *Clinical Practice Guidelines*, federally employed nurses are to "arrange for transfer to hospital for delivery at 36-38 weeks' gestational age according to regional policy (sooner if a high-risk pregnancy)" (Health Canada 2012:12). Women describe their experiences as "lonely, often plagued by insecurity, insufficient or inadequate food, unfamiliar and strange surrounding, missing family and other children, and an overall stressful experience" (NAHO 2005). This policy has resulted in women feeling alone and isolated, without family and community support, as well as disruptions to Indigenous traditions, culture and midwifery practices (see Couchie and Sanderson 2007; Kornelsen and Grzybowksi 2005; Kornelsen et al. 2010; Lawford and Giles 2012; O'Driscol et al. 2011; Olson and Couchie 2013). This large body of research has helped inform policy and programming to address the healthcare human resource gap and to bring birth closer to home through the creation and expansion of Indigenous midwifery and the Indigenous doula support program (Carrol and Benoit 2001; NAHO 2008; Vanwagner et al. 2007; FNHA 2015). A more thorough discussion of obstetric evacuation is discussed in the literature review on Indigenous women's maternity experiences below.

Another gap in maternal child health care (and research) is jurisdictional divides. For example, maternal child health funding and programming for status First Nation and Inuit women are offered by the First Nations and Inuit Health Branch (FNIHB), a division of Aboriginal people's health that operates under the umbrella of Health Canada. However, British Columbia is unique because in 2013 the FNIHB transferred all programs and services to the responsibility of the first province-wide British Columbia First Nations Health Authority (FNHA), which is discussed further below. The Public Health Agency of Canada (PHAC)

extends its programming to all Aboriginal people, including Métis and non-status peoples. Differing jurisdictions result in different governance, funding and program delivery. In chapter three I discuss how jurisdictional divides impact research; for example, research conducted by the PHAC excluded First Nation women on reserve for operational reasons.

In the next section I discuss distal determinants of health, which includes self-determination and the impacts of racism and colonialism on Indigenous women's maternity experiences.

1.2.2.3 Distal Determinants

Colonialism is the guiding force that has shaped Canadian history, politics, policies and practices, society, economics and the context of Indigenous people's contemporary realities (Czyzewski 2011:13; Kelm and Townsend 2006). The Merriam-Webster's Dictionary (2015) defines colonization as "the act of bringing into subjection or subjugation by colonialism," and "colonialism is defined as "the aggregate of various economic, political and social policies by which an imperial power maintains or extends its control over areas or people." Examining the historical and accumulated effects of colonization is imperative to understanding contemporary Indigenous peoples' and women's health (Cunningham 2009; Kelm 1998; Smith et al. 2005; Waldram et al. 2006). The impacts of colonization on Indigenous peoples have resulted in historical and cumulative emotional and psychological wounding (Duran and Duran 1995) over the lifespan and across generations (Bombay et al. 2009:6; Brave Heart 1998; 2003; Durie 2006; Ing 2006; RCAP 1996a, 1996b; Smith et al. 2005). Research illustrates how colonization has created emotional and psychological impacts (Brasfield 2001; Corrado and Cohen 2003), has impacted HIV rates (Barlow 2009), higher rates of fetal alcohol syndrome (Tait 2003), mental health (Hart-Wasekeesikaw 2003; Kirmayer et al. 2000, 2003), disruptions to cultural continuity, identity and its impacts on suicidal ideations and attempts (Chandler and Lalond

1998, 2009; Elias et al. 2012;).

Throughout Canadian history, Indigenous and non-Indigenous peoples "were taught that Aboriginal people were inferior, savage, and uncivilized, and that Aboriginal languages, spiritual beliefs, and ways of life were irrelevant" (TRC 2012:2). Assimilation ideologies to "civilize the savage and Christianize the Indian" (TRC 2012:11) were implemented to absorb Indigenous populations into a single Canadian body politic. These ideologies were centred and measured by colonial, European, Christian and patriarchal ideals that attempted to dissolve Indigenous cultures, languages, identities and autonomy as a means of gaining access to lands and resources (TRC 2012:2). Assimilation ideology is illustrated best by a quote from Duncan Campbell Scott, who served as the deputy superintendent of the Department of Indian Affairs from 1913 to 1932. Scott put it this way:

> I want to get rid of the Indian problem. I do not think as a matter of fact, that the country ought to continuously protect a class of people who are able to stand alone. Our objective is to continue until there is not a single Indian in Canada that has not been absorbed into the body politic and there is no Indian question, and no Indian department, that is the object of this bill (*Act for the Gradual Civilization of the Indian Tribes in the Canadas,* 1857).

Perhaps the most destructive assimilation policy was implemented through the creation of residential schools. Between 1883 and 1995, estimates are that approximately 150,000 Inuit, Métis and First Nation children attended Canadian government funded day and residential schools run by the Catholic and Anglican churches (TRC 2012). In addition to residential school, the 'sixties scoop' (Johnson 1983) refers to the removal of Indigenous children from their families into the child welfare system. Changes in the 1951 Indian Act enabled provincial child protection authority over Indigenous peoples, and as a result, there was an increase in child apprehension in Indigenous communities. For example, in 1951, nine Aboriginal children were in British Columbia government care; by 1964 there were 1,466 in care, representing 34 per cent

of the total number of children in foster care (Pivot 2008:21). It is estimated that one in four status First Nation children and one in three non-status and Métis children were removed from their families for part or all of their childhood (Fournier and Crey 1997:88). The contemporary over representation of Indigenous children in the Canadian child welfare system whereby Indigenous children are estimated to represent over 70 percent of the total number of children in foster care (Blackstock 2008; Trocmé et al. 2004).

Eurocentric, western hegemony and dominance has created a society in which Indigenous knowledge, understanding, and ways of being have been marginalized and excluded (NCCAH 2013). Negative stereotypes (Acoose 1995; Levin 2011) and epistemic, institutional, relational and internalized racism (NCCAH 2012) perpetuate discriminatory attitudes, beliefs, and misconceptions. In turn, negative attitudes and actions perpetuate violence towards Indigenous peoples, specifically Indigenous women (Anderson 2000, 2011; Lavell-Harvard and Brant 2016; Riel-Johns 2016: 37; NWAC 2002).

Historical racism and violence against Indigenous men and women has also manifested through bio political strategies such as forced sterilization (Grekul, 2004; Stote, 2015). For example, the eugenics legislation in Alberta was utilized from 1930-1951 to sterilize "weak and feeble minded" persons which included an over-representation of Aboriginal peoples.

> Aboriginals were the most prominent victims of the board's attention. They were over-represented among presented cases and among those diagnosed as "mentally defective." Thus they seldom had a chance to say "no" to being sterilized. As a result, 74% of all Aboriginals presented to the Board were eventually sterilized (compared to 60% of all patients presented) (Grekul 2004: 375).

In her book: *An Act of Genocide: Colonialism and the Sterilization of Aboriginal women,* Karen Stote (2015) documents the forced sterilization of Aboriginal men and women from 1970-1975 in "Indian hospitals" throughout Northern Ontario. Although exact numbers are unknown, it is

estimated that over 1600 individuals were sterilized in a five-year period and additional communities were targeted for birth control initiatives and abusive abortions for "unfit mothers".

Indigenous peoples' experiences with racism, including racism with Canadian health care have been described as First Peoples who receive second-class treatment (Allan and Smylie 2015). In 2002, 37.9 per cent of First Nation people on reserves had experienced a form of racism and of those, 13 per cent stated the experience(s) had a very strong effect on their self-esteem (First Nations Centre 2005). Prejudice, discrimination and racism have negative consequences and have been linked to negative health outcomes (Galabuzi 2004; Kirmayer et al. 2000; Utsey 1998) including impeded access to healthcare services (Krieger 1990; Krieger et al. 1993; Krieger and Sidney 1996) and distrust with medical care.

Traditionally, Indigenous women commanded the highest respect in their communities as water carriers and the givers of life. They were considered sacred (Anderson 2000:73) and powerful beings because they "birth the whole world" (Bear 1990: 133) and were part of the natural life cycle governed by the Creator (Carroll and Benoit 2001). Women were sacred, authoritative, respected and central to communtiy (Carroll and Benoit 2001; Fiske 1992; Laronde 2005; Lavell-Harvard and Anderson 2014; NAHO 2008). However,

> the social and economical marginalization of Indigenous women in Canada along with a history of government policies that have torn apart Indigenous families and communities, have pushed disproportionate numbers of Indigenous women into dangerous situations including extreme poverty, homelessness and prostitution (Amnesty International Canada 2005:5).

Indigenous women face multiple oppressions. The intersections of race, sex and class (Thornhill 1989:27) and the cumulative effects of colonialism, racism and sexism has marginalized Indigenous women. Racism, sexism and colonialism has impacted Indigenous women's identities, belonging, health, and access to resources and supports with social

determinants of health. This disparity can be attributed to the colonial experience in Canada, which is unique to Indigenous Peoples (Bourassa et al. 2009, 2015). For example, Indigenous women continue to experience gender oppressive policies and discrimination within the Indian Act that discriminate against women and extinguish their rights and title (Jamieson 1978; Lawrence 2004; Silman 1987). Discrimination and the Indian Act continue to perpetuate a struggle for Indigenous women and mothers (Lavelle-Harvard and Corbiere-Lavell 2006:187). For example, in chapter six, Karen's story illustrates how she chooses to identify as a single parent because of limitations for passing status to her child because of "Indian math" complications within the Indian act. This is explained as a

> classification of Indian(ness) in what some call "Indian math," a set of equations that continues to affect Indigenous peoples today, including access to education, health services and extended health benefits set out by the Indian Act. Those who held status under the Indian Act prior to 1985 are referred to as 6(1) Indians, whereas those who gained status through Bill C-31, or after April 1985, are categorized as 6(2) Indians… the three categories are NS [non-status], 6(1) and 6(2) extend to the classification of offspring. For example, children produced by a 6(1) and an NS union will be 6(2)—or as Indian Act math puts it, 6(1) + NS = 6(2). Furthermore, 6(2) + NS = 6(2), 6(1) + 6(2) = 6(2), and 6(2) + 6(2) = NS (De Leeuw and Greenwood 2011: 61).

As the previous sections illustrate, colonization and assimilation policies and ideologies have resulted in racist and sexist policies and practices that have had a profound intergenerational effect on identity, and connections to culture and community (Sinclair 2007: 66). Colonization has contributed to contemporary health disparities, social inequities, and has impacted Indigenous mothering (Ing 2006) and Indigenous women's health and wellbeing.

Maternal and child health disparities are embedded within a complex web and layers of proximal, intermediate and distal social determinants of health. While the statistics relay health disparities and inequalities, it is also important to include Indigenous peoples' experiences and perceptions of maternity care and mainstream health care. In the next section, I review the

literature on Indigenous women's maternity experiences within health care systems.

1.2.3 Indigenous Maternity Experiences Research

Understanding maternal child health from the perspectives of Indigenous women (Lauson et al. 2011) is important to understand their health needs, experiences, perceptions and the barriers that are needed to improve maternal and child health disparities. Indigenous women's perspectives and experiences have been largely ignored and absent within the literature (Valaskasis et al. 2009:1). In this section I review the literature on First Nation, Métis and Inuit women's experiences of accessing mainstream health care, maternity programming and support services.

Kornelson and Gzybowski (2005), found that "the experiences of Aboriginal and First Nation women warranted a separate investigation" because of Indigenous women's

> increased importance of kinship ties between women and members of their communities, especially around an event like the birth of a child, the socially complex life situation of many Aboriginal and First Nation women that puts them at an increased risk for adverse health and maternity outcomes (Kornelson and Gzybowski 2005:94).

Since the early 1990s, there have been a series of studies that examine Indigenous people's encounters and experiences with mainstream health care services and systems (see Dion-Stout 1996; Dion Stout and Kipling 1998; Hare 2004; Todd-Denis 1996). Indigenous people's healthcare experiences have since expanded to include and focus on Indigenous women's experiences (Browne et al. 2000; Van Herk et al. 2011). Browne et al. (2000) examined First Nation women's encounter with mainstream healthcare in Carrier First Nation reserve communities in northern British Columbia. Their findings suggest that women's experiences range between affirming and invalidating, but that healthcare experiences are also embedded within broader social, economic and political forces. Through ten in-depth

interviews, women described their invalidating encounters with healthcare, which include being dismissed, feelings of being judged based on negative stereotypes, discrimination and healthcare employees disregarding their personal circumstances and situations of vulnerability such as a history of residential school attendance. However, the participants also described affirming experiences, such as active participation in decision-making, affirmation of cultural identity and development of positive, long-term relationships with health care staff. The recommendations of these participants centered around cultural safety training to include socio-political factors and social determinants of health, addressing stereotypes of Aboriginal women as unfit mothers, examining punitive policies, developing more outreach and home visit programs, and including Aboriginal women's input in policy and program development. Another study found that Aboriginal single mothers in Saskatchewan reported significant and negative relationships with social exclusion, and lower perceived levels of health (Johner 2006:154). The recommendations included going into "more depth" regarding the social circumstances of single parent social exclusion.

In addition to research that focuses on Indigenous women's encounters with mainstream healthcare, there is a growing body of literature that examines Indigenous women's experiences with maternity care (Sokoloski 1995: 91; Watson et al. 2002: 155). Since 2000, a large body of literature focuses on rural and remote Indigenous women's maternity experiences of obstetric evacuation and Health Canada's evacuation policy. The research examines and advocates for Indigenous women to give birth closer to home and within their home communities (see Couchie and Sanderson 2007; Kornelsen and Grzybowksi 2005; Kornelsen et al. 2010; Lawford and Giles 2012; O'Driscol et al. 2011; Olson and Couchie 2013). Although there is some research on Inuit women's childbirth in the north (Webber and Wilson 1993) and childbirth among the Canadian Inuit (Douglas 2006), including epidemiological studies (Luo et al. 2004),

gaps remain. Maternity research on obstetric evacuation has created policies and programs aimed to address the healthcare human resource gap and to bring birth closer to home through the creation and expansion of Aboriginal midwifery since the 1980s (Carrol and Benoit 2001; NAHO 2008; Vanwagner et al. 2007) that has since expanded to include Aboriginal doula support programs (FNHA 2015).

Varcoe et al. (2013) examined rural women's experiences of maternity care and social determinants and the structural inequalities that shape those experiences. Their critical ethnographic research included interviews with 100 rural First Nation women from Nuxalk, Haida and 'Namgis, British Columbia on Aboriginal women's experiences of maternity care, their desires for future care, and what shaped their birth experiences and outcomes. Their research illustrates how First Nation women are faced with diminishing maternity care choices, racism, and challenging economic circumstances that arise from historical, economical and social circumstances. Rural Aboriginal women's birthing experiences are shaped by myriad intersecting rural circumstances, the effects of historical and ongoing colonization, and concurrent efforts toward self-determination and more vibrant cultures and communities.

In a participatory action research study, Whitty-Rogers, Caine and Cameron (2016) examined nine Mi'kmaq women's experiences with gestational diabetes mellitus (GDM). Indigenous women identified healthcare barriers, such as limited access to transportation for health care appointments, lack of choice for prenatal care, lack of daycare and expenses related to childcare to attend medical appointments. Indigenous women expressed a need for additional support during pregnancy, including support to address social determinants of health barriers that contribute to adverse pregnancy outcomes such as higher rates of GDM. In another study conducted by Oster et al. (2014), their ethnographic research in Alberta with 12 First Nations women with GDM suggested improved support systems (family, health care,

cultural/community and internal supports), as well as education and awareness are needed to improve pregnancy care.

In Search of a Healing Place: Aboriginal Women in Vancouver Downtown Eastside, Benoit et al. (2003) aim to give voice to urban Aboriginal women (N=61) by engaging the women in discussions on their health care concerns and needs. Through focus groups and semi-structured interviews with Aboriginal women and service providers, urban Aboriginal women expressed a need for non-judgmental support and culturally competent care from staff who understood Aboriginal women's "historical wounds." In addition, women expressed a need for programming that integrates Aboriginal healing and medicine through a holistic approach that is inclusive of women, their children and families. Women also expressed a need for additional sexual and reproductive health services, including access to contraception and abortion services. While this research showcases urban Aboriginal women's health experiences and needs, there is a gap in the literature that focuses on urban Indigenous women's maternity experiences. In addition, presently there are no studies that solely focus on Métis women's maternity experiences. There are also gaps in research that include the perspectives of young or teen Indigenous mothers.

In *Young and Aboriginal: Labour and Birth Experiences of Teen Mothers in Winnipeg*, Downey and Stout (2011) researched the experiences of labour and birth of 19 urban Aboriginal teen mothers (age 15 to 17). Their findings suggest that teenage Aboriginal mothers have both positive and negative experiences and they recommended additional research among young and Aboriginal women's birthing needs to understand additional support to inform culturally relevant maternity care. Although there are limitations to a small sample size, their research poses important questions for young and urban Aboriginal women, women who experience obstetric evacuation and issues of cultural safety when accessing maternity health care. There is

very little research currently that aims to understand young Aboriginal women's maternity experiences, particularly of those women who do not access community services and supports (Downey and Stout 2011:iii).

Recently, there have been quantitative research publications on Aboriginal women's responses to the Canadian Maternity Experiences Survey. In *Mental Health and Postpartum Depression Indicators among Pregnant Aboriginal Women in Canada: Results from the Maternity Experiences Survey (MES),* Nelson (2016) suggests that Aboriginal women have a higher prevalence of pre- and postpartum depression due to contributing factors such as abuse/violence and stressful events during pregnancy. A more thorough discussion of Indigenous women's responses to the MES is discussed in chapter three.

The above literature on Indigenous women's maternity experiences focuses on their experiences when accessing mainstream maternity healthcare. It is an equally important inquiry to include the voices and perspectives of Indigenous women who speak from diverse experiences on issues that intimately shape their lives. In the next section I draw on the literature that examines Indigenous women's stories and narratives as Indigenous women and mothers.

1.2.4 Indigenous Women Stories: More than just numbers

Fertility and infertility, pregnancy, childbirth and mothering "play a major role in women's health and wellbeing in most societies" (Liamputtong 2007:3). Maternity and perinatal health is not simply universal biological processes and physiological functions in need of medicalization (Jordan 1994; Davis-Floyd 2004; Shaw 2013; Stein and Inhorn 2002), but is a momentous and life-altering experience in a woman and mother's life (Lavell and Lavell-Harvard 2006). Thus maternity experiences go beyond the biomedical definition of health and are a "biosocial event" (Jordan 1983:1) that is embedded in the unique and complex social,

historical and cultural context in which women live (Jordan 1983; Liamputtong 2007; Mead and Newton 1967).

> Childbirth is an intimate and complex transaction whose topic is physiological and whose language is cultural. Topic and language or, to put it another way, content and organization are never available one without the other. For a holistic view of the phenomenon they must be considered together. It is for this reason that I propose to treat the process of parturition here within a biosocial framework, that is to say, as a phenomenon that is produced jointly and reflexively by (universal) biology and (particular) society. To speak of birth as a biosocial event, then, suggests and recognizes at the same time the universal biological function and the culture-specific social matrix within which human biology is embedded (Jordan 1983:1).

As a biosocial event, maternity experiences are "influenced by cultural beliefs, traditional practices, spiritual beliefs, maternal age and education, socio-economic status, parity, personality characteristics, and influence from health care professionals such as birthing environment, feeling of control, support and knowledge sharing" (Abboud and Liamputtong 2007:176). The majority of Indigenous women's maternity experiences research focuses on health behaviours, perceptions of healthcare. There is a need to move beyond the boundaries of clinic, hospital and delivery room and contextualize Indigenous women's experiences to identify the issues that are important to them. Indigenous women's experiences "put an identity and a humanity to what can be some very disheartening statistics about the crises that a lot of our women are facing in their day-to-day lives "(Lavell-Harvard and Anderson 2014: 291). Hence, Indigenous women's stories and experiences give spirit and voice to the statistics that are more than just numbers.

I was drawn to Indigenous women's stories and narratives about their lived experiences. I am fascinated with and inspired by the generations of Indigenous women writers and authors, who continue to resist oppression, reclaim Indigenous-mothering practices and restore the balance on inequity and injustice. Writers such as Maria Campbell (1973), Emma Laroque

(1975), Jeannette Armstrong (1988), and Lee Maracle (1996) gave voice to multiple perspectives and experiences among diverse Canadian Indigenous women's realities. Resistance to male domination and the oppression of Indigenous women created the Indigenous women's movement and the formation of the Native Women's Association of Canada (NWAC) in 1974, which was paramount to the advancement of Indigenous women writers and scholars of the 1980s (Bourgeault 1989; Etienne and Leacock 1980; Van Kirk 1980). Indigenous women's narratives provided a space for Indigenous women to speak out about the issues that intimately shaped their lives.

Perhaps the most influential Canadian Indigenous women's narrative of the 1990s was *Life Lived Like a Story: Life Stories of Three Yukon Native Elders* by Julie Cruikshank (1990). The life stories of

> Angela Sidney, Kitty Smith, and Annie Ned are [about] three remarkable and gifted women of the Athapaskan and Tlingit ancestry who were born in southern Yukon Territory around the turn of the century. Their life stories tell us much about the present as about the past, as much about ideas of community as about individual experience; they call our attention to the diverse ways humans formulate such linkages (Cruikshank 1990: ix).

Cruikshank illustrates how stories explain events in women's lives by combining personal experiences with traditional narratives (17). In addition to traditional narratives, Indigenous Elders play an integral part of Indigenous communities, including a connection to traditional birthing practices, culture and teachings (O'Driscoll et al. 2011).

Building on Indigenous women's narratives, Kim Anderson's *A Recognition of Being: Reconstructing Native Womanhood* (2000) explores forty life histories of Indigenous women from across Canada. Her narrative research expands upon Indigenous women's female identity, and how colonization has dismantled Indigenous gender roles, responsibilities and relationships. Anderson states that "strong, independent female role models provide Native girls with the

sense that they can overcome whatever obstacles they will inevitably encounter … the bond between Aboriginal girls and their grandmother is notably strong, and this relationship has taught many lessons about resistance" (118).

Strong Women Stories: Native Vision and Community Survival by Kim Anderson and Bonita Lawrence (2003) is a collection of grass roots essays focused on contemporary Indigenous women's experiences of coming home, asking questions, and rebuilding their communities. In coming home, contributors discuss women's perspectives and experiences of being disconnected and removed from their family, community and land base due to denial of recognition under the Indian Act, thus they feel disenfranchised and exiled. The second section includes essays on asking questions and "not only *what* questions to ask but *how* to ask them" (15). These include questioning colonialism and patriarchy and how it has impacted Indigenous women's lives; how traditions serve contemporary women and finding our voice to bring about social change. The final section is a call to rebuild our communities to improve and address sexual health, violence, education, internal oppression, gender roles, disability and loss of land and culture. Rebuilding communities begins with children, moves on to women, and concludes that change lies in the

> gender equity of balanced interdependency, renewed trust and true respect between men and women that Native people should strive to reclaim. In order to achieve this goal, we must live more like our ancestors. Our path must come to create a spiral, one that turns back to the past while at the same time progressing forward in order to survive in a different world (Fernandez 2003:254).

In the Days of Our Grandmothers: A Reader in Aboriginal Women's History in Canada, Kelm and Townsend (2006) state that

> this reader honours the field of Aboriginal women's history by presenting a number of key essays in such a way as to highlight both current developments in the field and the diversity of histories to which Aboriginal women lay claim. Just the sheer volume of work produced in this field has made selecting

> articles for inclusion difficult, but it has made clear the strength of the field and indeed, of Aboriginal women themselves. Refuting the myth of silence, this reader amplifies the persistent voice of Aboriginal women over three centuries of Canadian history (Kelm and Townsend 2006:4).

Building on Indigenous women's history, Valaskakis et al. (2006) bring together academics and artists from varying backgrounds and perspectives to speak about cultural continuity and community development. While the majority of literature focuses on describing the deficits and dysfunction of Indigenous peoples that perpetuate social stigmatization, their book aims to *Restoring the Balance* by taking a positive perspective. Their collection of essays illustrates how Indigenous women are protectors of culture, guardians of tradition, and agents of change within their own lives, as well as in the lives of their families, communities and nations.

In addition, Indigenous women's stories and narratives that resist colonialism emerged throughout the literature on maternal pedagogy and ideologies of Indigenous mothering.

> Throughout Indigenous women's stories and narrative, women are reawakened and empowered to the responsibility and transformation that occurs throughout pregnancy, birth and mothering (Cook, 2000 quoted in Lavell-Harvard and Lavell 2006:25).

Maternal pedagogy and maternal epistemology is "to know, understand or claim a particular authority and knowledge based on experiences of mothering" (Abey and O' Reilly 2007:330). Experiences, including the experience of mothering and motherhood, are a complex web of people, places, events and the interconnected relationships between and among threads of that web. Mainstream definitions of motherhood experienced by all women are defined through patriarchal (and Euro-Christian) ideologies (O'Reilly 2000:47) that continue to control, constrain and oppress women through constructs of the "good" mother. "Good" versus "unfit, negligent" or "bad" mothers are socially and culturally constructed "from the experiences or ideologies of white, middle-class motherhood in western society. "Women of colour have been

the subject of some scholarly work, but relatively little has been written about Native women" (Anderson 2007:761).

An alternative to patriarchal motherhood includes Indigenous maternal pedagogy and epistemology that describes Indigenous women and mothers as powerful. Mothering is empowered when mothering practices come from a position of agency rather than passivity, of authority rather than submission, and of autonomy rather than dependency; thus, all, mothers and children alike, become empowered (O'Reilly and Collins: 27). Empowering Indigenous women through birthing and mothering is reiterated by Memee Lavell-Harvard and Jeannette Corbier Lavell in their book *Until our Hearts are on the Ground: Aboriginal Mothering, Oppression, Resistance and Rebirth* (2006). They describe Aboriginal maternal pedagogy and epistemology as resisting oppressive models of motherhood, dominant culture, patriarchy and colonialism thus, leading toward a revolution of social change.

> The voices of our sisters, and their account of our longstanding resistance to the imposition of patriarchal motherhood and all it entails, can be a source of empowerment in the struggle for revolution. We, as Aboriginals, have always been different [othered], we have always existed on the margins of the dominant patriarchal culture (Lavell-Harvard and Lavell 2006:5-6).

One example of resistance to dominant patriarchal motherhood is Renee Elizabeth Mzinegiizhigo-Kwe Bédard's Anishinaabe-kwe ideology on mothering and motherhood (Bédard 2006:66). By connecting traditional ceremonies, such as the berry fast (a year-long fast from any berries that celebrates a woman's first moon time), and teachings associated with the strawberry plant, Bédard illustrates how Anishinaabemowin women's gendered ontology informs womanhood and mothering. In "Birthing an Indigenous Resurgence," Leanne Simpson (2006) addresses resistance to imposed colonial ideologies through decolonizing pregnancy and birth ceremonies. She explains how "colonialism hijacked our pregnancies and birth" and how "the western medicalization of birth replaced our ceremony."

> Bottles and substandard formula took the place of nursing, detachment supplanted attachment, and mothering was replaced by the physical, psychological, sexual and spiritual abuse of the residential school system (Simpson 2006:28).

Prior to European contact and the marginalization of Indigenous women and mothering, Indigenous societies were primarily egalitarian (Gunn Allen 1992:27; Mihesuah 2003) and "women served as spiritual, political, and military leaders, and many societies were matrilineal" (Smith et al. 2006:18). The colonization of childbirth (Jasen 1997) and wombs (Anderson 2006:25) has created Indigenous women's opposition such that birthing and mothering become sites of resistance and home becomes a space of self-determination and transformation.

> Patricia Montour-Angus writes that self-determination begins at home. I like to take it a step further—that self-determination begins in the womb. If more babies were born into the hands of Indigenous midwives using Indigenous birthing knowledge, on our own land, surrounded by our support system, and following our traditions and traditional teachings, more of our women would be empowered by the birth process and better able to assume their responsibilities as mothers and nation-builders (Simpson 2006:29).

Oneida scholar Lina Sunseri reinforces this statement, saying that, "Indigenous women like my aunt and grandma have offered us the opportunity to grow and develop in a positive way by giving us a space—our family—of resistance against racism and colonialism. Home and family are spaces where our identity is affirmed and valued, and where healthy lives are constructed" (2008:23).

Kim Anderson expands our understanding of how age impacts purpose, position and Indigenous women's identity. In *Life Stages and Native Women*, Anderson (2011) shares her journey of reconnecting to and restoring Algonquian oral history about pregnancy, infancy and toddler years through childhood and youth, young and middle aged women, to elderly women. Her "story medicine" and reconnecting to Algonquian history illustrates how the "more we understand about Indigenous experiences in the past, the better we will be to shape our future;

the more we understand about colonization, the better we will be at decolonizing ourselves and our communities" (4).

Lavell-Harvard and Kim Anderson (2014) include a series of international articles that aim to restore healthy beginnings, resilience, "other mothering" spaces, and multiple moms that are inclusive of diverse perspectives and building on the past to create a future. Thus illustrating the "global context of resistance, reclaiming and recovery among Indigenous mothers and their allies" (10). In doing so, they inspire Indigenous women, mothers, families, communities, their Nations and allies to forge a better, brighter and healthier future.

1.3 Summary

Research is illustrating disparities in Indigenous maternal child health in Canada and confirming that these disparate health outcomes are the result of the complex web and layers of proximal, intermediate and distal determinants of health, including the intergenerational impacts of colonization. However, few studies focus on the historical and social context of Indigenous birth outcomes and few studies include Indigenous women's experiences and perspective. The majority of maternity experiences research focuses on Indigenous women's experience with mainstream healthcare and there is a need to move beyond healthcare experiences in order to gain a holistic understanding of Indigenous women's maternity experiences as women and mothers. Canadian Indigenous women's experiences and perspectives can be understood in the literature on Indigenous women's stories, life stages, and Indigenous mothering. Strong women stories shape and give voice to Indigenous women's identities, histories, voice and perspective, including Indigenous ideologies of Indigenous mothering.

Chapter 2 (Niizh): Theory and Methods

2.1 Positioning of Research

In her book *Indigenous Methodologies*, Margaret Kovach presents "Miskasowin, a Nehiyaw term that means going to the centre of yourself to find your own belonging" in order to prepare oneself to answer the questions: "why are you doing this research and why are you doing it this way" (2009:179). Lettendre (2000) also raises questions concerning how one's choice of research methods can "reflect who you are … as an individual, as a member of a family and community, as an Aboriginal or Non-Aboriginal person" (10).

As an Indigenous woman and mother conducting research with, by and for Indigenous women, I do not claim to be "an official insider voice … or assume that [my] own experience is all that is required" (Smith 1999:139) or that my own experience is representative of all my participants' experiences (Weston 1997:173). My location (historical, geographical and generational) and position (age, gender, race, class, sexuality) influenced my decision on my research topic, questions, methods, analysis as well as the write up phase of my dissertation. Therefore, it is critical to position myself within my research.

I chose to conduct research at-home (Gupta and Ferguson 1997) in the Okanagan Valley and Canada rather than research abroad (Fainzang 1998; Van Ginkel 1994:7) because research is time consuming and expensive. As a single mother of two small children, traveling to conduct research was not only financially impractical but would also have been disruptive to my children. After residing in the Okanagan valley for ten years, I have created a social and community support system that enabled me to study and conduct research while working part time and raising my children.

As an Indigenous woman and mother conducting Indigenous health research, I am both an insider (Jones 1970) and researcher-activist (Gough and Leacock 1987). According to Jones, an

insider is “a person who conducts research on the cultural, racial or ethnic group of which he himself is a member” (Jones 1970:251), which may prove an advantage based on membership and community involvement (Smith 1999; Webber-Pillwax 1999). Throughout my interviews with my sister-participants, there are many examples where I shared common experiences and insider accounts (Acker 2000; Dwyer and Buckle 2009). For example, I have experienced and witnessed the intergenerational effects of colonization and residential school, racism, sexism, as well as the struggles and stereotypes of being a single Indigenous mother. I have also faced multiple barriers associated with adverse social determinants of health, including stress associated with education, employment and income. My position may have contributed to enhanced trust and rapport (Palmer and Thompson 2010:428). For example, in my conversation with Lisa, we discovered a common geography and connection, which facilitated her to feel more comfortable and to discuss her experiences more freely.

However, my own assumptions, biases and position within my research ran the risk of lacking cultural ‘distance’ and objectivity (Weston 1997:179) and the work could be critiqued as lacking scientific merit (Aguilar 1981:15; Godina 2003:479; Voloder 2008:29). Another potential research limitation was the risk of taking for granted common understanding (Simmons 2007:13) and, thus, failing to capture cultural subtleties (Aguilar 1981:16). In order to address these limitations, I used structured participant-observations (Appendix F) as a tool for reflexivity. I used my participant-observation and field notes to reflect on my research process, questions I could have gone into more deeply, as well as trends within my data. I discuss reflexivity further in the methods section.

2.2 Indigenous Health Research Ethics

I am passionate about improving Indigenous maternal and child health. However Indigenous and non-Indigenous alike, it is not enough to be well intentioned. Indigenous

peoples' negative experiences with research (Brant-Castellano 2004) have created mistrust and distrust because

> too often, non-Aboriginal researchers with little or no connection to Aboriginal communities conduct research about Aboriginal peoples that is based on western disciplinary-specific theories. The culturally relevant and often racist results of these studies are then disseminated to an often equally disengaged and uninformed academic audience, thus perpetuating the dominance of western research on Aboriginal people (NCCAH 2013: 4).

Not only is the dominance of western research perpetuated, but also research has been critiqued for ignoring the diversity within and among Indigenous groups and that results are often generalized, which perpetuates stereotypes (Letendre and Cain 2004). The increased need for protection and expansion of the Tri-Council Policy Statement 2 (TCPS2), chapter nine and Research Involving the First Nations, Inuit and Métis Peoples of Canada Indigenous Peoples serves as a framework for ethical conduct (TCPS2 2014). In addition to local Indigenous ethical frameworks and guidance, research involving Indigenous peoples is premised on respectful relationships and relational accountability (Wilson 2008) and the four R's of higher learning: Respect, Reciprocity, Relevance and Responsibility (Kirkness and Bernhardt 1991).

As I reflect on Indigenous health research ethics and how my methodology reflects who I am, the tepee teaching informs my research methodology.

2.2.1 Tepee Teaching

While preparing myself to conduct my doctoral research, I had a vision. I was struggling as a new student and mother and in my dream I met my grandmother Eva Cecile Chartrand. We were sitting next to each other beside the fire and when I looked up, I saw the intersecting teepee poles. I interpreted the dream as a sign to restore the relationships, knowledge and connections between land, family, spirituality, values and everyday living (Castellano 2004) and to restore the teepee teaching within my own life. I embarked on a process of decolonizing

(Smith 1999: 142-161) and reconnecting to my Indigenous roots, genealogy and teachings. After three years of collecting and peeling lodge pole pine and being gifted a tepee cover, I reclaimed and revitalized the teaching with my family and friends, with the support and guidance from Vern and Mona Tronson. On 20 May 2016, we had a tepee raising ceremony in commemoration of the third year anniversary of my mother's death and to honour all women and mothers.

From 2003 to 2005, I worked for the Department of Community Resources and Employment (DCRE) formerly known as Saskatchewan Social Services. During my employment, I was mentored by Ernestine Star and was introduced to Cree Elder Mary Lee. Mary Lee is from Pelican Lake, Northern Saskatchewan, and currently resides in Saskatoon Saskatchewan. I was struggling with my Indigenous identity when I met Mary Lee in 2004. It was her tepee teaching and Ernestine who inspired me to seek out more information and reconnect with my Indigenous culture, language, genealogy and identity.

According to Mary Lee's Four Directions Teachings, the tepee is a woman with her arms raised toward the sky, giving thanks to Creator. Mary Lee explains:

> The tepee is … the spirit and body of woman, because she represents the foundation of family and community. It is through her that we learn the values that bring balance into our lives. That is why, when you construct a tepee, it involves ceremony, because the ceremony of making a tepee represents the value of women's teachings (Lee 2008).

The tepee is constructed of 15 poles, each representing a value and teaching. The first pole is obedience, teaching us to accept guidance and wisdom from others. The second pole is respect and the teaching is respect for self and others. The third pole is humility; teaching is that we are not above or below others in the circle of life. The fourth pole is happiness, teaching us to show enthusiasm and encourage others. The fifth pole is love, teaching the love of oneself and love of others, not things. The sixth pole is faith and belief in the spirit world. The seventh pole is kinship, the forming of relationships with parents, siblings, extended relatives, and all our

relations. The eighth pole is spiritual cleanliness, teaching us to walk *bimatisawin*, in a good way. The ninth pole is thankfulness, teaching gratitude for life and family. The tenth pole is sharing and the teaching involves sharing our knowledge, stories and traditions with future generations. The eleventh pole is strength and the teaching includes having spiritual strength, to do things that are difficult. The twelfth pole is good child rearing and teaching that we must guide and protect the sacred gift of children. The thirteenth pole is hope, teaching hope that women, who are the life givers and the nurturers, will carry on these teachings to bring healthy and spirited people into the world. The fourteenth pole is protection and teaching is to protect the minds, spirit, emotions and health of the youth. The final and fifteenth pole is the control flap and the teaching is to find balance in life's journey (Lee 2008).

The poles also represent each individual's unique values, experiences, strengths and perspectives. Each pole is placed in opposition around the circle, teaching us that we each bring a unique perspective and story and to value of multiple ways of being, knowing and experiencing the world. Although the poles are separate and placed around the perimeter, they intersect at the top and are bound together. If only one pole were raised, it would fall to the ground, teaching us that no one stands alone; rather, we lean on one another for support. This teaches us the value of community, support, inclusion, relationships, connection and interconnection. The space within the teepee is an ethical and sacred space that represents diversity, equality, cross-cultural and interdisciplinary communication and collaboration. Much like Willie Ermine's "ethical space of engagement", the teepee is symbolic of the space between knowledge systems and disparate worldviews that aims to balance power into collaborative partnerships through the development of cross-cultural connections and dialogue (Ermine 2007:193; Ermine et al. 2004).

Erecting the tepee in memory of my mother and grandmother and in honour of all women is

significant to Indigenous women's health because the poles are symbolic of a woman's ribs and the fire in the middle of the tepee is symbolic of women's strength and power, especially her reproductive power. The canvas tepee cover is symbolic of a woman's shawl or blanket wrapped around her shoulders, thus illustrating the need to support our women throughout their reproductive journey. Setting up the tepee was a healing process and continues to be a gathering space where women from all walks of life come together to share teachings, stories and meals. It is a space to sleep, rest, recover and rejuvenate the strength that is needed to continue on our journey as women and mothers, children and partners, family and community.

Illustration 2.1. Jennifer Leason at the Teepee Raising Ceremony (Vernon, British Columbia). Photo Credit: © Lyanna Logan, May 2016

Illustration 2.2. Teepee erected at Teepee Raising Ceremony (Vernon, British Columbia). Photo Credit: © Jennifer Leason, May 2016

2.3 Gwayahkooshkaywin: Theory

The teepee teaching informed my interdisciplinary theoretical approach to researching Indigenous women's maternity experiences. Each pole around the parameter represents multiple perspectives. However, the poles intersect and lean on one another in the centre to create a space of understanding, growth and transformation. The tepee teaching is a "transformative method that build(s) bridges across theories, disciplines, paradigms, and strategies from the bottom up" (Chilisa 2012:264). Research/ers are encouraged to think about multiple perspectives and mobile subjectivities, of forging collaborations and alliances and juxtaposing different viewpoints (Evans et al. 2009; Wolf 1996: 14-15). As illustrated in chapter one, Indigenous health disparities is the result of complex genetic, biological, historical, social, political, economic, and cultural causes and contexts. Therefore, there is a need for collaboration, coalitions of knowledge systems, hybridity, alliances of world-views (Canella and Manuelito 2008) between and among a range of theories and methods to research and understand the complexity.

Much of the literature and debate on Indigenous peoples' health disparities centres on statistical evidence, focusing on size, proportion and the distribution of inequities. However, interdisciplinary dialogue and collaboration can inform and address the complexity of Indigenous peoples' health. One approach to research the complexity of Indigenous peoples' health is demonstrated by Mi'kmaq Elder Albert Marshall's conceptualization of *Etuaptmumk*, or 'Two-Eyed Seeing.' Two-eyed seeing is the ability to "see from one eye with the strengths of Indigenous knowledge and ways of knowing and from the other eye with the strengths of Western knowledge and ways of knowing ... and learning to use both these eyes together, for the benefit of all" (Hatcher et al. 2009:146). Two-eyed seeing expands on approaches to health that have historically been rooted in conventional scientific or Western definitions of health and

wellbeing and fosters creative and innovative solutions and methods to Indigenous people's health research. The Canadian Institute of Health Research has adopted the Two-Eyed seeing model "to create a more collaborative and comprehensive way to study health issues" by bridging Western science and Indigenous Traditional Knowledge (ITK) (CIHR, 2013).

> Two-Eyed seeing adamantly, respectfully, and passionately asks that we bring together our different ways of knowing to motivate people, Aboriginal and non-Aboriginal alike, to use all our understandings so that we can leave the world a better place and not compromise the opportunities for our youth (in the sense of Seven Generations) through our own inaction (Bartlett et al. 2012:331)

The teepee teaching as an ethical space of engagement (Ermine 2006) and Albert Marshal's Two-Eyed seeing inform the theoretical approach I have chosen. *Gwayahkooshkaywi*n, a Saulteaux-Ojibway word for 'balance', is an interdisciplinary approach to researching Indigenous women's maternity experiences.

In 2010, I had the privilege of taking *Enowkinwix* with Dr. Jeannette Armstrong (Armstrong 2005). The course centered on the Syilx-Okanagan *captikw* ('story'): How Food Was Given (Edwards 1984:27). In The Four Food Chiefs *captikwl*, each Chief Spitlem (Bitterroot), Siya (Saskatoon Berry), Ntityix (Spring Salmon), and Skimxist (Black Bear) gives their life to the People-To-Be, thus teaching the interconnection, relationships and the responsibility we have to local Indigenous knowledge systems, land and sustainability (pers. com Armstrong 22 July 2010). During the course, I designed *Gwayahkooshkaywi*n[4] to illustrate the collaboration and relationships between the Four Food Chiefs. I also integrated my own Anishinaabe teachings that are informed by the Ojibway creation story (Benton-Benai 1988), the four hills of life (Peacock and Wisuri 2006), Ojibway ceremonies (Johnson 1982), and the four directions model (NWAC 1989:134-35; Ouellette 2002:48).

*Gwayahkooshkaywi*n is an Indigenous research paradigm and my attempt at a collaboration, dialogue and balance between four disciplines (Illustration 2.1). The four disciplines include Indigenous scholarship, epidemiology and social determinants of health theory, critical medical anthropology, and feminist scholarship. The four circles represent each of the four disciplines and the larger encompassing circle is a holistic framework needed to understand the complex and interrelated determinants of Indigenous women's maternity experiences. The interconnected circles represent the relationship within, between and among each discipline.

In *Research is Ceremony,* Shawn Wilson (2008) encourages the development of Indigenous research paradigms that are based on relational accountability and the circle. He states that, by putting ideas in a circle, the

> ideas flow from one to the next, change in one affects the others, which in turn effects new change in the original. All parts of the circle are equal; no part can claim superiority over, or even exist without the rest of the circle. The entities are interconnected, inseparable, interrelated, whereby the whole is greater than the sum of its parts (Wilson 2008: 70).

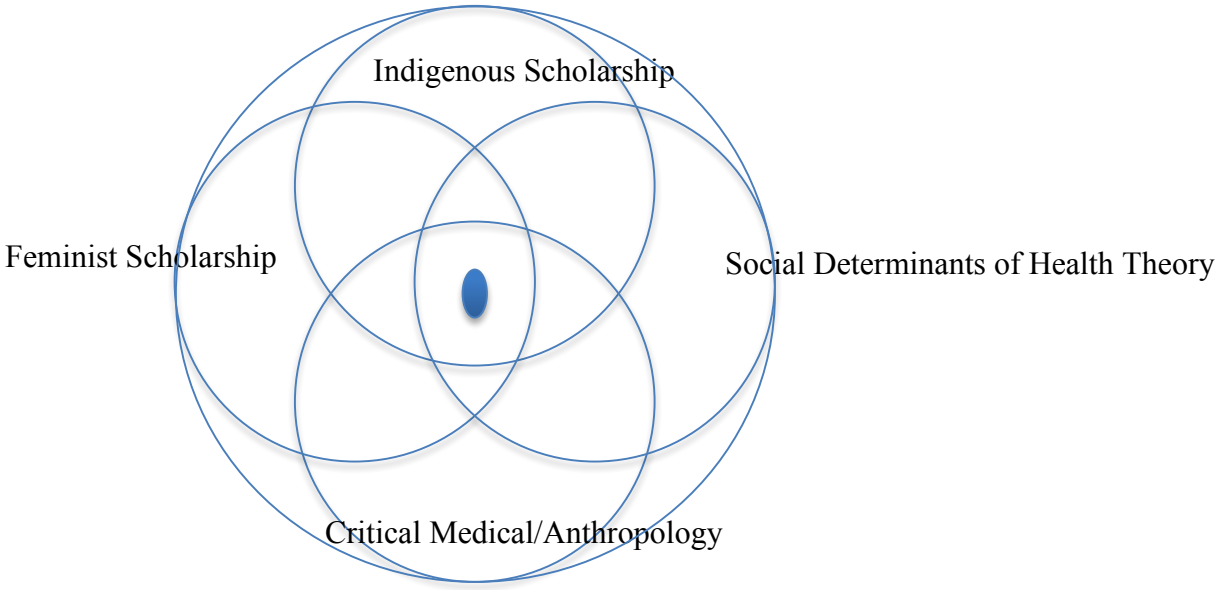

Illustration 2.3. Gwayahkooshkaywin: Indigenous Research Paradigm

2.3.1 Decolonized and Indigenous Methodologies

Decolonized and Indigenous research methodologies are important in grounding research within Indigenous epistemologies and cultural orientations (Archibald 2008; Cardinal 2011; Deloria 1996; Weber-Pillwax 1999; 2004). Colonial and Eurocentric history has created racially biased ways of knowing or epistemic racism whereby

> research definitions and methodologies [that] have been rooted in Euro-Western epistemologies-positivism to post-modernism, post-structuralisms- [that] arise out of a social history and culture of the dominant race. These epistemologies reflect and reinforce that social history and that social group and this has negative results for people of color in general and scholars of color in particular (Scheurich and Young 1997: 141).

Since 1999, a movement to dismantle, deconstruct, and decolonize Western epistemologies (Lincoln and Denzin 2008) has resulted in Indigenous peoples researching and writing about their own community epistemologies, needs, theory, methods and research ethics (Archibald 2008; Castellano 2004; Kovach 2008; Weber Pillax 1999, 2004; Wilson 2008). Based in a rich history of Indigenous scholarship (Alfred 1999; Battiste 2000; Cajete 2000;

Deloria 1964; Cardinal 1969; Manual 1974), there is a resistance to Western research (Van Ginkel1995: 6), colonial institutions, and research methods. A movement toward the critical expansion (Denzin et al. 2008; Kovach 2009) and decolonization of Indigenous methods (Battiste et al. 2002; Smith 1999) has created a call to transform research so that Indigenous peoples are no longer objects of inquiry or the "other" but are the authors, advocates/activists, researchers and agents of social change (Denzin et al. 2008). Social change is needed within Indigenous peoples' health to address and alleviate health disparities and inequities by moving "beyond the mere description of problems and issues to making sure that change does in fact occur" (G. Smith 2005: 41). There is a call for Indigenous health researchers to begin "researching ourselves back to life" (Castellano 2004:98). One way to address Indigenous maternal and child disparities and research ourselves back to life is to understand the social context of Indigenous women's maternity experiences or their social determinants of health.

2.3.2 Social Determinants of Health Theory

In order to understand maternal child health disparities and why Indigenous women experience higher rates of stress, violence and depression, the aim of my doctoral research is to contextualize the maternity experiences of Indigenous women in the Okanagan Valley of British Columbia. Contextualization has two aspects. One is to appreciate "people in context" (Blasco and Wardle 2007:4) thus situating their experiences within a culture of everyday social life. The second approach is to recognize the relationship(s) between local ways of life and "a larger social order" (Marcus 1995:95). As discussed in detail in chapter one, a social determinant of health lens helps contextualize Indigenous women's maternity experiences by situating their experiences within proximal determinants or everyday social life. In addition, intermediate and distal determinants of health situate Indigenous women's maternity experiences within a larger social order.

2.3.3 Critical Medical Anthropology

Contextualization also includes the examination of culture. Ethnography, or researching and writing about culture, has a long history within anthropology (Boas 1962; Evans-Prtichard 1976; Hallowell 1971, 1976; Leslie 1976; Malinowski 1972, Turner 1970). There is also a rich ethnographic history of writing about Indigenous women and birth (Cameron 1981; Landes 1971; McPherson 1994, 2007, 2016; Olbrechts 1931; Jordan 1980). As an Indigenous person conducting ethnographic research on Indigenous women's maternity experiences, I am aware that "as indigenous or non-Indigenous researchers trained in the disciplines such as anthropology (disciplines that emerged at the moment of European capitalist expansion), we are obligated to reflect critically on the foundations of our discipline" (Menzies 2001:23). The discipline of Anthropology has undergone scrutiny in recent years, even more so from Indigenous scholars (Battiste 2000; Battiste and Henderson 2005, Smith 1999) who signify that Indigenous peoples have been "othered", excluded and misrepresented.

Today, the concept of the field has undergone scrutiny (Gupta and Ferguson 1997) and concepts of culture have expanded to include not only the "exotic other," but also more recent applications in the examination of the ethnographer's own society and cultural orientation. When applied to studying health, illness and medical institutions, medical anthropology emphasized the role of culture and how culture shapes illness experiences, narratives (Kleinman 1988, 2010) and illness semantics (Good 1994), while at the same time, examining social hierarchies, power dynamics (Farmer 2005), and the socioeconomic context (Baer et al. 1995). Ethnographic research and health narratives inform our understanding about the social and cultural context of health experiences. "Medical anthropologists generally go beyond seeing health as primarily a biological condition, by seeking to understand the social origins of disease, the cultural construction of symptoms and treatment, and the nature of interactions between

biology, society and culture" (Singer et al. 2003:11). A critical medical anthropology refocuses our research lens and intervention gaze "away from those individuals and groups who are mistakenly held to be responsible for their condition, toward a range of broader upstream political and economic forces" (Singer and Bayer 1995:157) and urges us to "study up" (Nader 1972).

Historically, Indigenous women have been victimized, pathologized—and blamed—for their circumstances and thus their health, because of their "poor" individual choices. Maori Elder Merata Mita says this best:

> We have a history of putting Indigenous peoples under a microscope, much like a scientist looks at an insect. Those who do the looking are giving themselves the power to define (in Smith 1999:58).

By shifting our gaze away from Indigenous peoples towards upstream forces of power, we can then redefine health, wellness, and address health disparities and inequalities. Within the Canadian context and its history of colonization, it is important to shift our research gaze towards the examination of "communal and colonial violence, [disruption], displacement and remembered" (Good et al. 1995:5).

Not only does critical medical anthropology shift our focus away from individual health and circumstances, but it also a tool to bring about social change. Change is needed to improve Indigenous peoples' health because Indigenous communities have expressed that they have been overly researched (Denzin et al. 2008:4). As an applied practice, a critical medical anthropology approach "moves beyond the academy, the scholarly conference, and the academic journal into the applied fields of clinics, health education and development projects, federal health institutes, international health bodies, private voluntary organizations, health movements, and community-based agencies" (Singer and Bayer 1995:80-81; Lock and Nguyen 2010). Critical qualitative research empowers individuals and communities, and brings about emancipatory change and

transformation by challenging various forms of unequal power relationships, class exploitation, racism and sexism (Singer and Bayer1995:43).

2.3.4 Feminist Scholarship

Although there is no single agreed upon definition of feminism, for the purpose of my dissertation I define feminist research as research done with, by, for and about women (Oliver and Tremblat 2000) and as "a movement and set of beliefs that problematizes gender inequality (DeVault 1999:27). Examining the intersections of gender, race and class (Hankivsky 2012), sexism and power, privilege and oppression, are important when researching women's lives (Crenshaw 1993). A feminist lens challenges the "contours of power and inequity that reveal themselves through (disproportionate) population distribution of health, body, disease, disability, and death" (Krieger 2005:2). Whereby, imposed Eurocentrism and colonization, patriarchy, hegemony and socially constructed categories and concepts of "otherness" are the contours of power and oppression.

An Indigenous feminist approach encourages creating spaces for Indigenous voices and perspectives, as well as a process of critique, decolonization and Indigenization (Green 2007; Smith 1999: 152; Suzack et al. 2010; Ouelette 2002). Historically, Indigenous women have been excluded and misrepresented (Van Kirk 2006:196), homogenized, marginalized and "othered" (Smith 1999:67). As Patricia Monture (in Boulton 2003:4) puts it, "women have been a footnote in [a] male-defined system. And if women are the footnote, then Aboriginal women are the footnote to the footnote."

My research is an Indigenous feminist inquiry because my research is a "bottom up approach, using the experiences of women and the diversity of Indigenous knowledge systems and epistemological standpoints of women" (Chilisa 2012: 264). My research aims to create new knowledge specific to Indigenous women's maternity experiences and to create social

change through the inclusion of Indigenous women's voice in public health research in Canada. Secondly, my research is feminist because it aims to address power imbalances (Luttrell et al. 2007; Rowlands 1997), including Indigenous women's historical and contemporary struggles of oppression that is entrenched within a history of patriarchy and colonial systems. My location and position as an Indigenous health researcher discussed above and reflexivity within my participant observations are the third characteristic that frames my research within a feminist perspective. Positioning of the researcher not only allows and encourages feminist researchers to bring their own particular location and position into the research, but makes it imperative for them to do so before any discussion of another's reality can be introduced (Bhavnani 1991:97-98).

2.4 Methods

2.4.1 Canadian Maternity Experiences Survey (PHAC 2009)

Following my literature review, my wondering and wandering life led me to the Canadian Maternity Experiences Survey (MES). The MES (PHAC 2009) was initiated by the Canadian Perinatal Surveillance System (CPSS) of the Public Health Agency of Canada (PHAC) and was intended to provide representative, pan-Canadian data of women's experiences, practices and perceptions during pregnancy, birth and early postpartum months for evidence-based improvements in maternity care and infant health (PHAC 2009). The MES design and methods (Chalmers et al. 2008; Dzakpasu et al. 2008) were adapted from similar studies conducted in the United States, Australia, the UK, Scotland and Russia (PHAC 2009: 21). The questionnaire was gathered in 2002 to 2004 from three urban pilot study sites in Moncton, Vancouver and Yellowknife (Dzakpasu et al. 2005). The MES sampling frame was taken from the 2006 Census population and included birth mothers 15 years of age or older, who had a singleton live birth in

Canada and lived with their infants at the time of the survey. A stratified random sample was selected from 8,542 of 58,972 eligible mother-baby pairs who were randomly selected and a total of 6,421 biological mothers (78% response rate) completed the survey. "In consideration of the sample design and non-response, each responding woman was assigned a sample weight calculated within weighting classes" and the "6,421 respondents were thus weighted to represent 76,508 women" (PHAC 2009: 23). The sample received an introductory letter and survey pamphlet and telephone interviews with a Stat Can interviewer took place between 23 October 2006 and 31 January 2007 (PHAC 2009).

The MES identified recent immigrant, young (age 16-19), and Aboriginal women to be at higher risk of adverse pregnancy outcomes and that specific results from each population would be produced through focused publications (PHAC 2008:11). Subsequent publications were never produced. My initial research questions were:

i. What are Aboriginal women's responses to the MES?
ii. Do Aboriginal women's responses to the MES differ from the general Canadian population?
iii. What are the priority topics and areas of concern within Aboriginal women's maternity experiences?

To gain an understanding of Aboriginal women's maternity experiences and delivery of care, I accessed and disaggregated Aboriginal women's responses to the MES through the Canadian Research Data Centres (CRDC) program. The CRDC program is part of an initiative by Statistics Canada, the Social Science and Humanities Research Council (SSHRC), funded by the Canadian Institute of Health Research (CIHR) and the Canadian Foundation for Innovation (CFI). Research Data Centres provide researchers with access, in a secure university setting, to micro data from population and household surveys. Operated under the provisions of the

Statistics Act, in accordance with all confidentiality rules, the Centres are accessible only to researchers with approved projects who have been sworn in under the *Statistics Act* as "deemed employees." I conducted a descriptive analysis of Aboriginal women's responses to the MES at the University of British Columbia CRDC in Vancouver during three visits from October 2012 to January 2013.

2.4.1.1 MES Aboriginal Sample

Of the 6,421 women who participated in the MES, 6 per cent or 410 (weighted to represent 3223) self-identified as Aboriginal. Of the 410 Aboriginal respondents, 170 were First Nation (weighted to represent 1435); 142 were Métis (weighted to represent 1443); 89 were Inuit (weighted to represent 239); and 9 were "other," identified as dual citizenship, or "did not know." Sampling challenges within the MES resulted in the exclusion of First Nations women living on reserve and institutionalized women due to operational reasons"(Chalmers et al. 2007) and adoptive mothers, foster mothers or stepmothers were identified as out of scope (Dzakpasu et al. 2005). Aboriginal mothers were sampled according to their natural distribution and were not adjusted to address for small sample sizes or lower than expected response rates. Lower than expected response rates for Aboriginal women resulted in a 64 per cent response rate compared to 78 per cent for the non-Aboriginal population. As a result of a small sample size and lower than expected response rates, I was unable to report on all of the MES questions or disaggregate each variable by First Nation, Métis and Inuit. In some instances, the responses are lumped together into an "Aboriginal" category because cell sizes less than five (i.e., numerator with fewer than five cases) were suppressed as per Stat Can disclosure control rules. Initially I was interested in Aboriginal women's responses specific for British Columbia. However, the small sample size did not allow for further disaggregation by province. Therefore, my analysis is a national representation of Aboriginal women's responses to the MES.

2.4.1.2 MES Analysis

My analysis of Aboriginal women's responses to the Canadian MES includes descriptive statistics were calculated using Statistical Package for Social Science (SPSS version 17). All statistical analyses were vetted and released by a Statistics Canada CRDC employee to ensure participant anonymity and statistical accuracy. I chose to conduct a descriptive analysis to gain a comprehensive overview of Aboriginal women's maternity experiences, determine differences of experiences and to identify key issues and priority topics. Chapter three is an overview of Aboriginal women's responses to the MES and is compared to the total 6,421 MES population. Because I was only interested in a comprehensive overview, additional statistical tests were not conducted. In addition, I found the data quality limitations and the exclusion of First Nations women residing on reserve to be non-representative of Canadian Indigenous women and further analysis would be futile. Therefore, data quality limitations and comparisons between the total MES population and Aboriginal women are not statistically significant and should be interpreted with caution.

2.4.2 Experiential Focused Ethnography

My MES analysis provided an overview of Aboriginal women's maternity experiences as illustrated in chapter three and highlighted three key issues. The three key issues were Aboriginal women's experiences of stress, higher rates of violence and higher rates of postpartum depression. Following my MES analysis, I observed that the survey method reduced Indigenous women's lived experiences to a series of disconnected variables that did not do justice to the complexities of social life and the cultural context in which they live. Through an Indigenous lens, the findings did not include the voices and stories of Indigenous women who speak from diverse viewpoints. I questioned if the survey findings were reflective of Indigenous women's experiences and this led to my secondary research questions:

i. Why do Indigenous women experience higher rates of stress, violence and postpartum depression?
ii. What are Indigenous women's maternity narratives?

Ethnographic research "thickens" (Geertz 1973:6) our understanding of human behaviours through immersion by providing a holistic understanding of their social and cultural context (Angrosino 2007:1-2). The purpose of my experiential focused ethnographic research was not to replicate the MES survey. The purpose of the qualitative research was to ask women to describe or explain, "What is this [maternity] experience like?" in order to understand their perspectives and identify the issues and topics that were most important to them (Calabrese 2013; Luttrell et al. 2009; Ziebland et al. 2013). I wanted to gain a deeper understanding of Aboriginal women's lived experiences of maternity and what it means to "walk a mile in their shoes." Birth stories (Farley 2001; Vandevusse 1999:45) and maternity narratives also provided insights into health inequities (Popay et al. 1998) by explaining, through a detailed examination of context, why some individuals and groups experience health inequities by identifying strengths, gaps, needs and priorities that are important to Indigenous women.

I conducted ten semi-structured interviews from 29 January to 8 April 2015 that varied between two and five hours in one sitting. With permission, I audio recorded each conversation. Each conversation unfolded differently based on the unique experiences and circumstances, as well as the amount of information each sister- participant shared. The semi-structured interview (Fife 2005) included open-ended questions informed by an interview script (Appendix E). The interview script served as a guideline that directed and kept the conversation on track, but the conversations were not limited to these questions. The semi-structured questions and interview script were developed from and elaborated on my analysis of the MES data and included questions pertaining to:

1. Participant information and socio-demographics;
2. Prenatal experiences;
3. Labour and birth experiences;
4. Postpartum experiences (during the 6 months following birth of baby);
5. Maternal Stress;
6. Postpartum depression; and
7. Exploratory questions.

Participant information and socio-demographics provided information on my sister-participant's socioeconomic circumstance. Questions pertaining to prenatal, labour and birth, and postpartum experiences encouraged women to describe their thoughts, feelings, experiences and perceptions of perinatal healthcare and support. Additional questions were asked to determine if they experienced any barriers that prevented them from obtaining their optimal level of perinatal health. Specific questions related to stress and postpartum depression encouraged women to speak about the circumstances and context related to stressors and how it affected them personally, their relationship and their child or children. Women were also asked to describe the support (or lack thereof) that they received. Additional exploratory questions related to Indigenous mothering, suggestions for improvement, personal strengths and supports were used to summarize additional feedback that was not addressed in the interview questions but were important for my sister-participants to share.

2.4.2.1 Sister-Participants

Rather than use the term participant in my dissertation, I am using the term sister-participant as an Indigenous methodology to denote relational accountability (Wilson 2008). My sister participants were selected through purposive snowballing sampling. I chose snowball sampling because of my insider position and involvement with Indigenous communities and organizations, which allowed for ease of access to participants (Palmer and Thompson 2010).

Snowball sampling was the result of contact with one or two people already known to me, who then referred sister-participants within their social network to participate in my research, creating a "snowball" effect (Browne 2002).

Snowball sampling includes a small number of individuals selected for particular characteristics (Green and Thorogood 2004; Somekh and Lewin 2005) and my sister participants were selected according to following criteria, they

1. self-identify as First Nations, Métis or Inuit and reside in the Okanagan Valley of B.C. (including urban, rural or remote);
2. are 16 years of age or over; and,
3. are currently pregnant or gave birth between January 2012 and October 2014.

My sister participants included a diversity of Indigenous identities (i.e. Cree, Syilx, Blackfoot, Métis), and included differing urban, rural, remote, on or off reserve contexts and diverse experiences of colonialism.

2.4.2.2 Recruitment

Sister-participants were recruited via posters (Appendix A) and email list-serves. The posters provided my email and telephone number. Those who were interested in participating in the conversation were asked to contact me directly. A call for participation was distributed to:

1. Okanagan Nation Alliance (8 member bands within the Okanagan: Okanagan Indian Band, Upper Nicola Band, Westbank First Nation, Penticton Indian Band, Osoyoos Indian Band and Lower and Upper Similkameen Indian Bands);
2. Kelowna Métis Family Services; and
3. Vernon Friendship Centre.

Once my sister-participants initiated contacted either by email or telephone, I emailed them a letter of initial contact (Appendix B) to explain the purpose of the conversation and outline my research process. We then agreed to a scheduled time one week after initial contact to give my

sister-participants sufficient time to consider and confirm their participation. Each interview was held in an environment (coffee shop, in the park, sister-participant home) where she felt the most comfortable and was able to respond freely. Upon meeting, participants completed the consent form (Appendix C) and photo release form (Appendix D). Prior to the interviews, I utilized an Indigenous (Anishinaabek) methodology by presenting each sister with a cowrie shell, tobacco, sage, sweet grass and cedar in a small plastic bag as a gift to ask for their stories. Following the conversations, each sister-participant also received a $50.00 pre-paid VISA card.

2.4.2.3 Thematic Content Analysis:

One of the challenges I faced while trying to make sense of Indigenous women's maternity experiences was representing their lived experiences and stories in a holistic way, while adhering to page limitations and ethical considerations of confidentiality. Within my analysis, I compiled over 40 hours of interview tapes and over 180 pages of transcribed interview data. The large amount of data thus demonstrated the complexity and diversity of Indigenous women's maternity experiences. In my research analysis, I attempted to balance between the dual process of telling the story from the point of view of the research participants, and unpacking that story in some way such that the broader meanings can be elicited (Green and Thorogood 2004:175). Given the large amount of data, I chose Thematic Content Analysis (TCA), also known as Pattern Level of Analysis (LeCompte and Schensul 1999:154) as a way of sorting the salient issues or identifying typical responses and themes (Green and Thorogood 2004:177) in order to create a broader understanding of Indigenous women's maternity experiences. The recurrent or common themes serve as a means of evoking additional conversation about the underlying phenomena, relationships among the themes that emerge, and the context(s) in which they occur (Lincoln and Guba 1985). The aim of my data analysis was to give an overview of emerging themes, while respect Indigenous women's diversity and the

richness and complexity of their lives and maternity experiences in a meaningful way and create a space where Indigenous women speak for themselves. Therefore, my dissertation is a brief overview of Indigenous women's maternity narratives and by no means does it completely encompass the complexity of their maternity experiences.

I uploaded and transcribed conversations and structured participant observations notes into MAXQDA, which is a software program for qualitative and mixed methods data analysis. It organizes and sorts themes, categories and coding schemes based on word frequency and identified patterns and themes. After uploading all transcription data, I conducted a word frequency count. I then went through each interview to colour code system entries and I identified 17 category patterns. The 17 category patterns were education, employment and income, housing, homelessness, single parenting and relationships, violence and postpartum depression. Women also spoke about their fear and barriers when accessing mainstream healthcare. In addition, women also shared their experiences with foster care and a history of residential school, and the impacts of addictions. When asked exploratory questions about Indigenous mothering, women spoke about the importance of ending negative cycles, reviving culture and language and the role of being strong Indigenous women warriors.

After compiling a list of category patterns, I organized the17 patterns into five main themes including:

1. Social Determinants;
2. Stress;
3. Cultural Safety;
4. Trauma; and
5. Strength Based Narratives and Resiliency.

I then organized the themes into three sections related to proximal, intermediate and distal determinants of health and well-being. Chapter five is an overview of my sister-participants

narratives related to the proximal context of Indigenous women's experiences that includes education, employment, income, housing and experiences of homelessness. Chapter five also includes Indigenous women's experiences of stress related to parenting, relationships, violence and narratives of postpartum depression. Chapter six is an overview of my research findings related to the intermediate and distal context of Indigenous women's experiences including cultural safety and healthcare experiences, trauma and the historical and intergenerational impacts of colonization. Chapter six concludes with Indigenous women's strength based narratives and resiliency (Table 2.1).

Table 2.1 Thematic Content Analysis by Theme, Category, Code Number, Word Frequency and Number of Participants

Determinants	**Theme**	**Category Pattern**	**Number of Code System Entries**	**Word Frequency**	**Number Participants (N=10)**
Proximal Determinants Chapter 5	Social Determinants	Education Employment and Income Housing Homelessness (women's shelter)	27 21 6 4	43 21 12 8	7 6 4 2
	Stress	Parenting Relationships Violence Postpartum Depression	42 36 17 4	58 42 33 11	6 7 3 2
Intermediate Determinants Chapter 6	Cultural Safety	Healthcare Experiences Fears Barriers	8 4 5	16 8 6	4 3 3
Distal Determinants Chapter 6	Trauma	Addictions: someone close to them History of Residential School Foster Care Attendance	 22 12 8	 58 18 10	 6 2 1
Conclusion Chapter 6	Strength-Based Narratives/ Resiliency	Ending Negative Cycles Strong Women Culture and Language	21 8 6	32 12 8	6 3 3

2.4.3 Participant Observations and Reflexivity

In addition to semi-structured interviews, I also completed structured participant observations (Appendix F). Participant observation refers to a process by which a researcher immerses herself in the culture of a community to learn the native's point of view (Malinowski 1972: 24-25). Ethnographers studying health experiences immerse themselves in social context of illness and treatment for prolonged periods of fieldwork to collect descriptive data and form an understanding of local culture and embodied experience. Participant observations include observing the behaviours of group members, in these instance Indigenous women, while at the same time participating in those behaviours with the intent of 'knowing (how) people (experience the world)' rather than 'knowing about them' (Fife 2005:71-72).

My goal was to gain an understanding of the cultural and sub-cultural contexts of Indigenous women's maternity experiences by observing the people present, their environments (when interviews conducted in sister-participant's home versus public places) and non-verbal behaviour, such as tone of voice, posture, facial expressions, eye movements, forcefulness of speech, body movements, and hand gestures. This was informative when sister-participants elaborated on the content of the interview and I could ask questions, explore tentative hunches, and recognize trends and emerging patterns in the data. I was also able to develop my own impressions of the sister-participant and her level of discomfort with certain topics, emotional responses to people, events or objects.

Chapter 3 (Niswe): Findings from the Canadian Maternity Experiences Survey: What Aboriginal Mother's Say

3.1 Socio-Demographic Characteristics of Aboriginal Women in the MES

Of the 6421 MES respondents (weighted to represent 76,508 women), 410 (weighted to represent 3223) or 6 per cent self-identified as Aboriginal. Of the 410 Aboriginal mothers, 44.5 per cent were First Nation (N=170, weighted to represent 1435), 44.7 per cent were Métis (N=142, weighted to represent 1443), 7.5 per cent were Inuit (N=89, weighted to represent 239), and 3.3 per cent (N=9) did not know if they were First Nation, Métis or Inuit; or claimed dual Aboriginal citizenship (First Nation and Métis ancestry). Aboriginal respondents were from Ontario (21.3 per cent), followed by Alberta (19.4 per cent) and British Columbia (18.8 per cent). The maternal age of delivery varied and 10.8 per cent of First Nation women, 7.4 per cent Métis and 13.3 per cent of Inuit respondents were young mothers age 15-19 compared to 3.3 per cent of the total MES population. Over half (57.6 per cent) of Aboriginal women were never legally married, 37.5 per cent were married and 4.7 per cent were divorced, widowed or separated. Aboriginal mothers had lower educational attainment and income levels. Nearly one quarter of the Aboriginal MES respondents (24.7 per cent) had less than a high school education compared to 7.2 per cent of the general MES population. However, the lower education rates may also be reflective of the higher rates of young mothers age 15 to 19. Within my MES analysis, 46.1 per cent of Aboriginal mothers reported a household income of $39,999 or less, 35.7 per cent reported a household income below $29,999, and 28 per cent reported a household income of $19,999 or less. Aboriginal women were three to six times more likely to live in a household of five or more people. First Nation women were four times more likely and Inuit women were twice as likely to report being homeless at some point throughout their pregnancy (Table 3.1).

Table 3.1 Socio Demographic Characteristics of Aboriginal Women's responses to the MES, Canada 2006-2007 by First Nations, Métis and Inuit, Age, Province, Marital Status, Highest level of Education, Number of People in Household, and Total Household Income.

	Total MES N=6421 %	Aboriginal N= 410 %	First Nation N= 170 %	Métis N=142 %	Inuit N=89 %
Maternal Age at delivery					
15-19	3.3	10.8	11.7	7.4	13.3
20-24	44.6	30.2	25.4	26.5	38.2
25-29	22	31.1	32.2	31	30.3
30+	30	27.9	30.7	35.1	18.2
Province baby was born					
Newfoundland/Labrador	4.3	1.8			
Prince Edward Island	2.9	0.2			
Nova Sc/New Bruns.	10	0.2			
Quebec	19.6	5.6			
Ontario	28.9	21.3			
Manitoba	5.3	13.9			
Saskatchewan	5.3	10.4			
Alberta	10.1	19.4			
British Columbia	9.8	18.8			
Yukon	1	0.5			
Northwest Territories	1.4	3.2			
Nunavut	1.3	2.8			
Relationship Status					
Married	30.8	37.5			
Never legally married	65.2	57.6			
Divorced, widowed or separated	4	4.7			
Refusal/ Don't know	0	0.2			
Highest Level of Education					
Less than high school	7.6	24.2			
High school graduate	19.2	21.9			
Some post-secondary (College, CEGEP, Trades certificate or diploma)	37	44.4			
Bachelor degree/graduate	35.1	9.5			
Not stated	1.2	.3			
No. People in Household					
1 Person	0.4	*	*	*	
2-3 People	27.4	31.6	30.9	35.8	13.9
4 People		30.4	30.5	33.5	20.1
5 People	49.7	20.4	20.2	17.1	35.1
6 People or more	14.3	17.5	18.4	13.6	30.9
	5.2				
Household Income					
Less than $10,000		8.4			
$10,000-$14,999		9.1			
$15,000-$19,999		6.2			
$20,000-$29,999		12			
$30,000-$39,999		10.4			
$40,000-$49,999		4.6			
$50,000-$59,999		10.7			
$60,000-$79,999		10.6			
$80,000-$99,999		7.7			
$100,000-$150,000		9.4			
Don't know		10.8			

* Statistics based on cell sizes less than five (i.e., numerator with fewer than five cases) were suppressed as per Statistics Canada disclosure control rules.

3.2 Pregnancy

3.2.1 Reaction to Conception

Reaction to conception varies and is reflective of a woman's circumstance and stage in life (Klerman 2000). Studies have illustrated an association between intention and adverse infant and maternal health outcomes (Santelli et al. 2003). Most or 86.2 per cent of Aboriginal mothers were "somewhat" or "very happy" to be pregnant, compared to 93 per cent of the total MES and 35.3 per cent of Aboriginal mothers were satisfied with the timing of their pregnancy. Although Aboriginal women were happy to be pregnant and satisfied with the timing of their pregnancy, 31.4 percent would have preferred to be pregnant later, 13.7 per cent did not want to be pregnant at all (Table 3.2).

Table 3.2 Proportion of Aboriginal Women's Reaction to Conception and Timing of Conception, MES, Canada 2006-2007.

	Total MES N=6421 %	Aboriginal N=410 %
Reaction to Conception		
Very Happy	80.9	65.3
Somewhat Happy	12.1	20.9
Neither Happy nor Unhappy	4.2	7.5
Somewhat Unhappy	2.3	3.9
Very Unhappy	0.6	2.3
Don't Know	0	0.1
Reaction to Timing of Conception		
Wanted to be pregnant:		
Then	49.5	35.3
Later	20	31.4
Sooner	23.4	17.4
Not at all	7.1	13.7
Don't know	0	2.2

3.2.2 Prenatal Class Attendance

Prenatal care and education are important to alleviate adverse health outcomes as it provide primary care/intervention and an opportunity to prepare women and their families for pregnancy, labour and birth, care of the newborn and adjustment to family life (MES 2009). Prenatal education classes improve women's self-esteem and self-confidence, enhance family

relationships, promote breastfeeding and improve communication between the woman and her health care providers (Health Canada 2006, 2008, 2012; Chalmers et al. 2001). Overall, 30.8 per cent of Aboriginal women attended prenatal classes and younger mothers age 15-19 (55.5 per cent) were the most likely to attend.

3.2.3 Folic Acid

Adequate folic acid supplementation during the periconceptional period (the time just before and just after a woman becomes pregnant) substantially reduces the risk of congenital anomalies, particularly neural tube defects (NTD) which are abnormalities of the spine and brain resulting from failure of neural tube closure within one month of conception and the most common of these NTD are spinabifida, anencephaly and encephalocele (Eichholze et al. 2006; Lumley et al. 2001; Sahin and Gungor 2010). Within the MES Aboriginal mothers were less likely to take a multi-vitamin with a folic acid supplement (34.3% Aboriginal women versus 57.7% total MES) and 62.3% of Aboriginal mothers, were aware that folic acid reduces the risk of congenital anomalies compared to 77.6% of the total MES population (Table 3).

Table 3.3 Proportion of Aboriginal women by First Nation, Métis and Inuit, who attended a prenatal class and are aware of folic acid benefits and took a multivitamin with folic acid supplement during pregnancy, MES, Canada, 2006-2007.

	Total MES N=6421 %	Aboriginal N= 410 %	First Nation N= 170 %	Métis N=142 %	Inuit N=89 %
Attended a Prenatal Class	32.7	30.8			
15-19 Years of Age	49.5	55.5	30.6	31.4	31.4
20-24 Years of Age	33.8	39.8			
25-29 Years of Age	38.7	27.1			
30+ Years of Age	25.2	27.7			
Women who took a multi-vitamin with a folic acid supplement					
Before pregnancy	57.7	34.3			
Of those who took it before pregnancy: took it Everyday	90	85.3			
First 3 months of pregnancy	89.7	77.8			
Of those who took it for first 3 months: too it Everyday	92.2	86.9			
Women who are aware of folic acid prevents birth defects	77.6	62.3			

3.2.4 Smoking and Substance Use

Maternal cigarette smoking and exposure to second hand smoke is related to adverse pregnancy outcomes including intrauterine growth restriction, low birth weight, increase risk of preterm birth (Ion and Bernal 2014), spontaneous abortion, placental complications, and stillbirth (Cnattingius 2004). Long-term effects of children of mothers who smoke during pregnancy include higher rates of respiratory illness, asthma and neurodevelopmental and behavioural problems (Pattenden et al. 2006) as well as higher rates of Sudden Infant Death Syndrome (Shah et al. 2006).

In the three months prior to pregnancy or before realizing they were pregnant, 40 per cent of First Nations, 39.3 per cent Métis and 57.4 per cent of Inuit women reported smoking daily; 13.6 per cent of First Nations, 5.5 per cent of Métis and 14.6 per cent of Inuit women reported smoking occasionally; 46.4 per cent of First Nations, 55.3 per cent of Métis and 28 per cent of Inuit women reported not smoking at all.

During the last three months of pregnancy, Aboriginal women were at higher odds (OR 2.6, 95% CI: 2.4-2.9) of smoking whereby 12.2 per cent of First Nations, 16.7 per cent of Métis and 44.5 per cent of Inuit women smoked daily (Table 3.4).

Consequently, Aboriginal women and their infants and/or children are at higher odds of living with a smoker (3.2, 95% CI: 3-3.4). For example, 52.4 per cent of First Nations do not live in a smoke free home and 24 per cent of Métis youth aged 12 to 24, were exposed to second-hand smoke in the home compared with 14 per cent for non-Indigenous youth (Stat Can 2011). This is consistent with findings from the MES, where 50.9 per cent of First Nations, 46 per cent of Métis and 63.2 per cent of Inuit women and their children live with a smoker (Table 3.4).

Table 3.4 Proportion of Aboriginal women by First Nation, Métis and Inuit who smoked 3 months before and within the last 3 months of their pregnancy, and who lived with a smoker, MES, Canada 2006-2007

	Total MES N=6421 %	Aboriginal N= 410 %	First Nation N= 170 %	Métis N=142 %	Inuit N=89 %
Women who smoked 3 months before pregnancy	15.8	45.6	40	39.3	57.4
Daily	6.2	33.7	13.6	5.5	14.6
Occasionally	78	40.3	46.4	46.4	28
Nat at all					
Women who smoked in the last 3 months of their pregnancy					
Daily	6.9	24.5	12.2	16.7	44.5
Occasionally	3.6	38.9	8.3	12.5	18.1
Nat at all	89.5	65.9	89.5	70.8	37.4
Women who lived with a smoker	23.4	53.4	50.9	46	63.2
Women who reported using drugs 3 months before pregnant	6.7	24	25.3	27	19.7

3.2.5 Violence prevention and cessation

Violence against women is defined as "any act of gender-based violence that results in, or is likely to result in physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life" (WHO 2016). Previous research demonstrates that 30.6 per cent of Indigenous women experience violence while pregnant (Daoud et al. 2012). Compared to non-Aboriginal women, Aboriginal women have significantly higher odds (OR 2.0, 95% CI: 2.3-3.7) of violence whereby 33 per cent of First Nations, 25.5 per cent of Métis and 45.1 per cent of Inuit mothers reported physical violence within the last two years (Figure 3.1). Among Aboriginal women who experienced violence, 86.7% experienced violence before their pregnancy, 30.3% of women shared that the violence occurred during pregnancy and 32% said the violence occurred following the birth of baby (Table 3.5).

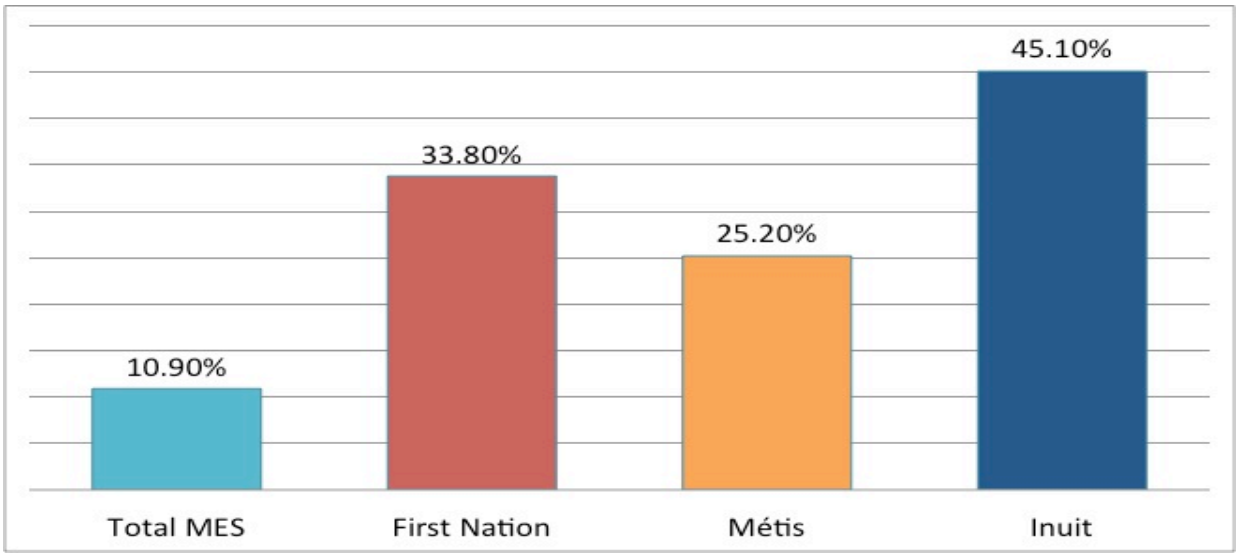

Figure 3.1 Proportion of First Nation, Métis and Inuit Women who experienced one or more abusive acts/ violence during the last two years within their pregnancy, MES, Canada 2006-2007.

Among the total Aboriginal population (N=410), 23.9 per cent of Aboriginal women were pushed, grabbed or shoved, 19 per cent were threatened with a fist, 13 per cent were kicked or bit, 12.5 per cent had things thrown at them, 10.6 per cent were slapped, 6.8 per cent were hit with other than a fist, 5.3 per cent were choked, 4 per cent were beaten, 2.6 per cent were raped and forced into sexual activity and 2.3 per cent were threatened with a gun/knife. Among Aboriginal women who experienced violence within the last two years, 48 per cent of First Nation 53 per cent of Métis and 68 per cent of Inuit women experiencing three or more abusive acts. This finding demonstrates that Aboriginal women were at higher odds of three or more abusive acts in the last two years (OR 4.4, 95% CI: 3.9-4.9). The majority of violence (51%) was perpetrated by a husband or partner. The ethnicity of the perpetrator is unknown. Of those who experienced violence, 62.7% of women discussed or received information on what to do and where to go to get support if they were being abused (Table 3.5).

Table 3.5 Proportion of Aboriginal women by First Nation, Métis and Inuit who experienced one or more abusive acts during their pregnancy, timing, type of abuse experienced, frequency, perpetrator of abuse and those who received information, MES, Canada 2006-2007.

	Total MES N=6421 %	Aboriginal N= 410 %	First Nation N= 170 %	Métis N=142 %	Inuit N=89 %
Women who experiences one or more abusive acts in the past 2 years	10.9	26.3	33.8	25.2	45.1
When the violence was experienced					
Incidents happen before you were pregnant		86.7			
Incidents happen during your pregnancy	30.7	30.3			
Incidents happen since birth of baby		32			
Type of abuse experienced					
Pushed, grabbed or shoved		23.9			
Threaten to hit with a fist		19			
Kick or bit		13			
Thrown anything at you		12.5			
Slapped		10.6			
Hit other than with a fist		6.8			
Choked		5.3			
Beat		4			
Forced into sexual activity		2.6			
Threatened to use gun/knife		2.3			
Frequency of abuse reported by women					
Happened Once	43.4	27.7	29	31	23
Happened Twice	19.9	16	23	16	9
Happened 3+ times	36.7	56.3	48	53	68
Perpetrator of Abuse					
Husband or Partner	52	51			
Family Member	16.5	19			
Friend	13	16			
Stranger	8.6	9			
Other	13	5			
Refusal		0.2			
Women who discussed or received information on what to do if they were abused	61	62.7			

3.2.6 Stress

According to my MES analysis and Aboriginal women's responses to the Pregnancy Risk Assessment and Monitoring System (PRAMS), Aboriginal women were at higher odds (OR 1.3, 95% CI: 1.2-1.5) of self-rating their level of stress as very stressful (Figure 3.2).

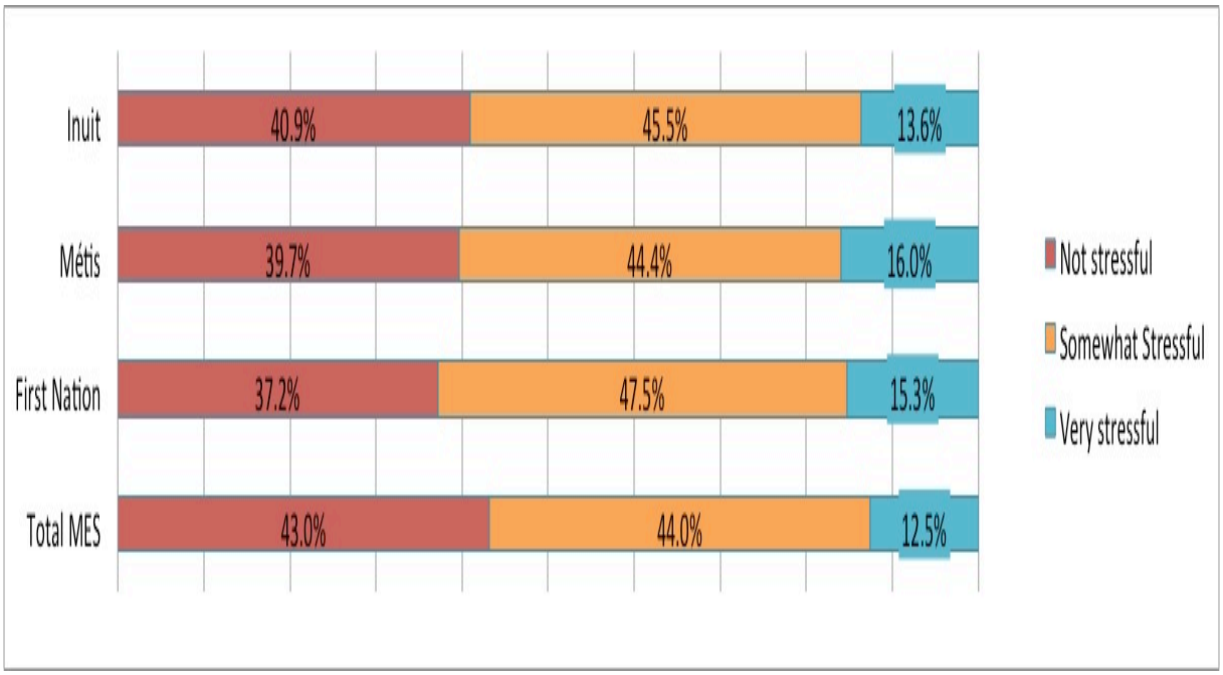

Figure 3.2 Distribution of First Nation, Métis and Inuit women's overall self-rated levels of stress, MES, Canada 2006-2007.

Aboriginal women were at higher odds (OR 3.3, 95% CI: 3.0-3.7) of experiencing three or more stressful life events within the last two years (Figure 3.3).

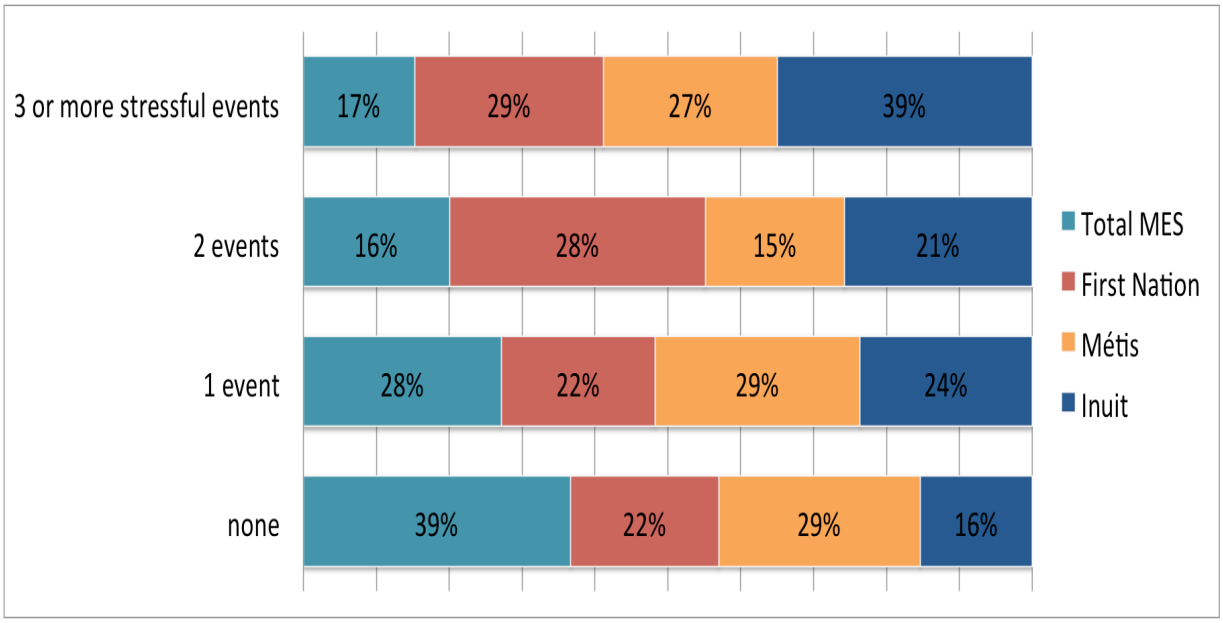

Figure 3.3 Distribution of First Nation, Métis and Inuit women's total number of stressful life events, MES, Canada 2006-2007.

The subjective experience of stress not only varied between Aboriginal and non-Aboriginal women but also varied among First Nation, Métis and Inuit women, thus illustrating the unique and diverse experiences of Aboriginal women (Table 3.6).

Table 3.6 Proportion of Aboriginal, First Nation, Métis and Inuit women's stress rating, number of stressful life events and types of stress related to the Pregnancy Risk Assessment and Monitoring System (PRAMS), MES, Canada 2006-2007.

	Total MES N=6421 %	First Nation N=170 %	Métis N= 142 %	Inuit N=89 %
Stress Rating				
Not Stressful	43	37.2	39.7	40.9
Somewhat Stressful	45	47.5	44.4	45.5
Very Stressful	12	15.3	16	13.6
Number of stressful life events				
None	39.1	17.9	24	14.5
1 event	27.8	18	23.6	22
2 events	16	23.2	12.5	18.3
3 events (or more)	17.1	40.8	39.9	44.8
Pregnancy Risk Assessment and Monitoring System (PRAMS)				
Emotional Stressors	21.9	*	29.9	*
Someone close to you was sick an go to hospital	15.6	29	22.1	35
A close family member died	9	31.5	29.3	24.8
Someone close to you had a bad problem with drinking or drugs	4.6	15.8	13.7	24.4
Relationship Stressors	16.3	24.5	*	20.2
Got separate or divorced from your husband or partner	4	*	*	*
You and your husband/partner argued more than usual	1.6	10.1	4.4	10
Husband/partner said they did not want you to be pregnant	1.1	4	*	13.5
Involved in a physical fight				
You or husband/partner went to jail or detention center	28.3	41.8	43.5	25.2
Financial Stressors	7.5	7.8	8.4	*
Moved to a new address	5.7	7.4	8.9	4.3
Husband or partner lost his/her job	11.4	*	19.3	25.4
Lost your job even though you wanted to go on working				
Bills you couldn't pay	10.9	33.8	25.2	45.1
Traumatic Stressors	1.0	3.9	*	1.7
You were kicked, hit, slapped or physically hurt by your partner				
Homeless				

- Statistics based on cell sizes less than five (i.e., numerator with fewer than five cases) were suppressed as per Statistics Canada disclosure control rules.

For First Nations mothers, 41.8 per cent stated that the most common stressful life events occurring in the 12 months before the baby was born included moving to a new address. In addition, 31.5 per cent reported that someone close to them had a problem with drinking or

drugs, 29 per cent had someone close to them die, 24.5 per cent argued more than usual with their husband/partner, 15.8 per cent separated or divorced their partner, 10.1 per cent were involved in a physical fight, 4.4 per has experienced incarceration or their partner was incarcerated, and 3.9 per cent were homeless (Figure 3.4).

For 43.5 per cent of Métis mothers, the most common stressful life event were bills they couldn't pay, followed by 29.9 per cent who reported someone close to them had to go to hospital, 29.3 per cent reported that someone close to them had a problem with drinking or drugs, 19.3 per cent had bills they couldn't pay, 13.7 per cent were separated or divorced, 8.9 per cent lost their job even though they wanted to work, 8.4 per cent stated that their husband or partner lost their job and 4.4 per cent were involved in a physical fight (Figure 3.4).

For 35 per cent of Inuit mothers, the most common stressful life event included someone very close to them die, 25.4 per cent had bills they couldn't pay, 25.2 per cent moved to a new address, 24.8 per cent reported someone close to them had a problem with drinking and drugs, 24.4 per cent got separated or divorced, 20.2 per cent argued more than normal with partner, 13.5 per cent stated their husband or partner went to jail or a detention center, 10 per cent were involved in a physical fight, 4.3 per cent stated they lost their job and 1.7 per cent of Inuit women were homeless at some point throughout their pregnancy (Figure 3.4).

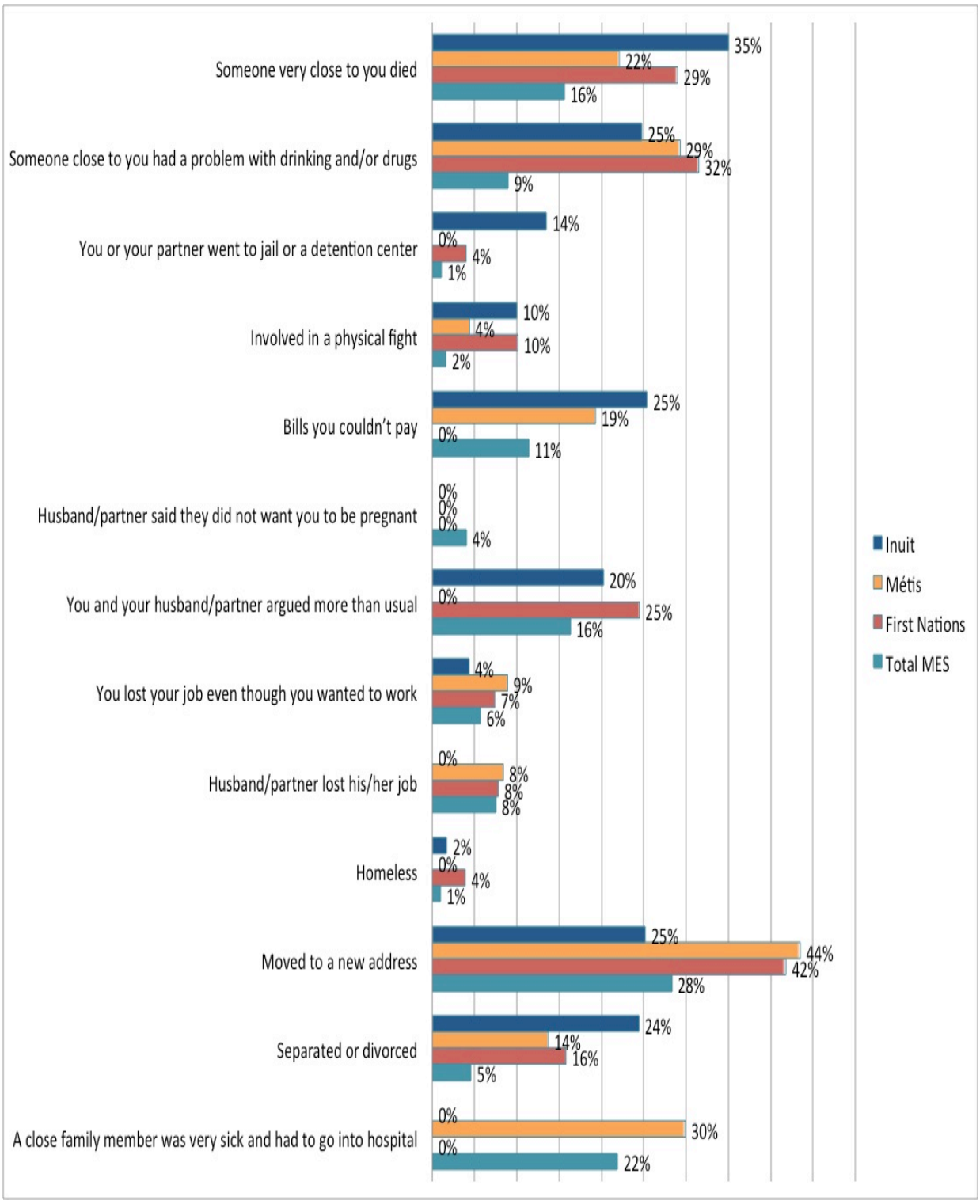

Figure 3.4 Distribution of First Nation, Métis and Inuit women's type of stressful life events identified by the Pregnancy Risk Assessment and Monitoring System (PRAMS), MES, Canada 2006-2007.

3.2.7 Social Support

Social support and access to supportive health care services has a positive psychosocial affect and is linked to better pregnancy outcomes (Hoffman and Hatch 1996). Within the MES, the majority of Aboriginal mothers (86.9 per cent) has social support most or all of the time. Unfortunately the MES does not clarify what types of supports are utilized, for example family, friends, community, or health care providers. Additional research is needed to clarify Aboriginal women's maternity supports and the systems or avenues of support.

Table 3.7 Proportion of Aboriginal women's availability of support when needed, MES, Canada 2006-2007.

	Total MES N=6421 %	Aboriginal N=410 %
Women's availability of support when needed		
All of the time	57.3	58.5
Most of the time	24.6	28.3
Some of the time	7.9	7.8
Little of the time	5.1	3.7
None of the time	5.1	1.2

3.2.8 Stillbirth, Miscarriage and Abortion

Of those women who reported having a live born baby die, 1.5 per cent of Aboriginal mothers responded yes. Aboriginal mothers reported similar rates of 1 pregnancy not ending in a live birth, however 14.1 per cent of Aboriginal women, compared to 7 per cent of the total MES population reported having had two pregnancies not ending in live birth. Among Aboriginal women, 20.8 per cent of First Nations, 15.9 per cent of Métis and 15.7 per cent of Inuit women reported having had an abortion (Table 3.8).

Table 3.8 Proportion of Aboriginal women who experienced a live born baby die, stillbirth, miscarriage and abortion.

	Total MES N=6 421 %	Aboriginal N=410 %		
Women who had a live born baby die	0.9	1.5		
Women with pregnancies not ending in a live birth (stillborn baby)	67.2	60.9		
None	21.6	20.4		
1 Pregnancy not ending in live birth	7	14.1		
2 Pregnancies not ending in live birth	3.7	4.5		
3 or more pregnancies not ending in live birth				
Women who experienced a miscarriage (embryo)		First Nation	Métis	Inuit
None		74.9	73.9	76
1 Miscarriage		12	17.1	13.2
2+ Miscarriages		13.1	9	10.2
Women who reported having had an abortion	11.8	20.8	15.9	15.7

3.3 Labour and Birth

3.3.1 Type of Birth

The types of birth are: spontaneous vaginal birth (the baby is born without assistance); assisted vaginal births (forceps or vacuum); and caesarean birth (surgical procedure). In 2004-2005, 63.4 per cent of hospital deliveries were spontaneous vaginal births, 14.8 per cent were assisted vaginal births (10.3 per cent vacuum and 7.4 per cent forceps) and 25.6 per cent had a caesarean (PHAC 2008). According to the MES, 68 per cent of Aboriginal women had a spontaneous vaginal birth, 7.6 per cent had an assisted vaginal birth (6.2 per cent vacuum assisted, 3.9 per cent forceps) and 24.4 per cent of Aboriginal women had a caesarean birth compared to 27 per cent of the total MES population.

Supine position, or giving birth on your back is associated with increased episiotomies, prolonged second stage of labour pain and increased perineal tears (WHO 2016). Thirty seven per cent of Aboriginal women reported having their legs in stirrups when the baby was born, compared to 57 per cent of the total MES population. The most frequent position reported by 55.2 per cent of Aboriginal women was propped up or sitting/squatting.

In Canada from 2004-2005, the rate of labour induction was 21.8 per cent (PHAC 2008). Among Aboriginal mothers with a vaginal birth or who attempted a vaginal birth, 34.2 per cent reported being induced and 27.2 per cent stated that their health care provider tried to speed up labour. Among Aboriginal mothers who had a vaginal birth or who attempted a vaginal birth, 90.4 per cent reported having electronic foetal monitoring at some time during labour and 57 per cent reported having continuous use of electronic foetal monitoring: EFM. Aboriginal women (13.2 per cent) reported lower levels of pubic or perineal shave and 6.7 per cent reported having had an enema. In the MES, 8.8 per cent of Aboriginal women with a vaginal birth reported having had an episiotomy, compared to 20.7per cent of the total MES population. Under half, or 43.5 per cent of Aboriginal women reported having had perineal stitches, compared to 64.1 per cent of the total MES population.

Table 3.9 Proportion of Aboriginal women's method of delivery, procedures and interventions in labour and birth position, MES, Canada 2006-2007.

	Total MES N=6421 %	Aboriginal N=410 %
Method of Delivery		
Vaginal	73.7	75.6
Spontaneous Vaginal	61.1	68.1
Caesarean Section	26.3	24.4
Labour		
Any EFM	90.8	90.4
EFM on admission only	5.2	10.3
Intermittent EFM	21.1	28.7
Continuous EFM	62.9	57
Unspecified	1.6	4
Induction	44.8	34.2
Speed up labour process	37.3	27.2
Enema	5.4	6.7
Pubic/perineal shaving	19.1	13.2
Pushing on Abdomen	13.2	13.9
Epidural	57.3	26.4
Birth		
Instrumental Delivery		
Forceps	3.6	3.9
Vacuum Extraction	7.2	6.2
Perineum		
Episiotomy	20.7	8.8
Sutures	64.1	43.5
Birth Position		
Supine	47.9	39.5
Propped Up or Sitting	45.8	55.2
Side Lying	3.3	1.6
Other	3.0	2.7
Legs in Stirrups	57	37.1

3.3.2 Birth Experiences and Satisfaction with Care

A positive birth experiences has been shown to improve self-care, adjustment to parenting and follow up care (Waldenstrom et al. 2004). Ratings and levels of satisfaction are also used to measure quality of care. The MES measured six aspects of quality of care women received by their health care providers including: information given from health providers, compassion and understanding shown, provider's competence, concern for privacy and dignity, respect shown to them and their personal involvement in decision making. Birth experiences and satisfaction of care from health care providers for Aboriginal women is important to understanding their perspective and perceptions and ensure that the health care system is

responsive to their needs and concerns.

Overall, 54.9 per cent of Aboriginal mothers reported satisfaction with their overall experience of labour and birth. Among Aboriginal mothers 75.1 per cent stated they were "very satisfied" with the respect shown to them, 70.5 per cent were very satisfied with the perceived competence of the health care providers, 60.6 per cent were very satisfied with the compassion and understanding shown, 72.1 per cent were satisfied with their personal involvement in decision making and 59.9 per cent were very satisfied with the information given to them (Table 3.10).

Table 3.10 Proportion of Aboriginal women's overall experience and levels of satisfaction with healthcare since birth, information given, compassion and understanding of healthcare providers, involvement, competency and respect shown, MES, Canada 2006-2007.

	Total MES N=6421 %	Aboriginal N=410 %
Overall experience of labour and birth	53.8	54.9
Very Positive	26.2	23.9
Somewhat Positive	10.7	10.8
Neither Negative or Positive	9.2	9.3
Somewhat Negative		
Healthcare Since Birth		
Very Satisfied	66.6	74.4
Somewhat Satisfied	24.9	18.4
Neither Satisfied or Dissatisfied	4.9	2.5
Somewhat or Very Dissatisfied	4.2	4.4
Information Given		
Very Satisfied	61.8	59.9
Somewhat Satisfied	30.3	30.3
Neither Satisfied or Dissatisfied	4	5.1
Somewhat or Very Dissatisfied	3.9	4.6
Compassion and Understanding		
Very Satisfied	65.4	60.6
Somewhat Satisfied	26.7	27.3
Neither Satisfied or Dissatisfied	3.7	3.4
Somewhat or Very Dissatisfied	4.2	7.5
Involvement in Decision Making		
Very Satisfied	72.6	72.1
Somewhat Satisfied	21.2	19.4
Neither Satisfied or Dissatisfied	2.7	1.9
Somewhat or Very Dissatisfied	3.4	5.7
Competency of Care Providers		
Very Satisfied	75.9	70.5
Somewhat Satisfied	19.4	19.6
Neither Satisfied or Dissatisfied	1.8	2.8
Somewhat or Very Dissatisfied	2.9	5.6
Respect Shown by Providers		
Very Satisfied	78.5	75.1
Somewhat Satisfied	16.7	15.3
Neither Satisfied or Dissatisfied	1.8	1.9
Somewhat or Very Dissatisfied	2.9	6.7

3.3.3 Breastfeeding

The positive effects of breastfeeding include positive effects on infant growth, immunity and cognitive development (Kramer et al. 2008), which in turn improve infant health in the first year of life. The WHO, Public Health Agency of Canada, Health Canada, the Canadian Pediatric Society and Dietitians of Canada recommend exclusive breastfeeding for the first six months after birth for healthy term infants, with the introduction of complementary foods at six months

of age and continued breastfeeding for up to two years of age and beyond (Critch 2014; WHO 1989; PHAC 2009). A majority, or 86.4 per cent of Aboriginal mothers reported similar rates of initiating breastfeeding, and 71.7 per cent remained exclusive breastfeeding after three months. This finding varied across Indigenous populations. Over seventy percent of First Nation mothers, 79.8 per cent of Métis and 48.1 per cent of Inuit women exclusively breastfed after three months (Table 3.11).

Table 3.11 Proportion of Aboriginal women's breastfeeding initiation and 3 months after birth, MES, Canada 2006-2007.

	Total MES N=6421 %	Aboriginal N= 410 %	First Nation N= 170 %	Métis N=142 %	Inuit N=89 %
Women who initiated breastfeeding	90.3	86.4			
Women's feeding method after 3 months					
Breastfeeding alone (includes pumping)	51.7	71.7	69.4	79.8	48.1
Combination formula and breastfeeding		14.3	16.4	10.2	26.2
Formula Alone		13.2	13.8	8.6	25.8
Don't know		0.9	5.0	1.4	*

3.3.4 Information Needs

Understanding women's postpartum information needs is important in preparing women to care for their infant and themselves, to respond to physical and emotional postpartum changes, and to transition to parenthood. Overall, Aboriginal mothers reported that they had enough information on basic infant and maternal care (e.g., car seats, birth control, postpartum depression), but were somewhat less informed on issues related to the transition to parenthood: e.g., sexual changes, physical demands on the mother's body after having a baby, effect on relationship with partner. The number one source of information for prenatal care for 38.9 per cent of Aboriginal women were books, prenatal classes and the internet, compared to 32.2 per cent of the total MES population who relied on health care providers (Table 3.12).

Table 3.12 Proportion of Aboriginal women's information needs and level of satisfaction with information received during pregnancy, MES, Canada 2006-2007.

	Total MES N=6421 %	Aboriginal N=410 %
Sources of Prenatal Information		
Books, Classes, Internet	22.3	38.9
Health Care Providers	32.2	30.65
Family or Friends	15.1	17.9
Previous Pregnancies	17.1	12
Level of Prenatal information Received		
Effects of medication on baby	93.9	89.6
Warning signs and complications	83.7	79.1
Emotional changes	89.4	85.5
Physical changes to your body	92.8	89.2
Level of Postpartum Information Received		
Formula Feeding	79.3	91.9
How to breastfeed baby	92.1	91.9
Changes in sexual responses	76.6	88.9
Birth control after pregnancy	88.7	88.6
Postpartum depression	91.2	87.6
Possible negative feelings	90.8	85.9
Using infant car seats	93.8	83.9
Sudden Infant Death Syndrome	90.1	82.8
Physical demands on your body	82.3	82.4
Effects of baby on your relationships	84.2	74.4

3.4 Postpartum

3.4.1 Maternity Leave

Amendments to Canada's Employment Insurance Act in 2000 increased the total employment-protected (not necessarily paid) maternity and parental leave period from six months to one year. In order to receive maternity benefits, a woman must be employed in insurable employment and must have accumulated a minimum of 600 hours of insurable employment while paying EI premiums during the qualifying period which is a maximum of 52 weeks before the EI/maternity leave is taken (any previous employment prior to the 52 weeks is not considered). A period of maternity leave following birth is important, as it allows mothers to care for themselves and their newborn. Within the MES, 47.4 per cent of Aboriginal mothers receive maternity benefits compared to 68.3 per cent of the total MES population (Table 3.13).

Table 3.13 Proportion of Aboriginal women who received maternity benefits, MES, Canada 2006-2007.

	Total MES N=6421 %	Aboriginal N=410 %
Received Maternity Benefits	68.3	47.4
Work since baby was born	18.7	16.2
Returned to work within 6 months after birth	11.6	10.3

3.4.2 Postpartum Depression (PPD)

After giving birth, women may experience adverse emotional symptoms that vary in severity. There are three major categories of postpartum emotional conditions: the postpartum blues (or baby blues) occur in up to 80 per cent of women and usually resolve within two weeks, postpartum depression occurs in 10 to 20 per cent of women, has its onset in the first year after birth and can last months or even years and postpartum psychosis is rare, occurring in about 0.2 per cent of women, but requires immediate medical care (Chalmers 1986; Stewart et al. 2004). The MES assessed women using the Edinburgh Postnatal Depression Scale (EPDS). The EPDS is a 10-item screening tool to identify postpartum depression was administered to identify postnatal depression at the time of the interview. A score of 13 or higher on the EPDS is considered indicative of postnatal depression and a score of 10-12 is indicative of being at risk for postpartum depression. The 10-item questionnaire asks women to rate their feelings within the last 7 days (Cox et al. 1987).

Table 3.14 Proportion of Aboriginal, First Nation, Métis and Inuit women who were diagnosed with depression, or identified as at-risk for post partum depression as per the Edinburg Post Partum Depression Scale (EPDS), MES, Canada 2006-2007.

	Total MES N=6421 %	Aboriginal N= 410 %	First Nation N= 170 %	Métis N=142 %	Inuit N=89 %
Edinburg Postnatal Depression Scale (EPDS)					
13+ Score Indicative of PND	7.5	14	13.6	9.3	19
10-12 At Risk for PND	8.6	9.2	10.2	8.8	8.6
Prescribed Antidepressants/ Diagnosed with Depression	15.5	19.5	21.4	27.9	9.2
EPDS by Age					
15-19 Years of Age					
13+ Indicative of PND	14	27.3			
10-12 At Risk for PND	10	15.4			
20-24 Years of Age					
13+ Indicative of PND	9.3	16.9			
10-12 At Risk for PND	9	7.3			
25-29 Years of Age					
13+ Indicative of PND	5.5	7.7			
10-12 At Risk for PND	8.7	10.5			
30+ Years of Age					
13+ Indicative of PND	8.2	8.1			
10-12 At Risk for PND	8	9.9			

First Nation and Métis women were at higher odds (OR 1.5, 95% CI: 1.3-1.7) of being prescribed antidepressants or diagnosed with depression prior to pregnancy (Figure 3.5). This finding raises questions and concerns around Indigenous women's access to prenatal care and psychosocial assessment during pregnancy. Indigenous women were also at higher odds (OR 1.9, 95% CI:1.6-1.9) of scoring 13+ on the EPDS, which is indicative of Post Partum Depression (Figure 3.6).

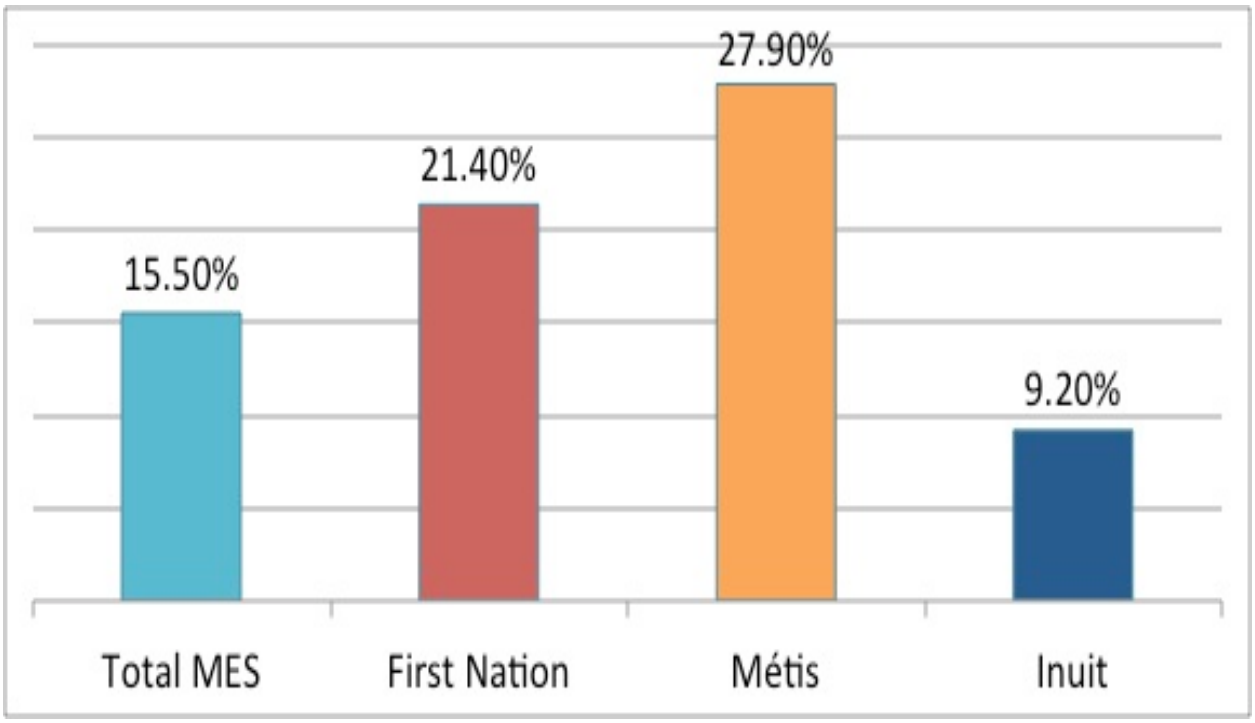

Figure 3.5 Proportion of First Nation, Métis and Inuit women who were diagnosed with depression or prescribed antidepressant medication prior to becoming pregnant, MES, Canada 2006-2007

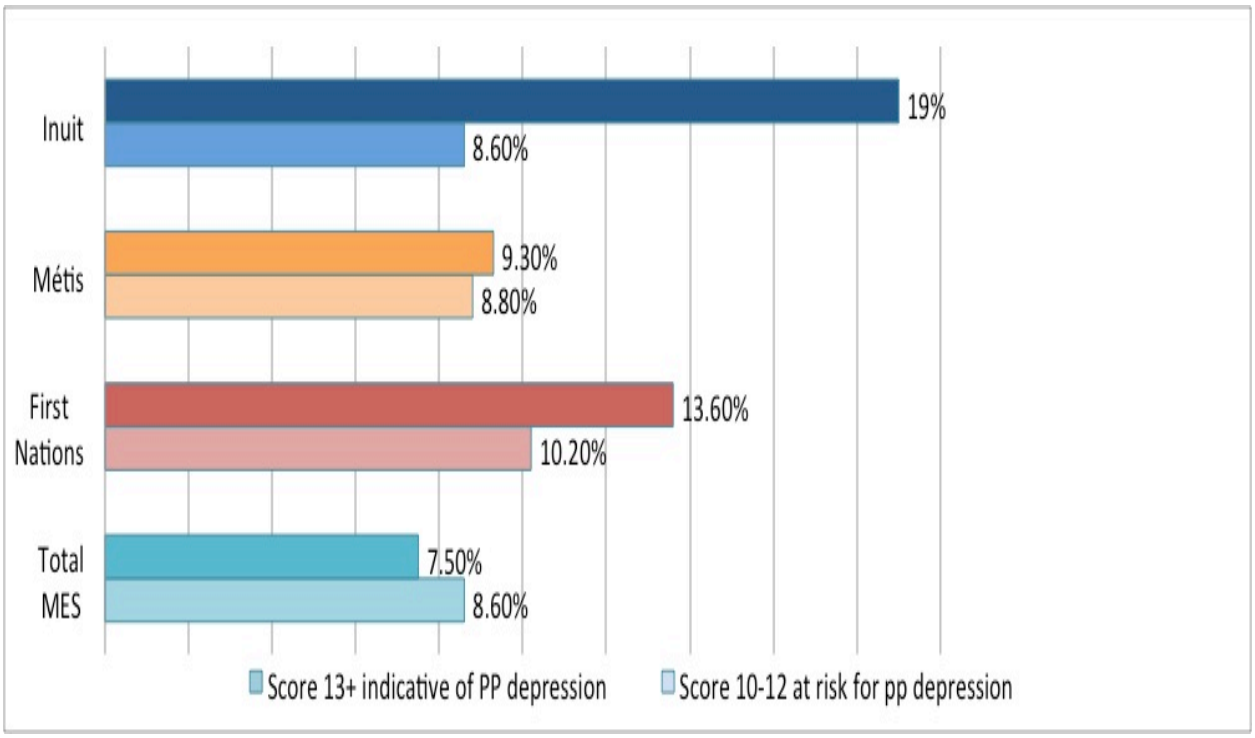

Figure 3.6 Proportion of First Nation, Métis and Inuit women who scored 10-12 and 13+ on the Edinburg Post Partum Depression Scale (EPDS), MES, Canada 2006-2007.

3.5 Discussion and Key Findings

As the first survey of its kind in Canada, the MES provides an important first step in surveying Aboriginal women's maternity experiences. Aboriginal women's maternity experiences are critical to understanding their reproductive, maternal and pre/perinatal health needs and outcomes to inform and improve perinatal policies, programs and services specific to Aboriginal women. Although there are a number of limitations with the MES, which are discussed further in chapter seven, the MES offers valuable insights. My analysis of the MES illustrates how Aboriginal women's maternity experiences are unique and diverse. Overall, Aboriginal women report positive experiences, as well as high levels of satisfaction with the care they received throughout pregnancy, labour, birth and postpartum. In some instances, Aboriginal women fared better. Aboriginal women had higher rates of breastfeeding initiation and rates following three months postpartum. Aboriginal women, specifically young mothers age 15 to 19, were more likely to attend prenatal classes. However, it is unknown if this is voluntary or mandatory attendance. For example, parents involved with the Ministry of Child and Family Services may have mandated prenatal class attendance as a requirement to prevent child apprehension.

Aboriginal women had lower rates of pubic shaving, episiotomies and perineal stitches, as well as lower rates of induction and speeding up labour. However, these rates were still higher than the national average. Aboriginal women had higher rates of unassisted vaginal births and were less likely to be in a supine position or have their legs in stirrups during delivery. In addition, Aboriginal women had lower C-section rates. However, it is uncertain if lower C-section rates are the result of a lack of access to caesarean birth for mothers who require it.

While the MES provides important insights into Aboriginal women's maternity

experiences, my analysis also underscores a number of gaps that need to be addressed to improve Aboriginal women's maternal health, maternity experiences, and services for mothers and their infants, families, communities and Nations in Canada. In the next section, I discuss my key findings and how I chose to focus on Aboriginal women's experiences of stress, violence and postpartum depression as guiding questions for my qualitative research.

3.5.1 Social Determinants of Aboriginal Women's Maternal Health

The median income for Aboriginal women in 2012 was $15,654 (Stat Can 2012) and estimates show that more than 36 per cent of Aboriginal women, compared to 17 per cent of non-Aboriginal women live in poverty (Stat Can 2006). Within the MES, 24.2 per cent of Aboriginal mothers had less than a high school education and 46.1 per cent of Aboriginal mothers reported a household income of $39,999 or less, 35.7 per cent reported a household income below $29,999, and 28 per cent reported a household income of $19,999 or less of Aboriginal mothers reported a household income of $29,999 or less (Table 3.1). Although there is no set definition of poverty in Canada, the low-income threshold in Canada is $41,568 for a family of four. This finding illustrates that nearly half of Aboriginal mothers (and their children) live in poverty. This finding is important because poverty has been linked to lack of access to nutrient dense food, higher rates of obesity and diabetes (Amin et al. 2014; Shaw and Cummings 2012). Poverty is also linked to social exclusion (Galabuzi 2004) resulting in increased anxiety, insecurity, low self-esteem and feelings of hopelessness. Poverty has also been linked to violence, addictions, poor parenting, and lack of social support (McEwan 2006). Lower education rates and income have also been associated with late and/or inadequate use of prenatal healthcare including entering care after 6 months (Feijen-de Jong 2012). Studies have found that Aboriginal women (15.7 per cent) are more likely than their non-Aboriginal counterparts (3.6%) to receive inadequate prenatal care (Heaman et al. 2005).

Housing quality and accessibility are important determinants of health (NCCAH 2013) and Aboriginal peoples are disproportionately affected by poor housing and living conditions (RCAP 1996). For purposes of observation and discussion only, the 2011 Canadian census number of private households by household size was included to illustrate the comparison in number of people per household. According to the StatCan 2011 census, the majority of Canadians live in a 2 to 3 person home (49.7 per cent) and the average number of persons in private households was 2.5 people. Aboriginal women in the MES were three to six times more likely to live in a household of five or more people. It is unclear if this finding is suggestive of overcrowding or of access to housing. First Nation women were four times more likely and Inuit women were twice as likely to report being homeless at some point throughout their pregnancy. These findings raise questions and concerns about overcrowding, homelessness and access to adequate and affordable housing for Aboriginal women and their infants and children. However, further research is needed to understand the socio-economic and social conditions in which Indigenous women live. Additional research is needed to contextualize and understand how social determinants of health affect Aboriginal women's maternity experiences and overall maternal and child health. Research is also needed to understand how poverty, lower socioeconomic status and adverse social determinants of health affect and influence levels of maternal stress.

3.5.2 Stress

Growing evidence suggests both direct and indirect associations between chronic stress and chronic disease, including obesity, cardiovascular disease, chronic respiratory disease and diabetes (Gross et al. 2002; Shankardass 2012:115). Chronic stress and uncertainty increase anxiety; hopelessness and exhaustion can make everyday coping, healthy eating and leisure activities more difficult, which in turn may lead to unhealthy coping behaviours (Mikkonen and

Raphael 2010). Maternal prenatal stress releases catecholamine, resulting in vasoconstriction with oxygen and calorie reduction to the fetus (Hobel 2004; Hobel et al. 2008; Lobel et al. 2008). Prenatal stress is also related to infection or inflammation during pregnancy, poor birth outcomes (Alder et al. 2007; Ruiz and Avant 2005), low birth weight and preterm birth (Borders et al. 2007; Dole et al. 2003). The number, frequency and duration of stressful life events impact social health and wellbeing including an increase in maternal psychological morbidity and postnatal depression (Alder et al. 2007; Clout and Brown 2015).

Apart from the epidemiological evidence, the effects of stress on Aboriginal women's maternal and child health are not well articulated in the literature. Aboriginal mothers in the MES reported higher rates of emotional stressors such as two times higher rates of having someone close to them die and three times higher rates of having someone close to them who had a problem with alcohol or drugs. Aboriginal mothers also reported having higher rates of relationship stressors such as three to six times higher rates of separation or divorce and more arguing/verbal disputes with their partner. Aboriginal women reported higher frequency of being in a physical fight and were two to three times more likely to be kicked, hit, slapped or physically hurt by their partner. Aboriginal women also had higher rates of husband/partner incarceration and financial stressors such as loss of employment and financial commitments they couldn't meet These findings raise concerns of how stress affects Aboriginal women and additional research is needed to understand stressors specific to Aboriginal women's experiences, as well as their coping strategies and the supports they utilize.

Research indicates that most women do not receive psychosocial assessment as part of their standard prenatal care (Kingston et al. 2012). It is uncertain within the MES if mothers received psychosocial assessment as part of their routine prenatal and postnatal care. Additional research is needed to determine if Aboriginal women are receiving psychosocial assessment as

part of their maternity care as well as the rates of anxiety, depression and mental health assessment and support.

3.5.3 Reproductive Health

Although Aboriginal women were "somewhat" or "very happy" to be pregnant and 35 per cent were satisfied with the timing of their pregnancy, 31.4 per cent preferred to be pregnant later and 13.7 per cent did not want to be pregnant at all (Table 3.2). There is limited research on Aboriginal women's sexual and reproductive health rights, realities, and access to services (Yee et al. 2011). This finding illustrates the need for additional research and support for Aboriginal women's and Aboriginal teen women's reproductive health needs, access to family planning information and birth control, as well as experiences of and access to abortion services.

According to the MES, 20.1 per cent of First Nation, 15.9 per cent of Métis and 15.78 per cent of Inuit women reported having had an abortion (Table 3.8). Abortion is a sensitive issue across Canada, and within Indigenous communities due to complex cultural stigmas. There is limited research on Aboriginal women's views, access and experiences of abortion (Benoit et al. 2003) as well as issues concerning geographical distance and a lack of confidentiality within small communities when dealing with preauthorized travel for abortion for women residing in rural and remote on and off-reserve communities (Yee et al. 2011). Aboriginal women have expressed a model of care where their health concerns are addressed in an integrated manner, where they are respected and given the opportunity to shape and influence decision-making about services that impact their own healing which also include access to an information on abortion services (Benoit et al. 2003).

3.5.4 Prenatal Classes

Although Aboriginal women in the total MES population report similar levels of prenatal

class attendance, there is a need to address Aboriginal women's prenatal health care utilization, prenatal health needs and avenues of access to identify barriers associated with late and/or inadequate use of prenatal healthcare. Research illustrates that lower socioeconomic status is associated with late and/or inadequate use of prenatal healthcare, including entering care after six months (Feijen-de Jong et al. 2011); and previous research has found that 15.7 per cent of Aboriginal women are more likely than their non-Aboriginal counterparts (3.6 per cent) to received inadequate prenatal care (Heaman et al. 2005).

Understanding maternal-child health from the perspectives of Aboriginal women is important in creating and delivering prenatal programming for Aboriginal women that is inclusive of culturally safe approaches (Hart-Wasekeesikaw 2009; PHAC 2007; NAHO 2008; Lavallee et al. 2009) to prenatal care through cultural competence (DiLallo 2014; Hart-Wasekeesikaw, 2009). The Aboriginal Prenatal Wellness Program (APWP) in Alberta is one model of a multidisciplinary team utilizing culturally safe approaches to prenatal care by addressing colonization, residential school, intergenerational trauma and how this history has contributed to health disparities (APWP 2008). There is an opportunity for service providers to create and deliver culturally safe prenatal programming.

3.5.6 Folic Acid

Higher frequency of spinabifida in Aboriginal populations (Arbour et al. 2002) illustrates the need to increase folic acid (FA) supplementation. Within the MES, 34.3 per cent of Aboriginal women took a multi-vitamin with a folic acid supplement compared to 57.7 per cent of the total MES population. Aboriginal women (62.3 per cent compared to 77.6 per cent of the total MES population) were also less likely to be aware that folic acid reduces the risk of congenital anomalies. This finding encourages culturally appropriate public health efforts in the identification of Aboriginal subpopulations that should be the target of educational or

interventions to further encourage FA use.

3.5.7 Maternal smoking and second hand smoke exposure

Although there are no national or provincial maternal smoking rates for First Nation, Métis or Inuit women in Canada, the research available indicated higher rates of maternal smoking. In a study conducted by Heaman and Chalmers (2005), the rate of maternal smoking during pregnancy was significantly higher for Indigenous women (74 per cent) compared to non-Indigenous women (34.6 per cent). In a study conducted by Wenman et al. (2004), the researchers found that 36 per cent of Métis women and 44 percent of First Nation women smoked during their pregnancy, compared to 13 per cent of non-Indigenous women. Higher rates of maternal smoking during pregnancy are reflective of higher rates of smoking in the overall Indigenous population. An estimated that 60 per cent of First Nation people living off reserve, 70 per cent of Inuit people living in the north and 48 per cent of Métis peoples are smokers (Physicians for a Smoke-Free Canada 2013; Stat Can 2015). Higher rates of cigarette smoking in First Nations communities has also been linked to mental health conditions such as depression and varies with access to social supports (Danielle et al. 2004).

Higher rates of maternal smoking and exposure to second-hand smoke environments within Aboriginal families and communities remains a public health concern and this is reiterated in my MES findings where Aboriginal women were two to four times more likely to smoke three months before pregnancy and two to six times more likely to smoke the last three months of pregnancy, with Inuit reporting the highest frequency. Aboriginal women were also two to three times more likely to live with a smoker (Table 3.4).

In an effort to reduce second hand smoke within the home, Aboriginal women's challenges include social dimensions of smoking in extended families and the structural and relational influences on women's efforts to minimize household second-hand smoke to protect

children's health (Bottorff et al. 2010). Gould et al. (2013) suggest that anti-tobacco messages and interventions should relate to Aboriginal women's experiences and aim to improve understanding of the quitting process, support efficacy, and to capitalize on the positive changes occurring. Varcoe et al. (2010) suggest more community involvement, specifically Elders supporting youth by sharing their wisdom and culture about traditional versus non-traditional tobacco use. As modifiable health behaviours, results from the MES indicate that there is room for public health education, awareness and prevention, as well as the need for Aboriginal women/family/community centered and culturally safe approaches to maternal smoking and exposure to second hand smoke cessation.

There is a lack of support for smoking cessation for pregnant and postpartum women including the absence of a provincial and local cessation strategies and funding, capacity and engagement/ accessibility, as well as the absence of resources tailored to Aboriginal women (Borland et al. 2013). There is a need to further develop tobacco control policies and target SDH through poverty reduction, housing and education support through incentives, transportation, childcare and meals/snacks; adoption of woman-centered, harm-reduction and stigma reduction approaches (Borland et al. 2013). Research with Aboriginal adolescents in British Columbia found that the mean age of initiation was 11 years and the most powerful predictor of smoking was having a best friend who also smoked (Hutchinson et al. 2008). In an effort to reduce second hand smoke within the home, Aboriginal women's challenges include social dimensions of smoking in extended families and the structural and relational influences on women's efforts to minimize household second-hand smoke to protect children's health (Bottorff et al. 2010). Gould et al. (2013) suggest that anti-tobacco messages and interventions should relate to Aboriginal women's experiences that aim to improve understanding of the quitting process, support efficacy, and to capitalize on the positive changes occurring. As modifiable health

behaviour, results from the MES indicate that there is room for public health education, awareness and prevention, as well as the need for Aboriginal women/family/community centered and culturally safe approaches to maternal smoking and exposure to second hand smoke cessation.

3.5.8 Violence prevention and cessation

Nationally, approximately seven per cent of women have experienced some type of intimate partner violence (Stat Can 2005) and six per cent to nine per cent experienced violence during pregnancy (Muhajarine and D'Arcy 1999). Violence against Indigenous women is also a concern. Data from Statistics Canada's 1991 Aboriginal Peoples Survey indicates that 36 per cent to 44 per cent of Aboriginal people identified family violence as a problem and 22 per cent to 35 per cent saw sexual abuse as a problem in their community (RCAP 1996b). In a study by the Ontario Native Women's Association (2003), 84 per cent of participants reported that family violence knowingly occurs in their communities and that 57 per cent of Indigenous women who reported family violence against them, stated that a child had witnessed the assault (NWAC 2003). More recent data suggests that Indigenous women experience two to three times higher incidences of violence (Benoit et al. 2015; O'Donnell and Wallace 2011), higher rates and more severe forms of spousal and non-spousal violence (Ipsos-Reid 2006; Mathyssen 2011) and that Indigenous women aged 25 to 44 are five times at higher risk of mortality due to violence (Stat Can 2013). Violence against Indigenous women is highlighted in the National inquiry of missing and murdered Indigenous women (Kubic and Bourassa 2016:17; NWAC 2015). National Data suggests that violence against Aboriginal women is as high as 24 per cent (Stat Can 2005, Brownridge 2003; NWAC 2009). Higher rates of violence against Indigenous women have been attributed to lower socioeconomic position (Daoud et al. 2013), as well as the ongoing effects of colonization and the marginalization of Indigenous women (Acoose 1995;

Bourassa et al. 2009; Green 2007; Valaskakis et al. 2009), that draw a

> direct relationship between racist/sexist stereotypes and violence can be seen, for example, in the dehumanizing portrayal of Aboriginal women, which renders all Aboriginal female persons vulnerable to physical, verbal and sexual violence (LaRocque 1994:74).

Violence against women is always a concern and violence against women of reproductive age is especially concerning. Violence during pregnancy has been linked to adverse pregnancy and birth outcomes (Boy and Salihu 2004; Heaman 2005), including lower infant birth weight and preterm birth (Altarac and Strobino 2002; Lipsky et al. 2003), foetal trauma, intrauterine growth restriction and perinatal death (Bernson et al. 1994). Violence during pregnancy is also related to higher rates of postpartum depression (Beydoun et al. 2010; Kendall-Tackett 2007; Urquia et al. 2011), substance use (Martin et al. 2003), and suicide (Smith 2002). Younger women, women with low income and education, and who lack social support (Daoud et al. 2012), as well as single mothers are at higher risk of violence during pregnancy (Janssen et al. 2003).

The higher prevalence and severity of violence endured by Aboriginal mothers in the MES, illustrates that violence against Aboriginal women and mothers is of great concern that requires immediate preventative action, treatment and interventions. Lack of research and understanding of Aboriginal women's experiences urges action on the monitoring and intervention of abuse before, after and during pregnancy, as well as providing cultural safe information and support for Aboriginal women, their partners and families need to become more available.

3.5.9 Post-partum depression (PPD).

Within the literature, it is suggested that Indigenous women are more likely to experience PPD (Daoud et al. 2013; Bowen and Muhajarine 2006) and self-harm thoughts (Bowen et al.

2008) related to social factors including financial hardship (Dennis et al. 2004) and stressors associated with significant life events (O'Hara and Swain 1996). As illustrated in the findings on stress and adverse socio-economic characteristics, many Aboriginal mothers were in the midst of managing major life events, including the birth of a baby, with a range of stressful life events, such as the serious illness or death of a family member or friend, moving house or stress related to not having enough money and bills they couldn't pay. The findings draw attention to social circumstances and potential stressors in Aboriginal women's lives that may place them at higher risk of poor mental health outcomes.

In my MES analysis Aboriginal women were two times more likely to have post-partum depression and younger Aboriginal mothers, women aged 15 to 19 years of age were at higher risk (Table 3.14). This finding is consistent with other studies that indicate Aboriginal women's postpartum rates are two times higher than non-Aboriginal women (Muhajarine and D'Arcy 1999) and that PPD occurs within approximately 17 per cent of First Nations and Métis women (Clarke 2008). While this finding focuses on the pregnancy and postnatal period, First Nations and Métis women were more likely and Inuit women were less likely to be prescribed antidepressants and be diagnosed with depression after pregnancy. While this finding suggests that First Nation and Métis women are at higher risk, the lower rates of Inuit prenatal depression and diagnosis may be the result of a lack of access to mental health resources when needed. There is a need to identify and support Aboriginal women who may be at risk for poor mental health outcomes before, during and following pregnancy and birth, as well as understand and address the social context of women's lives.

3.6 Summary

My MES analysis provided an overview of Aboriginal women's maternity experiences and illustrates the need to address Aboriginal women's adverse maternity experiences and maternal child health outcomes.

While the MES provides a description of Aboriginal women's maternity experiences, there is a need to understand the complexities of social life and the cultural context in which Indigenous women live through an Indigenous and feminist theoretical lens. The MES findings did not include the voices and stories of Indigenous women who speak from diverse perspectives and experiences. The survey excluded subpopulations of Indigenous women, the survey questions were not representative of Indigenous women's experiences, nor has the MES research helped to improve policies, practices and programs specific for Indigenous women and mothers.

I wanted to gain a deeper understanding around the context of Indigenous women's lives and the contributing factors that shaped their maternity experiences. While there are many public health applications within my MES analysis, the three key findings I chose to focus on are Aboriginal women's higher frequency of stressors, violence, and postpartum depression. This led to my secondary set of research questions:

i. *Why* do Indigenous women experience higher rates of stress, violence and postpartum depression?

ii. What, according to Indigenous women are their maternity experiences?

Additional research is needed to understand *why* Indigenous women experience higher frequency of stressors, higher rates of violence, and higher rates of postpartum depression. In order to gain insight into Indigenous women's maternity narratives and why Indigenous women experience adversity, I used experiential focused ethnographic methods to gain an understanding

of local culture and embodied experiences (Ziebland et al. 2013:16) and to contextualize Indigenous women's experiences. I continued with my research to conduct ten in-depth interviews with First Nation and Métis mothers from the Okanagan Valley, British Columbia, all of whom I would like to introduce to you in the following chapter.

Chapter 4 (Niiwin): Introduction to ten Indigenous Mothers in the Okanagan Valley, BC

Feminist methods discourage the objectification of women and encourage women's unique perspectives and voice. The importance of Indigenous women's voices through story telling (Monture and McGuire 2009; Wesley-Esquimaux 2009) and conversation as research method (Kovach 2000) demonstrate how narratives and stories are an important form of inquiry, identity and transformation. While the previous chapter highlights Indigenous women's maternity experiences through a population-based survey, the following three chapters speak to Indigenous women's maternity stories and who they are as Indigenous women and mothers by "putting an identity and a humanity to what can be some very disheartening statistics about the crises that a lot of our women are facing in their day-to-day lives" (Lavell-Harvard and Anderson 2014: 291). The maternity experiences of the ten women represent a diversity and complexity of Indigenous identities, socioeconomic statuses, histories and experiences; demonstrating how Indigenous women's stories and experiences give spirit and voice to the statistics and demographics that are more than just numbers. Rather than focus on Indigenous women's responses to the MES, it was important for me to hear from their own perspective what issues, concerns and narratives were important to them, because each individual story is powerful in and of itself. As Linda Tuhiwai Smith states, "each individual story is powerful. But the point about stories is not that they simply tell a story or tell a story simply. These new stories contribute to a collective story in which every Indigenous person has a place" (L. Smith 1999:144). Stories are a gift and "our stories are woven into the land and shape the way we raise our daughters. Their creativity [stories] carries us as women and carries our nations" (Monture and McGuire 2009:1).

The following three chapters are my attempt to balance the process of telling the story from the point of view of Indigenous mothers while unpacking their stories in a way that broader meanings can be elicited. There is a fine balance between listening to and recording women's stories, synthesizing each individual story in order to contribute to a cohesive whole and relaying them back to others. Given the depth and breadth of my sister participant's experiences, it was difficult relaying each story in its entirety and identify priority topics and areas of focus that are needed to improve maternal and child health. A more thorough discussion of the limitations of my research is discussed in chapter seven.

Chapter four is an introduction to ten remarkable Indigenous women with whom I had the privilege to talk with. The names given below are pseudonyms to protect them and their family's confidentiality and anonymity.

4.1 Sister-Participants

4.1.1 Lisa's Maternity Narrative

The first interview I conducted was with Lisa, at the "kitchen table" in her home. Lisa is a 29-year-old status First Nation woman originally from a small reserve community in Northwest Ontario. She explains that she has lived "all over the place" and had moved to the Okanagan two years before. She had followed her cousin, who was moving to Kelowna and, apart from her cousin, she has no other family in the area. When she opened the door to her home, she immediately greeted me with a smile and invitation: "Come on in. Would you like a cup of tea?" I was instantly reminded of the women in my life, where conversation is always coupled with a cup of tea or coffee. I respectfully decline and hand her a cup of Tim Horton's tea that I had stopped for along the way. I guess there's a part of me that doesn't like turning up empty-handed.

This was my first interview and I was nervous, as I really had no idea what was going to unfold, but I was immediately comforted by her warm hospitality. She motioned for me to sit down on the couch as she sat across from me in a recliner. Her youngest son, about eighteen months old, greets me with a toy truck, running it with *"vroom vroom"* sound effects down my leg. We laugh as she gets up to turn on a video for him while we talk. She explains it's easier to meet in her home because she doesn't have a vehicle; besides, it's difficult going out in public because her "son is such a busy body."

I identify myself to Lisa as a Saulteaux Métis woman and, as per tradition; I gift her with a braid of sweet grass, tobacco, sage and cedar. She gives me a big hug and places the baggie of gifts on her TV stand behind another braid of sweet grass. After introducing ourselves and sharing where we are both from, it became apparent that I lived two hours from her home community and that we knew some of the same people. She said, "I guess it's true there's only two degree of separation."

When I ask how many children she has, Lisa explains she is a single parent of four children ages thirteen, ten, seven and eighteen months. Her three younger children live with her and her eldest son is presently living with his father in Ontario. She is currently separated from her husband, but she explains that they have a "relatively good relationship because he pays support and keeps in contact with the kids." Lisa explains her main source of income is child support and that her annual total household income is between $20,000 and $29,999.

Lisa describes herself as a stay at home mom, but she would like to go back to school at some point after her children are older. Snacks and lunch, as well as her son asking for another video, a glass of milk, and numerous hugs, periodically interrupt our five-hour conversation. At one point, her son returned from the direction of the kitchen with a jug of milk and his sippy cup. We laughed and she said, "Poor guy, I got so caught up in sharing my story." Lisa talked

about her maternity journey and reflected on various experiences throughout her four pregnancies, her birthing and parenting her children, as well her history of residential school, foster care, and the importance of her culture.

4.1.2 Mary's Maternity Narrative

Mary is a 27-year-old St'át'imc Blackfoot status First Nation Woman who grew up in Kamloops but has resided in Kelowna for over five years. She and her partner have an eight-month-old son, who she describes as "the boss." I met Mary in a quiet booth in a restaurant and, after introducing ourselves, we both realized that our paths had crossed nearly a year prior. "It's a small world," she said. I gifted Mary with a braid of sweet grass, tobacco, sage and cedar. She opens the baggie and takes a deep breath, saying "I love that smell, it's so healing." Mary lives with her boyfriend, who is the father of her child, as well as her own father, who lives with them part-time while he travels back and forth to work. She explains that she is very close to her parents and family and that she comes "from very loving parents and a good relationship with my parents, so I want the same for my son."

Explaining her reaction when she found out she was pregnant, Mary recalled that she was nervous to tell everyone, including her parents, because she was "worried they'd be disappointed" as she and her boyfriend "hadn't been together long, only six months before" she got pregnant. Also, she had just finished her bachelor's degree and had hoped to continue further education. In the meantime, Mary was currently working with Indigenous families and communities, and she "loves her job and supporting other families." Her boyfriend and father of her child is currently working in construction and, between the two of them, Mary said their total household income is above $40,000.

Over lunch and a three-hour conversation, Mary shared her maternity experiences, including her difficult birth and hospital experience. Our conversation also included her

reflections on supporting Indigenous families and on stressors related to postpartum depression and relationships.

4.1.3 Susan's Maternity Narrative

Susan is a 28-year-old status First Nation woman, originally from a reserve community in Alberta, who has spent the majority of her life living in a large urban area. She has extended family in the Okanagan and moved here last year *"*to escape the city because it wasn't me anymore. Too busy too much going on." Susan tries to return to her home community in Alberta at least once a year, but regular visits can be difficult because it is expensive.

Susan is a single mother of three children. She describes her six year old daughter as "a little mom," her four year old son as a "little monkey," and her newborn girl as the "light of their life" and her "last chance to have another baby." When I asked where her other two children were, she said "I left them with a friend of mine. I don't have family that can take them, so thank goodness for great friends."

Initially, we met at a coffee shop, but after thirty minutes of her baby fussing, she suggested we could go for a walk instead, because her "baby loves to be outside and she'll fall asleep in the stroller if we're outside walking." I hold the car seat as she loads her stroller into the back of her SUV and she jokes "I'm going to have arms of steel with this baby." At a local park, I gifted Susan with a braid of sweet grass, tobacco, sage and cedar, which she placed in her overflowing diaper bag. We walked around the park as we chatted.

Susan explained she is currently separated from the father of her three children and that he periodically pays child support; however, her total household income is between $20,000 and $29,999. Throughout our conversation, she shared her experiences of intimate partner violence and how she left the relationship "to have a better life." Currently on leave from school, she plans to return to college in the fall term, when her baby is seven months old. Throughout our

three and a half hour conversation, she talked about her childhood experiences of witnessing violence, of overcoming barriers related to adverse social determinants, and of being a single parent. She spoke extensively on ending negative cycles to create a better future for her children, as well as drawing strength from her culture and teachings.

4.1.4 Sandra's Maternity Narrative

My fourth interview was Sandra, a nineteen-year-old, non-status mother who "was born and raised" in the Okanagan Valley. When I gifted Sandra with braid of sweet grass, tobacco, sage and cedar, she gave me a big hug saying, "I've never smudged before but I guess now I can."

Sandra is the mother of a two-month-old son and describes her family and boyfriend as supportive. She and her boyfriend, who is the father of her child, currently live together and their total household income is between $30,000 and $39,999. She frames her entire maternity experience as "more than positive" and, 45 minutes into our conversation she commented: "I don't have that much to share really. Everything went so smooth." Sandra graduated from high school the year before and was working full-time when she became pregnant. "It was a total surprise, a total oops, but I couldn't be happier." We met at a local coffee shop for an hour and a half, while her boyfriend took care of the baby. Our interview was cut short when her nursing pad was saturated with breast milk, and she "needed to run and feed the baby." After attempting to contact Sandra several times to complete her maternity narrative, a subsequent interview never took place. The short interview included Sandra's experiences with prenatal care.

4.1.5 Kim's Maternity Narrative

Kim is a twenty-year old status First Nation woman who offered that she is "not technically Aboriginal, but my step-dad who is [status First Nation] adopted me when I was

small and he's the only dad I've ever known." Kim asks if she's still allowed to participate in the study because it's a call for Aboriginal women and she expresses her concern that perhaps she isn't "Aboriginal enough." Rather than engage in a discussion on identity politics, I reassured Kim that her experience was greatly valued and contributed to the spectrum of Indigenous women's perspectives and experiences.

Kim is a single parent who is "loved and supported by my mom and dad, and my younger brother and two younger sisters." She and her one-year-old daughter live with family on reserve and her income is between $30,000 and $39,999. She has completed her college education and returned to work after a brief maternity leave with her daughter. Over the course of three and a half hours, Kim shared her maternity experiences as well as her struggles and strengths as a single parent.

4.1.6 Donna's Maternity Narrative

Donna is a seventeen-year-old non-status First Nation woman originally from Northern British Columbia. I met Donna at her apartment because, she pointed out, "It's hard to get out with the baby." After gifting Donna with a braid of sweet grass, tobacco, sage and cedar, we sat across from one another at her kitchen table that seated two. Donna had been residing with her ex-boyfriend for a year on his reserve in Northern BC. She moved to her current residence where she delivered her then six-week-old baby girl. She explains that she left northern BC and her boyfriend to escape intimate partner violence. When she arrived in the Central Okanagan, she explains: "I had nothing." Kim is currently on social assistance and her total annual income is below $14,999. She accessed programming and support through the Friendship Centre, including access to emergency housing. Donna did not complete high school. She dropped out when she was sixteen and became pregnant soon afterwards. She explains how she "feels overwhelmed most days" but is "doing the best I can."

Our four-hour conversation included Donna's birth experiences, as well as her history of witnessing and experiencing violence. Donna also shared her difficulties as a teenage mother and with various stressors related to adverse social determinants, her struggle with postpartum depression and her worries about "not having enough" money, food, and a place to live.

4.1.7 Karen's Maternity Narrative

My seventh interview was with Karen, a 24 year old status First Nation woman who lives on reserve. Karen is a new mother and lives with her aunt, her boyfriend, who is the father of her child, and her six-month-old daughter. Karen also points out she has two cousins and their three children also living in the house. However, she was "waiting for her trailer to be delivered to her auntie's property" and was "so excited to have our own home."

Karen completed her college education and is currently on paid maternity leave from a full-time position in health care. She stated that her total annual income is between $30,000 and $39,999. She plans to return to her job after her allotted one-year maternity leave. We met at a local restaurant and, over the course of three hours, Karen told me about her maternity journey, reflected on various experiences throughout her relationship, and spoke of the challenges related to living on reserve.

4.1.8 Michelle's Maternity Narrative

Michelle is a married, 27 year old, mother of three who also resides in the Central Okanagan. We arranged to meet at her family home. Michelle greeted me at the door with her eight month baby girl on her hip and two little girls, ages four and two years, who clung to her knees. The four-year-old stared at me with her big blue eyes and asked: "Who are you?" I chuckled and replied "I'm a friend of your momma's." Our conversation took place in Michelle's living room where her eight month old played on the floor. When I arrived,

Michelle's husband briefly introduced himself and took their two little girls outside. She explains that her husband typically "works out of town [in the oil fields in Northern Alberta] but is home for a few days in-between shifts." I compliment her on her beautiful home, to which she replies, "we just bought it a few years ago; it's small but it's home."

Michelle explained she is a "stay at home mom, at least until the girls get bigger" and that "being a mom is the hardest job in the world." As a stay at home mother, she is supported by her husband and that their total household income is "well above" $40,000 a year. Michelle and her husband are originally from the Okanagan Valley and they are supported and "blessed to have a lot of family nearby." Michelle's mother supports her by frequently taking the girls so she can have some time for herself.

Michelle self-identifies as Métis. "I'm only one-sixteenth Aboriginal. My great-great grandmother was Native, we think. But a lot of that history isn't talked about, so we're not really sure who that side of our family is." Over the course of two hours, Michelle shared her maternity experiences, which centred on her prenatal care, and her labour and birthing experiences with her three daughters.

4.1.9 Linda's Maternity Narrative

The next interview was with Linda, a 32 year-old Métis woman originally from Alberta. Linda has been married for eight years and has two children. Her eldest son is three years old and her youngest, a daughter, is four months. Linda does not have any family in the area but she is "surrounded by great friends and my husband's extended family." Linda and her husband have lived in the Okanagan for over ten years. Linda has completed her college education and is currently on a paid maternity leave from her full time position in the healthcare field. Their total household income is above $40,000. I met Linda for two hours at a local coffee shop and she talked about her maternity experiences and her experiences with mainstream healthcare.

4.1.10 Patricia's Maternity Narrative

My final interview was with Patricia, a 22 year old women who self-identified as Indigenous but was uncertain if she was First Nation or Métis. "I don't know a lot about my family because I grew up in foster care. All I know is that we're Aboriginal." Patricia grew up in various foster homes throughout the interior and moved to the Okanagan Valley when she was 18 years old, after completing high school. Patricia has been working primarily in retail and stated that her income ranges between $15,000 and $19,999 per year. Patricia's current relationship is a "complication" and she is currently single. I met Patricia at her apartment and over the course of five hours, she related her maternity experiences, as well as her experiences of being in foster care.

4.2 Socio-Demographic Characteristics

I interviewed ten Indigenous mothers in the Okanagan Valley, British Columbia. Seven of the ten participants self-identified as First Nation, that is, five status First Nation and two non-status First Nation. Two sister-participants self-identified as Métis and one sister-participant self-identified as Indigenous but did not specify which group because she grew up in foster care and did not know her biological family or where/whom she is from. Three sister-participants were from Kelowna, four were from Vernon and three resided on-reserve within the Okanagan Valley. Two sister participants owned their own homes, five were renting, and three were residing with family members. The majority of my sister participants had some post-secondary education. Three women had a high school diploma, one had a bachelor degree and one had not completed high school. Income also varied and seven sister-participants reported a total household income of less than $39,999. The majority of my sister-participants were married or living with their partner, two were divorced or separated and three were single. Seven sister-participants had more than one child and three indicated this was their first baby (Table 4.1).

Table 4.1 Sister Participant's Socio-demographic Information (N=10)

Self-Identified as:	
First Nation (status)	5
First Nation (non-status)	2
Métis	2
Aboriginal (stated but did not know which group)	1
Place of Residence	
Kelowna and West Kelowna	3
Vernon	4
On-Reserve	3
Living Arrangements	
Home owner	2
Rental	5
Living with family members	3
Age	
16 to 19 years of age	2
20 to 24 years of age	3
25 to 29 years of age	4
30+ years of age	1
Highest level of education	
Less than high school	1
High School graduate	3
Some postsecondary and/or College	5
Bachelor degree	1
Total Household Income	
0-$14,999	1
15,000- 19,999	1
20,000-29,999	2
30,000-39,999	3
40,000+	3
Marital Status	
Married or Living with partner	5
Divorced, widowed or separated	2
Single	3
Number of Children	
One child	3
More than one child	7

Chapter 5 (Naanan): Proximal Context of Indigenous Women's Maternity Experiences

5.1 Social Determinants

The context of Indigenous women's maternity experiences is unique and complex. After completing my analysis, I chose to organize my interview findings into proximal, intermediate and distal contexts. Like a stone thrown in water, the ripples that emanate from the centre represent multiple interrelated determinants and layers that contribute to women's overall experience. Chapter five is an examination of the first layer of proximal determinants that directly affect Indigenous mother's daily-lived experiences. This chapter is an overview of my research findings on Indigenous women's narratives related to proximal determinants of health including education, employment, income, food security, access to safe and affordable housing and experiences of homelessness. Chapter five also includes Indigenous women's experiences of stress related to parenting, relationships, violence and narratives of postpartum depression. The chapter concludes with Indigenous women's support systems and a brief discussion on the proximal context of Indigenous women's maternity experiences, which leads to the next two layers of intermediate and distal context discussed in chapter six.

5.1.1 Education, Employment and Income

Throughout my interviews, my sister-participants conveyed that education was very important for self-confidence, as well as income and opportunity for themselves as well as their children. Susan said that,

> education is key to a good income. You can't make money without an education; you can't even get a job without a grade twelve now. So education is key. I'm doing this [getting an education] for a reason. My reasons are my babies.

Linda also expressed the importance of an education and tells her son and daughter that "they can be anything you want to be. Nothing is out of your reach as long as you go to school. It's

important to go to school. You can't just be something without an education, you have to get educated. That's just the way it is." Karen also emphasised that "Everything costs money. Lunches, sports, outings … everything. And you can't make money without a good job. And you won't get a good job if you don't go to school."

Mary was the only participant with a university degree. She was employed in healthcare supporting Indigenous peoples, and was on paid maternity leave when we talked. She explained how her job gave her confidence and pride.

> I love my job. I love what I do. I can't wait to go back [after maternity leave]. School gave me confidence. I was so proud the day I got my degree. My whole family is proud of me. And I want that for my kids. I want them to go to school and have a good life.

Three participants: Lisa, Sandra and Patricia had a high school diploma. Kim, Karen and Linda had completed their college education and Susan was planning on retuning to college after her maternity leave. Lisa and Michelle preferred staying home with their young children but were interested in pursuing additional education once their children were older.

> I like being a stay-at-home mom. I want to take this time to raise my kids and be there for them. I can't imagine working or studying and raising my kids, it would be too much. … I might go back [to school], maybe later. But for now, I like being a mom.

Donna is currently 17 years of age and does not have a high school certificate because she dropped out of high school when she was sixteen and got pregnant soon afterwards. She also expressed her intent to return to high school and complete her grade 12 in the fall of 2015. However, she is concerned about finding safe and affordable childcare, a concern echoed throughout my interviews. As Susan put it, "sometimes there is not enough to get by month-to-month. You have to get a job on the side. Which is hard because you need daycare. It's hard 'cause you try to balance school and kids and work, and you work to pay your bills and day

care. It's expensive." In addition to the cost of daycare, Linda pointed out that "it's tough to find someone you can trust and leave your kids with. Plus, there are waiting lists for day cares. Not to mention [that] I can't afford forty bucks a day. I'm basically working just to pay my daycare bills."

Two sister participants currently on maternity leave planned to return to college in the fall to complete their certificate programs. When I inquired if there were any barriers to returning to school, my sister-participants all identified finances as the main barrier.

> I struggle to finish school. Finding the money to get by every month is tough. I was fortunate that my Band paid for my schooling and they gave me a living allowance, but even then it can take time. I was on a wait list for nearly two years before I got funding to go to school. But even with that [Band funding] sometimes it just isn't enough with how much it costs to raise kids and go to school. (Susan)

In addition to financial barriers, finding time for school could be a challenge.

> Finding the time for homework is the hardest thing. That's why I couldn't imagine going back to school because I barely had time to do my work with my other two kids. And then use the time you have away from your kids to do your homework? You have no life because your life is being a student. You don't get to see your friends or go to movies or do a whole lot. And it sucks sometimes because you feel like you have no life. I'll go back eventually. (Lisa)

Total household income varied among my sister-participants according to marital status. Women who were married or living with their partner had higher incomes because of multiple and higher sources of income. Michelle's husband has a trade in the oil and gas industry in Alberta and, although they have sufficient income, Michelle notes that her husband "makes good money, but he's always away. He works two weeks in [the oil fields and] one week off, and sometimes I struggle when he's away. Thank God we have family nearby."

Three sister-participants lived with family members. They reported their own income rather than including their other family member's income, because they were responsible for

their own living expenses. In a conversation with Karen, the question of what total household income meant raised confusion.

> **Karen**: What do you mean, like everyone in the house? I'm not sure how much my aunt makes or my cousins. Why do you need to know that?
> **JL:** I don't need to know how much they make, just you. It's kind of a standard question to see how much money you have compared to your expenses and if you live above or below poverty.
> **Karen:** Does child tax count?
> **JL:** Yes, all sources count. How much do you think you get a month? And how much do you think you spend on groceries and stuff like that?
> **Karen:** I get about $987 a month, not much. And it goes to pitching in for groceries and gas, and whatever else me and the baby need.

While half of my sister-participants don't worry about money and finances, the other half struggled with financial stress and worry about paying for rent, groceries, utilities, transportation and miscellaneous expenses.

Donna explains that she left northern British Columbia and moved to the Central Okanagan to escape a violent relationship. She expressed her concerns:

> I worry about money all the time. I worry about how I'm gonna pay the bills and if I have enough for rent. It's the third time I've been late with rent and I'm scared they'll ask me to leave. Then where are we gonna go?

Lisa also expressed how the stress and worry about how she was going to pay for everything affected her:

> I'm doing the best I can [tears rolling down her face, she hugs her two-year old son and kisses him on top of his head]. There are some days I just don't want to get out of bed, but I know I have to for my kids. I gotta be strong for them. But honestly, some days it's tough and I honestly don't know how I'm gonna pay for everything.

5.1.2 Food Security

Of the five sister-participants who struggled with financial stress and worry about money, three indicated they have experienced stress around not having enough food to eat and worry that their children were not receiving adequate nutrition.

> Some months I barely have enough to pay for rent and bills or food. Not to mention the cost of formula. We use the food bank and we get bread from the Friendship Centre, but [long pause; there are tears rolling down her cheek] but… [long pause as she chokes back tears as she tries to communicate with me] but… it sucks when you're waiting for your next cheque just so you can go get groceries. (Donna)

Lisa worries about her children not having adequate nutrition because of the cost of food:

> We use the food bank and the good food box, but I worry sometimes that my kids aren't getting enough fruit and veggies. Cuz in the winter, it gets expensive.

5.1.3 Housing

Three sister-participants own their homes, one on reserve and one off reserve. Linda and her husband, as well as Michelle and her husband own their own home.

Michelle said:

> We [her and her husband] bought our house just before the market went through the roof [in 2005]. We're lucky we did cuz I don't think we'd get into the market now. My husband works up north so, although he's gone for two weeks at a time, this is home. We got some work to do, but it's home and I like that my kids are going to grow up here, stable in one place. We moved a lot when I was a kid, so I wanted my kids to have a home.

Karen, lives on reserve and said she was fortunate to gain access to her own home through Band housing.

> I'm so fortunate. I'm just waiting for my trailer to be brought and set up. I live with my auntie and the trailer is going on her property. I'm so excited; we'll have our own place.

Two sister-participants had encountered difficulties accessing Band housing, including long wait lists and barriers associated with the National Occupancy Guidelines. Access to on-reserve social housing or rental units is based on Band eligibility. To be eligible, mothers are required to be a registered member of the Indian Band in which they reside and be 19 years of age or older.

Applicants are ranked based on the application priority/suitability rating system. However, there is limited housing and rental units available. Kim is concerned that she may never get Band housing: "I currently live with my [extended] family and I don't know if I'll access Band housing 'cause the wait list is so long."

According to National Occupancy Guidelines (NOS), there must be enough bedrooms for each member of the family and opposite sex children over the age of 5 years cannot share a bedroom. This posed a barrier for Lisa, who tells how she "applied for housing when we lived in my community, but I have a boy and a girl and the Band only had a two bedroom complex. So apparently, I'm not eligible because they can't share a room."

While Michelle and Karen own their own homes, home ownership is beyond the reach of many Indigenous women.

> I would love to own my own home and raise my kids in one place. But who can afford it? I can barely afford to pay rent, never mind a house. But I do dream of it. I dream of owning my own home and maybe owning a Bed and Breakfast. It's my dream to own a B & B. (Susan)

Lisa shared Susan's dream of home ownership:

> I think I'll own my own place someday. It's just so costly. I'm too busy being a mom so maybe when I'm done school and have a good job I can buy a house. But for now, this [rental apartment] is where we are.

Access to safe, affordable and stable housing was a concern for two sister-participants who shared that they were constantly moving.

> **Susan**: We're constantly moving. I swear to god we've moved like three times last year.
> **JL:** Why did you keep moving?
> **S:** Well, first we moved off the rez [reserve] and came here [to the Okanagan], then our first place was kind of a dump. It just wasn't good; so we came here [their current apartment].

Susan left her home community and migrated to an urban centre to escape a violent relationship:

> I lived out on the reserve and I felt like I had to get out of there. It [the violence] just got to be too much. I left. I was scared, pregnant, and had nowhere to go. So I went into a women's shelter in the city and I thought I needed a new start from there. That's what I needed to do, so I went to the shelter and I applied for low income housing and I stayed with family members for six months because I couldn't get into low income housing while I was at the shelter. So I eventually got into low-income housing and finally things were starting to come together.

Donna also left her boyfriend's reserve community because of violence and went to a women's shelter.

> So I left. I got out and went to a women's shelter. I didn't know where else to go. But most people stay [in the relationship], maybe 'cause they're scared [to leave] but I didn't want to live that way.

Three of my sister-participants indicated they had migrated from being on reserve to urban areas within the Okanagan Valley. In addition to fleeing abusive relationships, Lisa shared that she left her home community because of a lack of employment and educational opportunities.

> Unless you were social worker, which I'm not, I couldn't find employment anywhere. So we had to move. I moved to go to school and to have more opportunities for me and my kids.

In addition to leaving a violence relationship, Susan also moved to the Okanagan to get away from a large urban area because she felt the city "beat her spirit' and she wanted to raise her children in a smaller city.

> I guess I just decided to leave the city because it wasn't me anymore. Too busy, too much going on. I thought, 'I want to raise my kids in a small town' and so I had been here back and forth throughout the year visiting my grandparents in the summer and I had an aunt who used to live out here too. I was really close to my aunt and I would spend the summers with her. I always loved the Okanagan and knew I wanted to come back here to raise my kids. I got sick of the city and I needed a change. I thought I was drowning in the city. Just too busy for me. Too busy for my spirit. I needed to be calm in my life. I'm an outdoorsy person and [missed] not being able to see the mountains and snow or go to the lake and swim in the clean water.

5.2 Stress

In addition to stress associated with proximal determinants related to education, income, food insecurity, housing and homelessness, my sister-participants also shared their narratives of stress. The majority of sister-participants, indeed, 8 out of 10, said they had experienced stress within the last year. They describe feeling overwhelmed juggling responsibilities and that the weight of the world rests on their shoulders. Susan explains it thus:

> You know, sometimes I get so busy with everything that I sometimes don't even have time to shower. Like… sometimes, I don't even have time to use the bathroom. I literally get so busy sometimes it's overwhelming. I feel like I can't breathe at times and [can't] catch up with things. So much going on all the time and she [her eight month old daughter] is so much work. And it's pretty overwhelming at times, well, most of the time!

Linda, a single parent, also discussed feeling overwhelmed and that her sources of stress centred on supporting her family.

> I take the weight of everybody else's problems. I shouldn't do that but I can't help but worry about everybody else. I'm considered the glue in my family. To keep our family together… so no matter how overwhelming things get, I have to keep it together.

In addition, Lisa is overwhelmed trying to balance parenting with working part time.

> I feel like I'm juggling a million balls in the air. I have four kids; well, three that live at home. I plan to go back to work part time, raise my kids… and sometimes it gets pretty overwhelming.

5.2.1 Parenting

When discussing sources of stress, my sister-participants experienced parenting as stressful.

> My kids stress me out. Like… when my son doesn't listen to me and throws tantrums. I think, 'oh my God, I have to dig deeper and find patience' and sometimes I get so frustrated and grit my teeth. Calm down. I hide in the bathroom and lock the door. (Susan)

Another source of parenting stress was teenage children:

> **Lisa:** He [her son] was getting into more trouble at school and was coming home and causing trouble. The whole house was in disarray. He's in Ontario right now. He had to go to Ontario because he was getting involved with other kids in the neighbourhood. So he's back there. Hopefully he can take the time he needs to get sorted.
> **JL:** Who's he living with?
> **L:** He's living with his dad. I needed a break, we needed a break. It was just too disruptive for the whole house. There's three other kids and my hands were just too full.

In addition to parenting, my sister-participants indicated that family stress, such as having a close family member who is sick or in the hospital or having to deal with addictions was stressful.

> I have my family that I worry about, and my mom's health. She's an alcoholic and I worry about her and her health and that's a lot of stress for me also. And I try not to let things just stress me out and take it as it is. (Susan)

Another form of stress for Susan was the death of a close family member and she did not have enough money to attend the funeral. She felt disconnected from family and feelings of isolation and loneliness contributed to her overall stress. Susan described her situation:

> My aunt passed away last month and it was stressful being away from family. It's expensive to drive back … it's about $200 each way. And that's just for gas. Plus, the kids are in school and it has to be a long weekend [to make the return drive], so we need the time and we need the money. And it hurts not to see family. Family is everything for us. Even for my mom, not to see the kids a lot and for me not to see my brothers and sisters and all my nieces and nephews. But every time we see each other it's like we never left. We just pick up where we left off. We're really close like that. It hurts a lot not being able to see everyone and I worry about my mom because she had a heart attack. I didn't feel like I could take care of her. And now I'm not there to take care of her. I worry about her a lot.

Worrying about family was also a stress for Mary:

> My partner's brother is struggling with addictions right now and he's 22 years old. He drinks every day and he has mental-health issues. He's on antidepressants. He has social anxiety. We went over there and he was drinking. I was talking to him and I said, 'You've been struggling with this,' and I asked 'when are you going to draw the line'? No one wants the same thing. No one wants to be an alcoholic. Is he going to have to end up in the hospital or die for

> him to realize it? Because even his mom was through this depression and she gets suicidal and ends up in the hospital once every 3 months and now she's in a low point.

5.2.2 Relationships and Lone Parent Families

Half of my sister-participants considered they were well supported throughout their pregnancy, birthing, and early months of parenthood. The other half of my sister-participants explained that a main source of stress for them was their relationship with their partner. Negative maternity experiences were related with a lack of support from their partners and "bad relationships." Susan explained:

> Well, the reason why I didn't have good pregnancies was because I was always in bad relationships … that had a lot to do with it. With my firstborn, when I was pregnant with her, I went through a breakup with her dad and it was really horrible. I moved into my own place, then I got back with her dad and I invited him to live with us. It was a big mistake because he was always leaving me. I felt like he was just using me. Like he would come and just do his own thing at the house and be with me and then leave, all the time. Often time, he was leaving me to be with other girls. I was just there to take care of him. Gosh, I don't know why I was there for him. He just used me. It tore me apart. It broke my spirit. I was so hurt and crushed and betrayed. It was the worst possible thing a woman can go through, I think. To have someone they love such as their partner; it was a bad time in my life when I was pregnant with my son and my girl was just a baby and … it was horrible. So I left that place and I ran again. I'm always running from him. I ran from him and ran to another shelter again.

Lisa explains that, "this is the kind of things our parents did." This comment is in reference to her parents who attended residential school and suffered from addictions, which led to her and her siblings being apprehended and placed in foster care. She states that "it's not acceptable to me" and explained later in our conversation that she wants a better life for her children. She did not feel supported and she asked her partner to leave.

> That was the last straw, when I asked the kids where he was [he was out partying with friends]. He is supposed to be home. And that was the day before I kicked him out. I said that's it. I will not put my kids, our unborn baby, through this kind of life. This is the kind of stuff our parents did and passed on but it's not acceptable to me. I'm tough on my partners and I love them. But I

> want them to be someone who is there for me and the kids and that is a tough task to take on too. I pretty much told him to leave. He's still really connected to his kids and we are very civil to each other. He pays support and stuff like that. So that is perfect.

In addition to a lack of support from birth partners and fathers, four of my sister-participants shared that they argued too frequently with their partners. Mary explained that the arguments were the result of adapting to parenting and adjusting to changes within their relationship.

> Besides my son being colic, I think our relationship was stressful because we were sleep deprived, so we argued a lot. It was hard because I was adjusting to being home and being a first-time mom and first-time parent. So I would say that was stressful.

In addition, their birth partner did not support three of my sister-participants. The relationship each had with their children's father was difficult because the men did not want them to be pregnant. Susan spoke of her pain when,

> With my pregnancies, the dads would say, 'it's not mine' or they would encourage me to have an abortion because they weren't ready [to be a father]. And that was always a shot to the heart. So I felt like my partner didn't want me to be pregnant.

Donna also did not feel supported by her partner, who also wanted her to have an abortion.

> He said I was cheating on him and that it wasn't his. He said. 'Why don't you just get rid [have an abortion] of it?' I thought about it, but I couldn't.

As the sole provider for their children, five of my ten sister-participants felt alone and isolated. This was true for Susan who said:

> I'm single. I've been single for a while. I've been in unhealthy relationships for a long time. It's been tough having other kids, having more than one child and single parenting. Sometimes I feel so alone. It's tough because you want someone there, to kind of balance it all. I would much rather handle it on my own because I know I can do it on my own now, so I am happy.

Kim also not supported by her partner, noticed that

> What really hurt was my partner not supporting me. At the time, that really crushed me. That was heart wrenching for me. Sometimes I feel so alone.

Patricia's partner wasn't supportive throughout her pregnancy and delivery and she also felt afraid of raising her child alone.

> It's complicated. I have a boyfriend but I don't l know if he's going to stick around or not, so I might as well be single. I keep hoping he'll change his mind because I'm terrified of raising this baby alone. He wasn't really there throughout my pregnancy or the birth. I had to do everything on my own. I still feel alone, which sucks… but so be it.

When I asked the women to elaborate on why they are single, many responded that they left or had their partner leave due to issues of violence. Lisa asked her partner to leave because of his violence and his addictions.

> I asked him to leave. I could never let a man ever again make me feel worse. I could never let a man ever again treat us the way that he treated us. He neglected us. He was never home. When he was home he was getting mad because he couldn't get high. I never used drugs. I never drink. It was a learning thing for me. I learned a lot from him.

Two women said their birth partners weren't "man enough" [to parent] and that they would rather parent their children alone. Kim said:

> Your world becomes a lot more real when they decide that they're not ready or man enough or that you're not enough for them to stick around.

Susan explains that the father of her children struggles with addictions and she left the relationship due to intimate partner violence. She explains that he is constantly leaving her with the children to "party" and that she couldn't rely on him to support her and the children. She explains that she also asked her partner to leave because she didn't want her children to grow up thinking that this behaviour was okay.

> If my partner can't step up and be a man and look after his children like a man should, then [he] shouldn't be around. These children will learn from them, especially my eldest daughter. We don't need anybody here. So hopefully I'm

not scarring them [her children] that way [Laughing].

Karen is in a relationship with her partner who is non-status, but prefers to identify as single because of limitations related to the Indian Act.

> I've never been legally married or listed my child's birth father on the birth certificate. I'm a 6(2) Indian and he's non[status], so if I put him down on the birth certificate or if we're married, then she [her baby] isn't eligible for status or to be a member of our Band. And, to be honest, I can't afford a dentist or prescription if they need it. At least this way we don't have to worry.

5.2.3 Violence

In addition to stressors related to proximal determinants, two of my sister-participants had additional stressors due to intimate-partner violence. Their experiences illustrate the detrimental effects of violence against women, including low self-esteem, poor mental health, and suicidal thoughts and actions. Donna's words express this:

> I was so stressed and I couldn't take it anymore, the drinking, the fighting, and just feeling like I was a piece of shit. I hated looking in the mirror and seeing the bruises and [having] this feeling, like I was going crazy. What was wrong with me? Why? I was lying on the bathroom floor, 6 months pregnant, praying to creator to make it stop. I thought of killing myself. I was looking for an out.

Violence was one of the most difficult things Donna and Susan have had to endure in their lives. As Susan said:

> I can honestly say that I lived the hardest life in my eyes and being in an abusive relationship is one of the hardest thing you can ever live through. I was pregnant and I had a horrible pregnancy because of that [the violence]. I didn't have anybody to take me to the ultrasounds or talk to my belly are talk sweetly to me. Or to massage my feet. He was never there to massage my back or buy me little things. […long pause, tears rolling down her cheek] I never knew what it was like to be cherished when I was pregnant. The entire time while he beat the shit out of me, all I could think is 'what's wrong with me'? I almost had my clothes ripped off of me and [was] ditched on the side of the road in the middle of the night. I didn't know where I was. It started raining and I thought I was going to die that night. I didn't even know which way to run because I didn't know where I am. I was freezing and he left me there. He was a lot more violent back then. He always tried to hurt me and put me down. He kept me

> down as low as I could be in my life.

Both Donna and Susan have left their abusive relationships and spoke of being stronger now and that they would never tolerate violence again. Donna said:

> If I ever met someone who was ever physically abusive with me again, we would be done. I don't give a shit if you hit me, I'm going to charge you. I'm not one of those people that don't call the cops. Because I will, I will call the cops.

Susan refused to let her abusive relationship keep her down and ending her relationship and overcoming the violence has made her stronger.

> I don't know what scares men about being a strong woman. Probably because I don't need to rely on him. I don't need a vehicle or a place to stay. I don't stay down for very long. He knows that now; he knows I can get through anything. I can get through a lot. That man has tested my strength as a woman like no one has ever done before. I almost appreciate everything he put me through because—I know this might sound silly—but I think I'm stronger now because of it.

It is difficult to leave an abusive relationship and the cycles of violence are complex and rooted in emotional and financial control, as well as feeling stuck and fearful of leaving. Susan said:

> I'm always taking him back. I'm always going through rough times with him and taking him back. I don't know what it is about him. I feel sorry for him. It took me a long time to be where I'm at now in my life. To not go back with him and to not believe his words and just stay away. Get away from the unhealthy cycle. We met on the reserve and when I asked what he thought of me the first time we met, he said, 'I thought you were so beautiful' and he said he fell in love with me the first time he saw me. Maybe that's why I kept going back. I hold onto that moment because it was really good but it quickly turned into lies and abuse and everything horrible.

Donna, who was living on her boyfriend's reserve with his family, stayed in an abusive relationship because she felt she didn't have anywhere to go.

> I can't leave him because I have nowhere to go. It's like … where are you going to go? I had nothing.

Susan and Donna felt their partner's control over them; they still loved their partner and stayed because their partner was the father of their child. Susan said:

> I was scared to leave because of the control, plus I still loved him. He's the father of my kids. But it turned into this continuous cycle until, eventually, I was so dependent. And I was just numb. Numb inside.

5.2.4 Social Support

The majority of my sister-participants do have support from family. Mary related that,

> My dad just turned 65 and right now they [mom and dad] are my main support, besides my partner. My dad lives with me and my mom turned 60 this year. My parents would be my biggest strength because they are the only people I trust to take care of my son. Because they know him and they see him a lot. My mom and dad are my biggest support.

Kim also felt her family, especially her mother, is her biggest support. "My mom has been my biggest support through all of this. She's so amazing." Sandra also felt well supported by family who she describes as her "rock."

In addition to family support, my sister participants also utilized community resources and supports offered by the Friendship Centres and prenatal wellness programs. Lisa thought it was important to know what is available within the community.

> I sought out support. I just sought out flyers and looking for things that catch my eye. Stuff like that. And now I am more and more involved and know more about our community. I know what's available. I'm just getting to know more and more as I go along. There's no welcoming party when you move to the city. You just go out and look for it.

Susan is from another reserve community in Alberta and she discussed the difficulties accessing supports from reserve communities when you're not a Band member in that community.

> I have to be honest but I find it difficult sometimes to be part of another reserve because we are very territorial. It's just how we are. Sometimes it's hard to get along but I feel like, for the most part, most people have been very welcoming to me especially at the Friendship Centre.

However, four of my sister-participants felt alone and isolated because they did not have family living nearby. Susan speaks of this issue:

> I had a hard time being away from family and feeling isolated. Nobody helping me there. I felt like I should be with family, in a time like this [while pregnant] but I just wanted to run away from him [her abusive partner and move off reserve]. So that's my reaction. When my life is in a crunch, it's fight or flight. But it's tough when you don't have anybody nearby to help you.

Lisa also feels alone and isolated:

> I don't have any family here and I don't mean to isolate myself, but some days it gets pretty lonely, like it's just me and my kids.

Patricia grew up in foster care and she often feels alone.

> I grew up in care so, to be honest, I don't have anybody. The only person I rely on is myself. And my friends. I have good friends.

Susan and Lisa also rely on support from friends. Susan said:

> I have to say that I have amazing friends. My aunt is huge in my life. She is my mom away from home. And I have really darling friends. I have a good circle of friends here and probably only a handful of friends but that's all I need. But they're like sisters to me. They're there to help me with the kids and we do everything together. They have kids of their own, so we go out and do family things together. I wouldn't know how it would be, if I didn't have close girlfriends here. I probably would have moved back a long time ago.

5.2.5 Coping with Stress

When discussing ways to cope with stress, my sister-participants discussed the importance of sharing and dealing with complex emotions, as well as using humour. Susan explains that her mother attended residential school and growing up, she and her siblings were discouraged from talking about their feelings and expressing their emotions. Thus, she said it was important to talk about their experiences and emotions, rather than covering them up. Michelle also reiterated the importance of sharing thoughts, feelings and emotions:

> What I learned along the way is that I need to express myself all the time. If I'm sad or crying, people tell you not to cry in front of your kids. I will cry and he will see me and think, 'what is going on now.' And they come and hug me and I just tell them, 'It's okay, mommy is just having a bad day' and that it is okay to have a bad day and that it is okay to cry and be upset

In addition to expressing themselves, my sister-participants identified how important it is to keep moving forward and to focus on the positives. In times of stress, Linda relies on a quote:

> There's a quote I recently came upon: "This too shall pass." Sometimes when I'm at my breaking point, I think this too shall pass… this too shall pass… this too shall pass. It helps me get through whatever is bothering me that day.

Patricia said:

> It took me a long time to be at this place where I am. One day at a time, one moment at a time. Don't get stuck on what is happening now, just focus on what's important [and] for now, that's my baby.

When coping with stressful events, four sister-participants got strength for coping with their stress from cultural practices, such as sweat lodges and smudging.

> For me, for my strength, I pray a lot. That was one thing my parents told me. I pray before I go to sleep and I pray in the morning. I started smudging again and I smudge every day before I go to work. I sweat [sweat lodge ceremony] a lot, at least I used to go to sweats [before baby was born]. I pray a lot and smudge. But I wasn't introduced to culture until I was 10 because we were apprehended and placed in foster care. Then, when I was learning about my culture, I knew this is how I want my life. I believe in my surroundings and I believe in nature. I believe in the drum. I learned about the drum and it's still very healing to me when I hear that drum. I ache to hear it sometimes. (Susan)

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> I pray a lot. I smudge in my house and I find that, when I'm getting too tense with the kids and with everything else, bills, money, I just need to shut my house off. Turn off the electronics. Turn off my radio, TV, anything that's on, to have quiet and pray. Pray and smudge. And I feel instantly better after that. Clear my head. (Lisa)

Lisa struggled with postpartum depression and turned to cultural practices and traditional healers to help her overcome depression.

> You feel very disgusting [after taking anti-depressant medication]. So that's when I started going to sweats and seeking medicine healers. That's when I

> started seeking out our culture and understanding it more. Accepting it. And it really did help. It helped a lot because I don't think I've had postpartum depression with this baby because of my reconnecting with culture.

Mary attributes her strength to her cultural practices.

> I think that culture has a lot to do with my strength. When I pray, I pray to Creator. I take everything out of my body and I need to clean my body. It [the stress and worries] leaves our body and I need the stressors … or whatever it is that time… to literally come out of my body and go into the smoke and be taken up to Creator. Putting it in his hands now. When I pray I really let it go. You can't hold onto all of that. When you hold onto all that stress and you don't have a way to let it leave your body, you get physically sick. I can't imagine walking around with all that stress. That's why people commit suicide. That's when women turn to drugs. By not releasing it. They're keeping it in here [she points to her heart] in the heart and in their body. It's like a backpack. We're putting everything in our backpack and eventually the next load is too heavy and that's when you can't take it anymore. You turn to alcohol or take your own life. Because it tends to be too much. Releasing stress. Dancing, smudging, beating the drum… all of that helps.

Susan also draws from her culture for strength when coping with stress, especially the importance of cultural practices around pregnancy.

> We don't attend funerals when we're pregnant. It's because the spirit is going to go to the next world and they're going to look for someone to take with them on their four-day journey. Their spirit takes a four-day journey to where they need to go. The first people they are going to look to take with them are children. Pregnant women and children are not to come to the wake, funeral, or the burial either. And if you do go, the Elders put ash on your forehead, or on your belly if you are pregnant, and it marks them so the spirit can't see the child or the baby in the pregnant belly.

In addition to cultural practices around pregnancy, Susan also spoke about the role of women and Elders in baby naming ceremonies and traditions.

> It [her daughter's traditional name] was [given to her] from a family member and traditionally that's how it was. The community and Elders always named the babies.

However, Susan knows that many of the traditions have been disrupted but she hopes to restore the culture and traditions with her children by reconnecting to land and family:

> We lost the women that used to do that [midwives] in our lives and it hurts that we have lost part of that way of ourselves. I don't like that my kids are on electronics, that they don't want to go for a walk. I don't allow them to be on the electronics too long. I don't want them to lose touch of nature and reality, even though the world is turning to computers and technology. We care more about taking care of the land and having fresh water. Sustainability. I don't want my kids to lose touch of that and it's important to me that they don't lose touch with Mother Nature. And, when we go out on our walks, I tell them to pick up a rock talk to that rock. You don't think they [rocks] can hear you. They can hear you. Don't lose that. We are from this land. We are stewards of the land and this should be more important to you than anything in the world. Your family and this land.

In addition to family and land, Mary talked about the disruptions to culture and language caused by the residential schools. She is trying to relearn her Indigenous language because it is important for her children to understand where they come from and language is a way of connecting to land and creating a sense of belonging.

> I speak a little bit. I wouldn't say I am fluent but I understand. They [her parents] were discouraged from speaking our language [because of the residential school system], so they never taught us [her and her two brothers]. But I'm trying to relearn it. I think it's important to understand the language and where we come from. I think it's important that our children know the language, their ancestors as a way of belonging. Language connects us to that. (Mary)

Connection to land was reiterated in my interview with Mary who used nature as a way to cope with stress.

> How do I manage stress? Well, I have to say I turned to nature a lot. When I start to feel the weight of the world, I need to get out and I need to go for a walk. I need to go for a walk where there's no one around and where it's just me and the baby. I just have to have time to think and get back to nature. Mother Earth. And I need to connect with her because that's the only way I can get back to myself. My *kookum* ['grandmother'] would say, 'My girl, don't you cry; come on now, let's go.' She didn't want me sitting in bed crying all day, wasting a whole day away. 'Let's go pick berries,' she would say and I would feel instantly better. She never wanted me to feel sorry for myself, and I don't very often feel sorry for myself, because I know I can have it a lot worse. And as soon as we were out on the land, picking berries, I'd instantly feel better.

Linda also turns to nature to cope with her stress.

> I connect with nature. I get my head in the water. I go for a swim or grab some soil in my hands and feel the earth. Touch a tree. We're part of the earth and people don't realize that, if you let it happen and you give yourself to nature it will take all your worry and stress away.

Kim also turns to nature and animals, especially horse riding:

> The way I deal with stress is I go riding. When I ride, all my stress and all the worries of the world are gone. When I'm riding, I feel free.

In addition, my sister-participants thought that self-care and physical exercise were other sources of release and to cope with stress.

> I also have to take care of myself physically. I do yoga. I walk a lot. I exercise and do workout videos. I can't get to the gym because of my kids, so I lift weights at home. I take hot baths at night to release the stress, and deep breathing… that really, really helps. I've been going for massage too. (Michelle)

5.3 Postpartum Depression

Three of my10 sister-participants had suffered from postpartum depression. They describe their experience as feeling *empty, crazy and living in hell.*

> **Lisa:** I really didn't know that I had postpartum depression [with her first born child] until after my second baby. I was reading an article about it [PPD] and I was like … 'Oh yeah, this makes total sense.' It's a feeling of desperation, that's how I felt. I felt empty. I went on medication for under a year after I had her because they [children] were all little. So, when I went on medication, I also knew about the medication because my mom was on the same medication. She told me later on, as I was older, 'If you decide it's best for you then don't stay on it past a year. Don't stay on it past a year because, if you do, it will just be a cycle of medication after medication after medication and more medication.' So I did it for 8 months and then I told my daughter, 'Okay, it's time for me to get off.' I have an understanding of where I am and what to do. I did lots of reading about healing and I sought out a psychiatrist. I was determined not to fall into the cycles. So he told me how to wean off the medication. It was crazy. It was crazy. That medication just changed me. If you miss a day you're really sick.
> **JL:** Why do you think you were depressed?
> **Lisa:** I guess because there was so much going on and maybe because of my relationship. I was away from family and relied on him… but he wasn't there, so I was always alone.

Donna recalls her PPD experience:

> The baby kept crying and, I dunno … and I was alone. Alone in my apartment with this screaming baby and being a new mom. I didn't know what to do or who to call. I was just getting through the day. And I thought, 'there's something wrong with me, I'm all fucked up'… And all I wanted to do was hide. Leave me alone… yet, I had a baby to look after. Maybe it was the blues or postpartum. I dunno what it was… but it was hell.

Mary thought she was on the verge of postpartum depression:

> I think I was on the verge, but I didn't. I think it was because I wasn't sleeping. I was stressed out. I was on the verge of getting there but I didn't. I think it just got better. So, it worked out. I think with being sleep deprived and arguing with my partner and the colic … almost sent me into depression but I didn't get there.

Susan and Donna felt it was important to have someone to talk to and not to suffer in silence.

> If you have a bad day, talk to somebody. Let it out, don't hold it in. Don't suffer in silence. I suffered in silence because I thought I had to be this strong woman and I didn't want people to see me fall. And so, I suffered in silence. (Susan)

5.4 Summary

Indigenous women's experiences related to proximal social determinants of health such as education, employment and income, food security and housing varied among my sister-participants. Nine of my sister-participants had completed high school, four had obtained some postsecondary training, and one had completed a university degree. Barriers to obtaining an education included pregnancy and lone parenting, lack of support and access to daycare, as well as financial barriers associated with tuition and training costs and living expenses.

While half of my sister-participants don't worry about money and finances, the other half of my sister- participants struggled with issues related to poverty. As discussed in chapter one, poverty is an important determinant of health because it is linked to social exclusion (Galabuzi 2004) and has also been linked to violence, addictions, poor parenting, and lack of social

support. Although there is no set definition of poverty in Canada, the low-income threshold in Canada is $41,568 for a family of four (Stat Can 2015). According to this definition, five of my sister-participants (who are also lone parent families) live in poverty. Their narratives of financial stress and worrying about paying for rent, groceries, utilities, transportation and miscellaneous expenses demonstrate their struggles. As Lisa said "I'm doing the best I can." Many Indigenous low-income families, particularly lone parent Indigenous mothers can barely afford to pay the rent and put food on the table, let alone pay for dental care, eyeglasses, school outings, sports equipment for their kids, internet access or prescription drugs. These are things that most people in Canada take for granted and would consider necessities.

Low-income levels and poverty also determine food access, food availability, nutrition and food security. According to Chen and Che (2001), 27 per cent of Aboriginal people living off-reserve and 32 per cent of lone mothers with children experienced "any food security," a concern that there will not be enough to eat because of lack of money in the previous 12 months. This concern was expressed by Donna who is a single teenaged mother living on assistance. In addition, 24 per cent of Aboriginal people living off reserve and 28 per cent of lone mothers experienced a "compromised diet" where the quality or quantity (or both) was compromised because of the lack of money (Chen and Che 2001). Donna expressed her concerns about the cost of food in the Okanagan Valley and how she worries that her children are not receiving the proper diet and nutrition.

In addition to issues related to poverty and food security, access to safe, stable and affordable housing was a concern for my sister-participants. Although three sister-participants own their own home, home ownership is beyond the reach of many. The average housing price in the Central Okanagan in 2012 was $377, 979 and $487,551 in Kelowna. The average rental cost for a two-bedroom apartment in the Central Okanagan was $785, with a vacancy rate of 9.3

per cent, and the average two-bedroom rental cost in Kelowna was $1225, with a vacancy rate of 0.9 per cent (CMHC 2013). Five of my sister participants struggled finding adequate and affordable housing, as well as the stress associated with moving and having enough money to cover rent.

Although none of my sister-participants were homeless at the time of the interview, Susan and Donna had experienced homelessness within the two years prior to our interview. Although there is no concrete definition of homelessness in Canada, the Canadian Homelessness Research Network (CHRN) defines homelessness as follows:

> Homelessness describes the situation of an individual or family without stable, permanent, appropriate housing, or the immediate prospect, means and ability of acquiring it. It is the result of systemic or societal barriers, a lack of affordable and appropriate housing, the individual/household's financial, mental, cognitive, behavioral or physical challenges, and/or racism and discrimination. Most people do not choose to be homeless, and the experience is generally negative, unpleasant, stressful and distressing (CHRN 2012:1).

Both Donna and Susan described their experience as negative, unpleasant, distressing and very stressful. They did not choose to be homeless. They were homeless after migrating off reserve into an urban center to escape violent relationships.

Violence against women is always a concern and violence against women of reproductive age is especially concerning. Younger women and women with low income and education and who lack social support (Daoud et al. 2012), as well as single mothers, are at higher risk of violence during pregnancy (Janssen et al. 2003). Susan, a single mother of three children and Donna a single teenaged mother were two of my participants who experienced intimate partner violence. Their accounts illustrate the detrimental effects of violence against women, including low self-esteem, poor mental health and suicidal thoughts and actions. Susan, Lisa and Donna had contemplated suicide in the past and had suffered from postpartum

depression. This finding is consistent with previous research that demonstrates how violence is associated with suicide, particularly among pregnant teens (Bayatpour et al. 1992), as well as with higher rates of postpartum depression (Beydoun et al. 2010).

My sister-participants shared various ways they coped and managed stressful life events. This ranged from exercise and yoga, to going for a walk or swim and reconnecting with Mother Earth, to cultural practices, such as smudging, sweating and drumming. Culture as coping strategy can also be understood within the literature of cultural continuity and identity. Cultural continuity is a connection to one's past and present self (identity) and connection to culture and identity serves as protective and resiliency factors (Chandler and Lalonde 1998:193; Greenwood 2005).

Social support and access to supportive health care services have a positive psychosocial affect and are linked to better pregnancy outcomes (Hoffman and Hatch 1996; NAHO 2008). Although the majority of my sister-participants had supportive partners, family or friends, Susan, Patricia, Lisa and Donna often felt alone and isolated. The lack of help and support left them feeling overwhelmed. In addition to feeling alone and overwhelmed, my sister-participants shared their narratives of stress. As discussed in length in chapter three, prenatal stress and uncertainty increases anxiety, hopelessness and exhaustion and is related to adverse health outcomes. Sources of stress for my sister-participants included challenges and barriers associated with adverse social determinants, relationships with family and partners, intimate partner violence, parenting and lone parent/single mother families. Among my sister-participants, half were lone parents/ single mothers. According to the Canadian National Household Survey, about one-third (34.4 per cent) of Indigenous children (37.1 per cent of First Nation, 29.8 per cent Métis, and 25.8 per cent Inuit children) lived in a lone-parent family compared with 17.4 per cent of non-Indigenous children (Stat Can 2011).

Another source of stress was dealing with alcoholism and addictions related to extended family members. In addition, Susan, Lisa and Donna identified their own personal history of residential school and foster care as sources of stress. In the next chapter I elaborate on Susan, Lisa and Donna's history of residential school and experiences of foster care to further demonstrate the historical and intergenerational effects of colonization. I begin with my sister-participant's experiences with healthcare systems and barriers to accessing supportive health care services.

Chapter 6 (Nggodwaaswi): Intermediate and Distal Context of Indigenous Women's Maternity Experiences

6.1 Intermediate Context

In chapter five, I gave an overview of Indigenous women's narratives related to proximal determinants and the context of their daily lived experiences related to education, employment, income, food security, housing and experiences of homelessness. Chapter five also includes Indigenous women's experiences of stress related to parenting, relationships, intimate partner violence and narratives of postpartum depression. In chapter six I discuss the next two layers that contextualize Indigenous women's maternity experiences, including intermediate and distal determinants. The intermediate determinants include cultural safety and barriers to accessing mainstream healthcare, including Indigenous women's fear of child apprehension, and how those fears surface when women access maternity health care services. I then discuss the external layer of Indigenous women's experiences that are related to distal determinants, including colonialism, racism, social exclusion and self-determination. I include data from my interviews on Indigenous women's experiences of residential school and foster care. Chapter six concludes with strength-based narratives of self-determination, resiliency and strength from women warriors who continue to resist, reclaim, restore, revitalize and reconnect with Indigenous mothering, identity, family and community.

6.1.1 Healthcare Systems

The majority of my sister-participants' health care experiences were positive, including with healthcare providers, and particularly so with the care they received from their healthcare midwives.

> She [the midwife] was sensitive. She was really caring and she would always ask how I was doing. She would give me suggestions and ask how my family was. She was really caring, supportive and that's really what I needed. I told her

> I wanted a home birth … to have baby at home. I told her we wanted to smudge and pray or anything like that and she said for sure, she was all on board because she worked with Aboriginal people. She wasn't questioning me about everything; she was just on board and really supportive. I just remember being so tired. I had a hard time with latching [initial breast feeding], so my midwife stayed on my service longer. It was painful and I was having a really hard time. I was ready to give up breastfeeding and she helped me. (Mary)

Sandra's pregnancy and healthcare experiences were also positive and "everything went smoothly." Kim's healthcare experiences were mostly positive. The only negative experience Kim had was with her relationship with her ex-boyfriend and father of her child.

Although the majority of experiences were positive, four sister-participants did have negative experiences when accessing postpartum and maternity healthcare and support. Although Mary had a positive experience with her midwife, she elaborated that she felt she was being judged and watched by other [healthcare] staff, and kept her son for observation longer than what she felt was necessary.

> I felt like I was being watched because they [nursing staff] gave me this thing [a nursing tube that pumped formula into the baby's mouth, while attached to her breast] whenever I had to feed him and it felt like they tested me for the night. Then I got sent home. I don't think that's normal behaviour [to keep her son for observation when there was no indication of anything wrong]. I don't know, I don't know. Because I see smaller babies than him go home. Like, I don't know ... I could see if he wasn't sucking or, if he wasn't latching properly, I could see it. But my counsellor was so mad after I told her the story, because we don't know if it was because of racism or because I was First Nation. I'm just wondering if that's standard practice.

6.1.1.1 Fear of Child Apprehension

Although none of my sister-participants were involved with the Ministry of Child and Family Development (MCFD) or experienced child apprehension, three sister-participants expressed fears about accessing mainstream health care because they were afraid of being judged and judged negatively and thus their children would be apprehended.

> I think there's a fear admitting that we can't do it [raise our children] or admitting that we're struggling—it's seen as a weakness—or because we [Aboriginal mothers] are scared that the kids will be taken away. They're afraid of being labelled an unfit parent. That's a huge fear for me! When I think about it now, it still scares me inside, because it happens all the time. It happens all the time still … kids are taken away. And it's scary when it does happen because I see people who struggle trying to get their kids back and they can't. It's so hard for them to do that. So, yeah, I try to look after myself so I can look after my kids. They're the number one key. But there's definitely a lack of places to go to.

Lisa shared those fears and describes how women's fear of child apprehension affects their decisions when accessing healthcare.

> I'm afraid someone's gonna judge me … You know, my cousin … she lost her kids. She's been fighting to get them back and … I don't know, I guess it [dealing with things on her own] is just easier that way. I do feel so alone sometimes.

Donna, age 17, a new mother and single parent, was also struggling but was afraid to reach out for help.

> **Donna**: I didn't know where to go [for help while struggling]. I think it's that, I didn't know where to go and maybe I'm scared to go, so I just dealt with it on my own.
> **JL:** Why don't you reach out for help?
> **D:** I guess because I was scared that they'd see me as a bad mom or that I was too messed up to take care of my baby.

Negative experiences such as these impede Indigenous women from accessing mainstream health care and supports. In addition, negative experiences, such as embarrassment and loss of dignity, can also deter Indigenous women from accessing future healthcare and support. In one extreme, but probably not unique case, Lisa recalled a very negative experience of racism from her family physician.

> I was in my doctor's office for a routine visit a month after my baby was born. The doctor is a recent immigrant physician. I asked her for a prescription for Tylenol, calcium, vitamin E, Polysporin and Band-Aids, because it's covered under FNIB [First Nations Inuit Health Branch]; but you need a prescription in order for it to be covered. She asked why and when I explained I was First

> Nations and that it was covered, she said, 'I'm tired of you people abusing Tylenol, you… Abinationals.' When I corrected her and said we were Aboriginal, she said, 'I'm tired of you people abusing Medicare, you're a drain on Canada's medical care.' She refused to write a prescription, and told me that if I had a headache, I could make an appointment and that she would write me a prescription for two Tylenol then. Or, if I cut myself and needed one band aid that I could come in and she would write me a prescription for a Band-Aid then. When I walked out of there, I have never been so embarrassed in my life. It was so degrading. I felt terrible. After I left the office she came out to the waiting room and spoke to her secretary that she couldn't believe that I would even ask for a prescription for Tylenol. There were people in the waiting room and I was so embarrassed. I'm still embarrassed when I see that secretary downtown. I was really upset. You can't not give it to me. I wasn't asking for a controlled substance or even a prescription drug, I was just asking for over the counter medications. I didn't know what to do, so I phoned Aboriginal Affairs and the lady from there said 'well, find another doctor.' But the truth is, she's the only one in town and I was so humiliated and embarrassed that I'll probably never go back again.

6.1.1.2 Confidentiality

In addition to experiences of racism, judgementalism, and fear of accessing healthcare, one sister-participant highlighted the lack of patient/client confidentiality, specifically when accessing abortion services on reserve.

> The first time I got pregnant was when I was 15. It was an 'oops,' totally not planned. I wasn't on the pill or anything; it was in my party days and we didn't use a rubber or nothing. I knew I couldn't keep the baby and I thought about adoption, but … I couldn't do it. So when I found out, I was so scared … and I didn't know who to talk to. It's a small rez and I was scared someone was going to find out … and they did anyway. The closest [urban hospital] was over 200 kilometers away and we need Band permission for travel. So everyone knows, everyone talks. And I felt judged, like my choice was something bad. And maybe part of me does regret it, but I can't live in regrets. I made the right decision at that time, 'cause I wanted to finish school. I wanted more, and a better life for my kids and I couldn't give it to them then … I was just a kid having a kid. I didn't want to be stuck and I wanted more. Is that so bad?

6.1.2 Barriers to Accessing Healthcare

In addition to issues related to cultural safety, Indigenous women also face additional barriers when accessing healthcare. These include accessing programs during scheduled hours at specific

locations, as well as transportation. Programs are too often scheduled according to the needs of the organization, rather than the needs of Indigenous women.

> Some of these programs aren't very realistic and you have to conform to their times and locations. You can't have a program at 10 in the morning and think people are going to show up. Moms can't go for 10 o'clock; you're just getting your kids ready for school and then you have to drive there to go to program and it is just difficult. It's difficult trying to balance naps and schedules and even when I wasn't working, I struggled to get to the 11 o'clock program. So I was always late. And I can't even imagine doing it with more than one kid or having to take a bus everywhere. No one is going to come to a class at 10:30 in the morning. (Mary)

This issue of access is further elaborated by Susan:

> Our emotions aren't on a schedule. For healthcare providers and program people to be present is important too. Just being there, listening, having tea and just talking is good. Sometimes you just need to feel like you're not alone in this world.

6.1.2.1 I'd rather deal with it on my own

The women felt uncomfortable accessing mainstream supports and services. Indigenous women's fears of judgement, racism, loss of dignity, or being labelled a 'bad mother' that the women experienced when accessing mainstream healthcare, inhibits them from reaching out to access the help and supports they need. However, mainstream supports and services are the only health care services available. Rather than access mainstream services and supports, a common theme throughout my interviews was that, Indigenous women chose to deal with it on their own, which left them feeling alone and isolated. In our conversation, Susan told me she had been sexually abused as a child.

> **JL:** Have you ever talked to anyone, like a counsellor or …?
> **Susan:** I went to counselling once; but, to be honest I don't think it was that helpful. It was hard talking to this white guy about my experiences. Sitting in an office … I don't know. I guess I just try to deal with it on my own.

Lisa has also struggled with her history of foster care and dealing with things on her own.

> **Lisa:** I've struggled with suicide. I've struggled a lot.
> **JL:** Have you ever reached out for help
> **Lisa**: Yeah, when I've needed it. My family has helped me though, a lot.
> **JL:** What about healthcare providers or mental health professionals?
> **Lisa**: No, I'd rather not. I either choose to deal with it on my own or with family or friends. Less judgement.

Rather than reaching out to external health care providers, programs and supports, Donna also chose to deal with things on her own because there is less judgement:

> I don't really access any of the programs except the ones at the Friendship Centre. But even then, those are few and far between. I just try to deal with things on my own.

The intermediate contexts of Indigenous women's health care experiences illustrate my sister-participant's experiences with institutional and relational racism. In addition to racism, Indigenous women's maternity experiences are also embedded in the distal context of colonialism. The following section includes Indigenous women's narratives of residential school and foster care.

6.2 Distal Context of Indigenous Women's Maternity Experiences

When I set out to research Indigenous women's maternity experiences, none of my guiding interview questions included a history of residential school or foster care. As our conversations unfolded and the women felt free to discuss issues and experiences that were important to them, it became evident that the history of colonization has impacted these young Indigenous women. In this section, I draw from their narratives to illustrate the effects of the foster care system and the residential school attendance on their parents continues to effect Indigenous women's maternity experiences. The theme of parental and grandparent residential school attendance was an issue of importance to three of my sister-participants. The intergenerational effects of residential school are reiterated in the following conversations.

6.2.1 Residential School

Lisa spoke of her mother's residential school experience and how the abuse her mother experienced contributed to her mother's alcoholism:

> Our parents and their parents before us … they went through all the residential school stuff. My mom, she was abused. I think that's why she drank … she went to residential school and went through all that [physical and sexual] abuse too. She was trying to survive. She didn't raise us... She didn't raise us, but she is my mom. My mom started talking to me about that kind of stuff [history of residential school] when I was 14 because, I think, she needed me to know why she was the way she was.

Some of Lisa's earliest memories were when she and her two siblings were apprehended and placed in foster care as a result of her mother's addiction.

> **Lisa**: We were put into foster care [in a home] maybe an hour or so from where we lived. But after three months of going through treatment and stuff, they [her parents] called to get us back but the ministry told them that we had already been adopted out. When my mom found out we were adopted out, her heart broke. She was heartbroken. She said she burned her pictures of us because it hurt her so much. She gave us up. [I looked around her living room, at the numerous framed photos hanging on the wall of her children and family. As I turn back to her, I see her eyes welling with tears and, after a long pause, her voice cracks.]
> **JL**: Do you mind sharing how you feel when you say that she gave you up?
> **L**: [… Long pause]. I feel angry. But I forgive her, she tried. I think she did the best she could and I learned a lot from her. I also learned from my step-dad because he is so patient and calm. He's been through his demons too so he's just like my mom. My mom and dad are my go-to people when I need something. They are the first two people I go to talk to, calm me down, and they just keep me level. I learned from experiences. I learned from the people that I looked up to. I learned from them.
> JL: What kinds of things did you learn?
> L: Forgiveness. Compassion. Our culture is huge … and [I learned] to do better for my kids.
> JL: So where did you go?
> L: The ministry moved us to northern Manitoba to live with a Cree family in a fly-in reserve. They were like Christians or something. The ministry thought it was an ideal family, probably because they were Aboriginal, but they were physically and sexually abusive and it was hell. When I talk about it, I talk about it as a hell. Because I just couldn't. It is just insane my memories … my memories … I will never forget So after a year or year and a half of living with them, I remember finally telling the foster family father that I was telling on him. He didn't believe me and laughed at me. I snuck

> out of the house and went to the next house where his family went and I told this lady what he was doing. And from then on, I don't know how it happened … I don't member the time, but we were walking home and everybody was telling us go home! Go home! You have to go home now! When we got there, there was a helicopter waiting for us and there were social workers and police officers and they shipped us out of that house immediately. It was insane. We were just north of Winnipeg. I had my brother and my sister, my twin brother and sister, with me and we went to a temporary home in Winnipeg. I don't know how, okay, I just don't understand how we ended up in Winnipeg. He [foster father] had beaten his wife and she ended up in the hospital in Winnipeg and that's why they were in Winnipeg. He found out where we were, and I don't know how he could do that, and he came to us and he said I want to say sorry, sorry, sorry… it won't happen again and all those kind of things. I just looked at him and thought what the hell is going on? [… long pause]
> JL: Do you think your experience has impacted your kids or on you being a mom?
> L: Definitely. It's not that I think about it every day, but it's definitely a part of me. I struggle sometimes… not so much with drinking or drugs, but I feel sad some days.
> JL: So what happened after that?
> L: And then we went to this family, there were amazing people. I always talk about them, about saving our lives, because they were an amazing, amazing family. They lived on a farm and their story was that they prayed when they found out there were 3 of us. They only wanted one [foster child] … they were only looking for one. But they [Social Services] asked them to take all three [of us] and they prayed and they said okay. We lived with them for 3 years when I was seven. There were other temporary homes as well, in between that, but they saved our lives.
> JL: Did you stay with them?
> L: No. By the time I was 12, I was in 14 different homes. Fourteen different foster homes! From a baby, I was in fourteen different homes. Wow, that's sad. That's not normal. Every time I had to leave, for whatever reason … I would put all my stuff in a big black garbage bag, like it was garbage. But it was all I had. [There is a long pause as she looks down. When she looks up, there are two tears rolling down her cheek]. Like I was garbage. Like I don't matter.

Susan said that, "we carry out a lot from our past and I don't know how anybody can't." Susan talked about her mother's experiences of residential school and how she struggled with depression.

> **Susan:** My mom went to residential school … and she had a nervous breakdown when we were young and she never got back from it. It was life-changing for her and I saw her go through those changes. I saw her live the good life, from that to depression. I remember her just sitting there at the

> kitchen table being a zombie. Not talking to anybody and not all there. And I didn't want that for myself. And seeing my mom go through that really gave me some perspective.
> **JL:** What do you mean like a zombie? Do you mind sharing what it was like?
> **Susan:** She was in the house but she wasn't ever present, like really there. She always shooed us away. She didn't want us to see her like that.

6.2.2 Foster Care

Patricia related her experiences growing up in foster care.

> I don't know a whole lot about my family because I grew up in foster care. I was placed in foster care when I was four. My mom drank and I don't think my dad was around for much. All I can say is that I'm going to be a better mom than my mom ever was.

In addition to women's experiences of intergenerational residential school and foster care, Mary talked about her partner who also grew up in foster care and how his experiences affect their relationship.

> **Mary:** It would be really interesting to know what it was like for him from his perspective and what it [pregnancy, birth and parenting] was like for him. My parents are always really supportive of me but my partner grew up in care, so he's missing that unconditional love. He never really got that. He's visibly Aboriginal and grew up in a White home. So even now, when I get emotional—[he'll ask] 'why are you crying; what's wrong with you?' I feel bad … I feel bad for him because he never had that. He didn't have anybody to take care of him when he was sick. There were periods he was out on the streets when he was a teenager.
> **JL**: How do you think that has affected your partner?
> **Mary**: Well, that's one thing … I struggle with my partner because he does drink. And I struggle with that, because, I tell him, [drinking is difficult] for someone who is very spiritual growing up and her parents never drank. We do argue; we argue like any other couple. I think [we argue] because of his history and abuse that he's endured. I wish he would go to counselling to deal with some of the trauma he's endured so that he can see his behaviour. But, like I said, he's never had unconditional love, so trying to teach them what unconditional love is and what's normal or not normal and what is healthy or not.

The final distal context of Indigenous women's maternity experiences I would like to end with, is Indigenous women's self-determination as women warriors. I conclude my research findings with strength-based narratives of resilience and persistence as a way of looking "at

birth instead of death, wellness instead of illness, positive behaviours instead of guilt" (Stout et al. 2001:25). The section on women warriors serves as a counter-narrative to research that portrays Indigenous peoples as sick, disorganized and dysfunctional (Reading and Nowgesic 2002) and portrays Indigenous women's resilience and persistence as water carriers.

> Women are the water carriers; they carry the waters of life and, therefore, water represents the female element. It is this belief in one's own ability—that like the water, we can adapt to and eventually overcome any obstacle—that inspires resilience and persistence in the face of adversity (Lavell-Harvard and Anderson 2014: 1).

6.3 Women Warriors

Susan spoke about the strength and resiliency of generations of Indigenous women and the role of strong warrior women.

> I come from a long line of strong women. My grandma was also abused by my grandfather and she had a tough life, let me tell you. She got through it. She shared her secrets with my mom and my mom shared her secrets of me. And it's that warrior woman in all of us that we pass down. It's that strong blood and we can't give up because of our babies. We were taught not to give up on our babies and to take responsibility.

The resilience and persistence of the sister-participants throughout our conversations are inspiring. Susan's continues, saying

> We are built tough. Creator gave us something extra as women and when we need an extra bit, we can dig deep and we know it's there. Don't give up! Find that little bit extra to help you on your journey. Then you tell yourself, 'this too shall pass.' Quotes help in times like that. It all gets better and it will eventually all work out.

My sister-participants were "proud" of who they were as Indigenous women and mothers, and proud of their children. They drew strength from their culture, its teachings, and their Indigenous identity.

> I decided along the way that I'm proud. I don't care [about racism]. As a mom, it makes me proud because I am raising some really amazing kids! I'm teaching

> them how to be proud of who they are and what they do and how they speak. If you teach your kids to be engaged, they will do good. I am proud of our culture and teachings and the way that we live. (Lisa)

Mary told me she was proud of her Indigenous identity and hopes to pass her traditions to her son, her culture, and her sense of pride in their identity.

> To be Indigenous for me is to be free to be who I am. I'm St'át'imc and Blackfoot. So that's my identity. So my culture and my spirituality come first. I came from very loving parents and a good relationship with my parents, so I want the same for my son. My culture and my identity and who I am. I want him to go to ceremonies. He will go to ceremonies with me. It's important to me that he cherishes ceremonies and language and is proud of who he is.

Lisa, too, is proud of her Indigenous identity; however, in the past she struggled with her identity. Lisa experienced racism growing up and was tormented and teased by other non-Indigenous children. However, as she got older, she no longer senses racism.

> I don't sense racism, I don't sense exclusion. I don't sense any of that when I'm out because I am proud to be who I am. I wasn't proud when I was younger because I was excluded and told I was different. But I'm proud to be Native.

6.3.1 "I make humans, what's your superpower?"

Despite her adverse experiences, Susan hopes to continue her education and to support other Indigenous women.

> You're not alone in your experience. Women are strong. A lot of people think they're not. They just need to realize they are [strong] and it takes time for that to happen. You need someone to say that. Yes, you're pregnant and you may be alone. You're strong, you're making a human being! I make humans, what's you're super power? (Susan)

Lisa's strength comes from not giving up, from persevering for her children's sake.

> When days get tough, you can't give up. You got to keep going for these babies. We were taught not to give up on our babies and to take responsibility because babies are a gift.

Mary spoke about resiliency and overcoming barriers.

> That's where our brain comes in. That's where mind comes in. I will be taken care of. I can make it happen. I can do it. I can deal with it. We don't have the best but I have it really good right now. I just believe that it's our hearts and minds that keep us going and keep us strong. We are very resilient people. Honestly, it's our hearts. Listen to your heart. Our hearts tell us everything we need to know, like honestly. We listen to our hearts. We can just stop and close our eyes and think, what do you need? What is important? It's all in there and we already know. It's an instinct and we just have to listen to our gut when we get that feeling it's not right.

Karen choses to focus on the positive, rather than the negative.

> I don't get down on myself. I don't have time to feel down. I don't want to get into depression because there is no turning back when I get depressed. For me, I realize that if I don't want that in my life … I need to make positive changes. I need to see and live on the positives and the good side of life.

Mary also focuses on the positive:

> I tell myself when I'm having a hard time that things can always be worse. I tried not to get down on myself and I appreciate the things that I do have. That's what I look at. I look at the things I have, rather than the things I'm going through, or what happened to me, or what I don't have. I focus on the positives in my life. Look at those women in Africa who don't have proper houses to live in. They don't have stoves to cook on and a bed to sleep on. And they live.

Three sister-participants drew strength from the powerful women in their families and the role women played in sharing teachings and in supporting one another.

> I was very fortunate to have strong women in my family and we take care of each other. We shared our teachings with each other. (Lisa)

Intergenerational strength and resiliency are evident. Lisa observes that, "if they [my mom and grandmother] can survive that [residential school and violence], then we can too." Although they have challenges and obstacles, three sister-participants felt fortunate because "things could always be a lot worse."

> I'm very fortunate to have a vehicle to get around because most moms don't even have the cost [of bus fare] and they walk everywhere with their babies. My mom never had a vehicle. We would pack five bags of groceries on each side of the stroller when I was my daughter's age [six years old]. And I

> remember doing that in the winter time and fighting through snow because we didn't have a vehicle. So when my daughter complains about carrying one bag from the grocery store to the car, she's gonna hear about it.

6.3.2 "Enough is Enough"

Building on the past to create a better future was a common theme throughout the conversations with all my sister-participants. Wanting more for their children and being a catalyst for change included ending negative cycles and learning from past mistakes.

> Enough is enough. Why would I ever want to put my children through that? Why would I want to give them a hard life, when I could save them from all that hardship? I have to keep it together for my kids. I think about how my mom went crazy and I think I don't ever want that for my daughter or my son or my baby. It was hard. I just think about all the alcoholism in my family and the child abuse and I don't want my kids to go through that. I do not want them to see that. I want to give them the best possible upbringing I can and I want them to have possibilities. (Lisa)

Growing up living in adverse conditions, Susan witnessed and experienced violence as a child.

> **Susan:** I wasn't on the streets per se, but we moved to the city and my mom chose an apartment in the wrong side of town. It was considered the slums of the city. So I grew up in the ghetto. And I seen a lot go down. I saw women being raped, guys being beaten, people getting stabbed, and real horrible things that I should never have been exposed to. And through it all, I just stayed away. I tried my best to stay away from that kind of stuff. And say no to drugs. I always knew I was better than drugs. I experimented with a few drugs and drank, mostly hard stuff. I never tried coke because it scared me. I'm scared of drugs and have always been scared of drugs. I've seen people overdose all the time and when you see somebody doing the chicken on the floor, foaming from their mouth, and all that shit drugs cause … for me, that was enough for me, because I've seen horrible things.
> **JL:** Where do you think your decision comes from?
> **S:** I think a big part of my decisions came from my mom; mother to mother. She drove it into me from a young age that it's not worth it. She witnessed a lot too. She was on the streets. She would take off from the reserve and go into the city … she said it was dangerous on the street She would get taken by strange guys and go to parties and she didn't know these people and, for all she knew, they could have raped her and dropped her off in the countryside somewhere. That happens all the time. She just told me some horror stories when I was old enough to hear them and she said she wanted more for me. She said, 'it's not worth that,' my girl. This is what happens when you do drugs. She told me as it

was. As it is. I will always remember my mistakes, and they were harsh.

Mary also wants her son to learn from her mistakes and to make better choices.

> I want him to have choice and learn from my mistakes. I want to live an alcohol and drugs free life. So I encourage that. What he does when he's 19 is his choice but, until then, I'm his role model … that it [using drugs and alcohol] is not normal. And it's not part of our lifestyle.

Lisa talked about the influence of her mother and how her mother shared stories as a way of deterring Lisa to live a better life:

> She wanted me to have a different life than her. She told me exactly what was happening and she shared some of her stories about how men abused her and how she woke up in strange houses. Scary things. Scary things to hear and it was traumatizing to hear things like that, about what my mom went through. When I was in situations like that, I would go through hell. I don't want to be thrown in a ditch out in the country not knowing what happened to me. So I would go home and sleep in my own bed. Those are my choices. And I always chose to do the right thing.

Patricia's motivation for change stemmed from a very young age.

> I want more for my kids. I remember thinking, when I was little, when all this [child apprehension] was going on, that I was going to have kids and I would never treat my kids like that. Even at 5 years old, I said I would never treat my kids that way. So I think that's where that totally comes [from].

6.4 Summary

6.4.1 Cultural Safety

The intermediate context of my sister-participant's maternity experiences illustrate that the majority of their experiences with health care were positive. However, when accessing maternal health care, four sister–participants felt judged and fearful, because of their fears of child apprehension. This finding is consistent with previous research into Indigenous women's invalidating encounters with healthcare including feelings of being judged according to negative stereotypes and discrimination, and having healthcare employees disregard their personal

circumstances and situations of vulnerability such as a history of residential school attendance (Browne et al. 2000; Dion-Stout 1996; Stout and Kipling 1999; Varcoe et al. 2013). Previous research demonstrates that Indigenous peoples experience longer wait times, fewer referrals for specialized diagnosis and disrespectful treatment (Narine 2013; Tait 2014), which negatively impact their utilization to essential medical treatments (Hawkins et al. 2009). As a result of invalidating experiences by mainstream healthcare, my sister-participants preferred to deal with things on their own. Isolation, delay or avoidance in health seeking behaviours such as late and/or inadequate use of prenatal and other healthcare supports and services (Feijen-de Jong 2011), can negatively impact maternal child health outcomes (see chapter one).

Previous research found barriers to abortion services, including geographical distance (Rodgers and Downie 2006). Susan experienced a lack of confidentiality when accessing reproductive abortion services and barriers to this service associated with preapproved or reimbursed medical transport for status First Nation persons. According to the First Nation and Inuit Health Branch (FNIHB) pre-authorization and/or travel reimbursement is needed for non-insured health benefits, such as medical transportation to access medically required health services that are not provided on the reserve or in the community of residence. A recent report from the Office of the Auditor General of Canada (2015) on Access to Health Services for Remote First Nations Communities found that medical transportation benefits were available to registered First Nations, but those who were not registered were denied access to benefits and that additional documentation is needed to facilitate delivery of benefits (4). Medical transportation benefits are administered by Health Canada's regional office or by First Nations communities under agreement. However, Indigenous women have expressed a concern for the absence of confidentiality in small communities and lack of anonymity when dealing with preauthorized travel (Hankivsky et al. 2007). Indigenous women have expressed a need for a

model of care wherein their health concerns are addressed in an integrated manner, and where they are respected and given the opportunity to shape and influence decision-making about services that impact their own healing, including access to information on birth control and abortion services (Benoit et al. 2003). There is a need to further advance the reproductive rights and access to reproductive healthcare for Indigenous women (Yee et al. 2011).

The undesirable experiences of racism, fear, and a lack of confidentiality when accessing maternal health care that my sister-participants described, illustrates the need to address power imbalances, institutional discrimination, colonization, and colonial relationships (NAHO 2008) and what the patient perceives as "safe service" (Lavallee et al. 2009). Cultural safety aims to address negative experiences within health care by eliminating the harmful effects of prejudice, discrimination and racism.

Originating in New Zealand, the concept of "cultural safety" emerged in response to the ongoing effects of colonization on the Maori. Cultural safety aims to empower patients and participants in the patient-physician relationship by taking into account the individual's culture, history, and personal sociocultural background through cultural awareness, cultural sensitivity and cultural competence (Brascoupé and Waters 2008; NCCAH 2013; Smye and Browne 2002). Indigenous health experts from Canada, Australia, New Zealand and the United States have created an international collaboration on the Competencies for Indigenous Public Health, Evaluation and Research (CIPHER) to develop a set of core competencies aimed at improving and standardizing "academic curriculum, training programs, profession certification, health services planning, health policy, and health program evaluation standards (Baba 2013:5).

Within Canadian health care, cultural competencies and safety are important to address the unique health needs, circumstances and the context of First Nation, Métis and Inuit people's health. Within mainstream health care, Indigenous cultural competency (ICC) and Indigenous

cultural safety training for healthcare practitioners and providers are being adopted (PHSA 2015; Smylie 2001). Culturally safe approaches are being applied in the creation and delivery of programming (Browne et al. 2009, 2011; NAHO 2008; Lavallee et al. 2009), including Indigenous women's prenatal care (Di Lallo 2014; Smith et al. 2006). The creation of culturally appropriate prenatal care models for Indigenous women (British Columbia Maternal Health Project 2006; Buchareski et al. 1999:152) has informed programs such as the Aboriginal Prenatal Wellness Program (APWP) in Alberta. APWP utilizes a multidisciplinary team that implements culturally safe approaches to prenatal care by addressing issues of colonization, residential school, intergenerational trauma, and how this history has contributed to health disparities (APWP 2008). Six Nations Maternal Child Health Centre, *Tsi Non:we Ionnakeratstha Ona:grahst* ('the place they will be born,' a birthing place) in Ohsweken, Ontario is one example of combining traditional and contemporary midwifery and choices for women, families and communities. Other programs such as the Maxxine Wright Place Project in Surrey, BC.; the Healthy, Empowered, Resilient (H.E.R) Pregnancy Program in Edmonton, AB; HerWay Home in Victoria, BC; and *Manito Ikwe Kagiikwe* in Winnipeg, MB illustrate best practices when serving First Nation, Métis, Inuit and other Indigenous women and their families (Nathoo et al. 2013:93).

It is my intent that my research should contribute to expanding research on culturally safe and improved maternal and child health and healthcare. Cultural safety, when accessing mainstream healthcare, as well as culturally informed and relevant maternal child health programming, is a step in the right direction. However, Susan expressed that she would rather not access services and supports because it was difficult sitting in an office talking to a "white guy" about her foster care experiences and sexual abuse. This raises the question: is cultural safety enough?

6.4.2 Racism

There is a need to transform assumptions about Indigenous people's realities, to eliminate discrimination and prejudice by challenging and replacing negative stereotypes and racism that permeate Canadian society. The Royal Commission on Aboriginal Peoples (1996) examined representations of Indigenous peoples in Canada and concluded that,

> Aboriginal people are portrayed in a historical past reconstructed in present stereotypes: the noble Red Man roaming free in the forest; the bloodthirsty savage attacking the colony or the wagon train; the drunken Indian; the Aboriginal environmentalist; and, most recently, the warrior in para-military dress, wielding a gun…. As with all stereotypes, there is a kernel of truth in the images, which assume a dramatic profile and become etched in the popular consciousness. But stereotypes block out complexity of context and diversity of personality and perspective" (RCAP 1996a:118).

Negative stereotypes in Canadian society have created discriminatory attitudes, beliefs, and misconception (Henry et al. 2006). Stereotypes such as Indigenous people are drunks, lazy and irresponsible, troublemakers or, they are portrayed as the "good Indian" (Maslin 2002) and the "native-as-environmentalist" (Harding 2005). The portrayal of Indigenous women as "drunken squaw, dirty Indian, easy and lazy" (Anderson 2000:99) and "stereotypic images of Indian princesses, squaw drudges, suffering helpless victims, tawny temptresses, or loose squaws, falsify Indigenous women's realities and suggest in a subliminal way that those stereotypical images are Indigenous women " (Acoose 1992:1). Not only are these stereotypes racist and unjustified, but also they are also dangerous because they can "foster cultural attitudes that encourage sexual, physical, verbal, or psychological violence against Indigenous women" (Acoose 1992:2), which further marginalizes and excludes Indigenous women.

In addition to stereotypes, racism harms health. The imbalance of power is reinforced through systemic racism and maintained through inequitable and unfair treatment of Indigenous peoples through laws, policies, rules and regulations (Leyland et al. 2016). Racism perpetuates

health disparities (Allan and Smylie 2015; Hart and Lavalee 2015; Krieger 2011) and negatively impacts Indigenous people's health. Racism is a

> pervasive condition capable of poisoning the perceptions of everyday people and corrupting the structure of entire societies. It is perpetuated by strangers and colleagues, and sometimes even by friends; it happens in grocery stores and halls of justice and even in places of worship. It has condemned entire nations and countless generations of people to untold suffering. Whether subtle or overt, racism commits assaults on the minds, spirits and even the bodies of those racialized and consequently marginalized to 'minority' status (Reading 2013:9).

Perceived and anticipated racism contributes to avoiding health care or delay seeking healthcare when it is needed (Kurtz et al. 2008; Browne et al. 2011) and is a barrier when accessing maternal health services (Lawrence et al. 2016). Lisa's experience of direct racism from her family physician and being called an "Abinational" and "a drain on the Canadian healthcare system" clearly calls attention to the reality of interpersonal or relational racism against Indigenous women when accessing healthcare. Whether the physician's comments were intentional or unintentional, Lisa lost trust in her health care provider, as well as the healthcare system and systems of accountability (Thibodeau and Peigan 2007:51). The physician's comments illustrate assumptions based on negative stereotypes and a lack of awareness and understanding of Indigenous peoples' health, history and rights. Lisa explained she was embarrassed and ashamed, and further marginalized by her experience. Additional work is needed to address negative stereotypes, discrimination and racism that permeate Canadian society and institutions, such as education, justice and corrections, and social services.

Lisa was not the only sister-participant who preferred to deal with issues on her own. My sister-participants expressed feeling uncomfortable accessing mainstream supports and services because of their fears of judgement, racism, loss of dignity, or being labelled a "bad" mother. In chapter three, I discussed the exclusion of subpopulations of Indigenous women and mothers in

public health research. I contend this exclusion is the result of mainstream patriarchal (and Euro-Christian) definitions and ideologies of the "good" or typical mother. "Mother" in such an ideology is defined as white, feminine, able-bodied, middle-to-upper class, heterosexual, preferably married female (Anderson 2008:61). Not only do institutions reinforce these racist ideologies but they are also further reinforced in the minds and experiences of Indigenous women and mothers through internalized oppression and internalized racism. My sister-participants avoided seeking support and healthcare because they are afraid of being labelled as "weak" and "unable to take care of their children." In addition, they mother under the state's gaze (Cull 2006:142) and were afraid their children would be apprehended. This fear and concern is reinforced by the overrepresentation of Indigenous children in the child welfare system (Trocmé et al. 2004; Blackstock et al. 2004, 2005); a system that is described as a contemporary residential school system (Blackstock 2007).

When I first shared my thematic content analysis and selected quotes with my Ph.D. supervisor Dr. McPherson, I was quick to dismiss Indigenous women's fears of child apprehension as common or normal. Dr. McPherson said "Jen, that's not normal." The normalization and internalized oppression and racism (Battiste and Youngblood-Henderson 2012:90) in everyday life "is perpetuated through violent acts that are not necessary physical in nature but silent, ideological but powerful in the influence" (Bennett et al. 2005:34). Although none of my sister-participants were engaged with the BC Ministry of Child and Family Development, the indirect effects of the history of colonialism is expressed and reinforced in these women's fears. Thus demonstrating the power and influence of colonial history and racist ideologies. The systemic and ongoing effects of racism targeting Indigenous women have immediate and long-term consequences. Not only is there a need to reawaken our women (and society) to the power that is inherent in that transformative process that birth (and life) should be

(Cook 2006:25), but there is also a huge need to liberate Indigenous women and our entire society from the internalized and systemic racism that imprisons our hearts, minds and actions.

6.4.3 Colonization

Health disparities and social inequalities embedded within proximal determinants, intermediate interaction with healthcare systems. They are also rooted in the distal context of colonization. As discussed in chapter one, the historical context of colonialism in Canada has had profound consequences for Indigenous peoples. The residential school system and the sixties scoop have had an indelible effect on generations of parenting and attachment, especially reflected in

> the influence of alcohol and the coming to parenthood of a generation of people, who through the residential school had little opportunity to learn parenting skills (Haig-Brown 1988: 37).

My research found that colonization has had profound direct and indirect intergenerational effects on women (Deiter and Holst 1999:65) and is a negative determinant of health for pregnant women and mothers (Moffitt 2004:328) in contemporary society. The direct intergenerational impact of colonization was apparent in my conversation with Lisa. Both of Lisa's parents attended residential school and later suffered with addictions. As a result she and her siblings were apprehended and placed in foster care, where she was sexual abused by her foster-father. Lisa's maternity narrative clearly indicates that she has had to overcome many barriers associated with adverse social determinants, intimate partner violence, postpartum depression, and she has struggled with suicidal ideations.

Susan's mother also attended residential school. Susan's account of her mother's struggles with alcoholism, violence, depression and poverty has affected Susan. She has overcome many barriers and challenges, including intimate partner violence and postpartum depression.

In addition to residential school, Mary explains that both of her partner's parents also attended residential school and as a result of their alcoholism, her partner was placed into a "white foster home." She explains that "he's missing that unconditional love" between parent and child, because he didn't have anyone to take care of him. She said he was periodically homeless throughout his teenage years and struggles with addiction, which consequently affects his parenting and attachment to his children and his relationship with Mary.

Colonization has directly and indirectly affected Indigenous women, mothers, their partners and consequently, their infants. Therefore, particular attention must be given to gender when addressing the historical and ongoing effects of colonization. My research is just a small piece of the colonial puzzle and additional action is required to reconcile our Canadian colonial history (TRC 2012; 2016). In the next section I discus how Indigenous women are reconciling their history to create a better future.

6.4.4 Strength, Persistence and Resilience

Indigenous scholars describe the act of mothering as the first instrument of Indigenous governance and law (Armstrong 1996:ix) and that liberation from addiction, violence, poverty and hopelessness comes from women and mothers who teach that another way is possible (Simpson 2006:30). In this section I emphasize Indigenous women's stories of resilience, persistence and strength. Indigenous women's narratives illuminate their experiences of overcoming adverse circumstances and working to end negative cycles in order to create a better future for themselves and their children. Despite adverse histories of colonization, barriers associated with adverse proximal social determinants of health, stress, and invalidating experiences related to racism, the women's narratives as warrior women are inspirational.

Throughout my literature review and analysis, I struggled trying to balance Indigenous women's adverse experiences and lived realities with strength-based narratives. Dion-Stout and

Kipling (1998:7) caution that, "with surprisingly few exceptions, work dealing with Aboriginal women has tended to be highly problem-focused, and it has pathologized these women's agency and realities." Therefore, it was important to me to include and highlight Indigenous women's strength-based narratives, persistence and resiliency.

The growing literature on historical trauma and Indigenous peoples' resiliency (Fast and Collin-Vézina 2010; Fraser and Richman 2001; Lalonde 2006) demonstrates the historical consequences of colonization, but reiterates the strengths and persistence of Indigenous peoples to overcome adversity. Resiliency is defined as the "capacity to be bent without breaking and the capacity, once bent, to spring back (Vaillant 1993:284). Resiliency is the ability to overcome adversity or having more protective factors than risk factors (Nichol 2000; Richman and Fraser 2001). There are various protective factors according to the Resiliency Initiatives Canada (RIC), including

> internal strengths-personality characteristics or attributes of the individual (e.g., empathy, self-esteem, self-efficacy), and ... external strengths—inter-personal settings or environments (e.g., supportive family, positive peer influence, caring school and community environments) (RIC 2012:ii).

The narratives of my sister-participants illustrate a diversity of internal and external protective factors, as well as a variety of strategies of resilience. Their resilience came their internal strength and from external strengths gained from other women's strengths, from traditional knowledge, values, and cultural practices. Others explained that their resilience was based in their pride and Indigenous identity. Sister-participants, who experienced adversity expressed how their resilience and motivation to create a better future for their children came from their sense that, "enough was enough." It is important to consider resilience from Indigenous perspectives through stories grounded in local culture and language (Kirmayer and Valaskakis

2009), and I would further add, through Indigenous women's and mother's perspectives and stories grounded in experience.

Chapter 7 (Niizhwaaswi): Conclusion

In this dissertation, I began by reviewing the literature on Indigenous maternal and child health in Canada. Research illustrates maternal and child health disparities that are the result of inequities related to proximal, intermediate and distal determinants of health discussed in chapter one. My initial research commenced with disaggregating Indigenous women's (N=410) responses to the Canadian MES (PHAC 2009), which is discussed in chapter three. My MES analysis underlined a number of important findings, including Indigenous women's higher frequency of stressors, violence and postpartum depression. After completing my MES analysis, I was left with additional research questions including why Indigenous women experience higher rates of stress, violence and postpartum depression. In order to understand why, the second part of my research process was to engage Indigenous women in a conversation about their maternity experiences from their point of view. Indigenous women's maternity experiences encompass their histories, social contexts, and stories of mothering and motherhood. My interviews with ten Indigenous mothers in the Okanagan Valley, BC demonstrate how health disparities are not only the result of biology, genetics or individual health behaviours and choices, but are embedded within their complex proximal, intermediate and distal contexts. Chapter five is an overview of my research findings on Indigenous women's narratives related to education, employment, income, housing and experiences of homelessness, as well as stress related to parenting, relationships, violence and postpartum depression. Chapter six highlights the intermediate and distal contexts of Indigenous women's maternal experiences including healthcare experiences and cultural safety, and the historical and intergenerational impacts of colonization. The chapter concludes with Indigenous women's strength based narratives and resiliency as women warriors.

In this chapter, I discuss how my MES research and experiential focused ethnographic research contributes to the literature on Indigenous women's maternity experiences. I then discuss my research limitations, future research directions and conclude the chapter with recommendations.

7.1 Contributions to Maternity Experiences Survey Research

Understanding maternal and child health from the perspectives of Indigenous women is important to understand their health needs, experiences, perceptions and the barriers associated maternal and child health disparities. Indigenous women's perspectives and experiences have been largely ignored and absent within the literature (Valaskakis et al. 2009:1). The majority of research has focused on experiences with mainstream health care services and systems (see Dion-Stout 1996; Stout and Kipling 1999; Hare 2004; Todd-Denis 1996) and there is limited research on Indigenous women's healthcare experiences (Browne et al. 2000; Van Herk et al. 2011) and experiences of maternity care (Sokoloski 1995:91; Watson et al. 2002:155). A large body of literature focuses on rural and remote Indigenous women's maternity experiences of obstetric evacuation and bringing birth closer to home (see Couchie and Sanderson 2007; Kornelson and Grzybowksi 2005; Kornelson et al. 2010; Lawford and Giles 2012; O'Driscoll et al. 2011; Olson and Couchie 2013). In this respect, my doctoral research provides a comprehensive overview of Indigenous women's maternity (prenatal, labour and birth and postpartum) experiences by highlighting the diverse of maternity experiences of First Nation (women living off-reserve only), Métis and Inuit mothers from across Canada. This research is important because Indigenous women's maternity experiences are critical to understanding their reproductive, maternal and pre/perinatal health needs and outcomes in order to inform and improve perinatal policies, programs and services specific for Indigenous women.

Within my analysis, I found that Indigenous women report affirming experiences such as high levels of satisfaction with the care and information received, high rates of prenatal class attendance, and higher rates of breastfeeding initiation and rates following three months postpartum. Indigenous women had lower rates of pubic shaving, episiotomies and perineal stitches, as well as lower rates of induction and speeding up labour, as well as higher rates of unassisted vaginal births and were less likely to be in a supine position or have their legs in stirrups during delivery, which may have contributed to lower C-section rates. However, it is uncertain if lower C-section rates are the result of a lack of access to caesarean birth for mothers who require it.

My analysis underscores a number of invalidating experiences and gaps that are needed to improve Indigenous women's maternal health, maternity experiences and services for mothers and their infants, families, and communities. My research shows that nearly half of Indigenous mothers (and their children) live in poverty, which is linked to food insecurity, social exclusion, insecurity, low self-esteem and feelings of hopelessness, violence, addictions, parenting challenges, and lack of social support. In addition, poverty affects late and/or inadequate use of prenatal healthcare and has direct impacts on maternal and child health outcomes. Indigenous women were three to six times more likely to live in a household of five or more people. First Nation women were four times more likely and Inuit women were twice as likely to report being homeless at some point throughout their pregnancy. This finding raises questions and concerns about overcrowding, homelessness and access to adequate and affordable housing for Indigenous women and their infants and/or children. My research makes a significant contribution towards explaining and drawing attention to the social circumstances and context of Indigenous women's lives including issues of poverty and lower socioeconomic status, as well as contributing factors associated

with adverse social determinants of health. Stress related to adverse social determinants of health is also a concern. My MES analysis demonstrates that Indigenous women experience higher frequency of financial, relationship, emotional and traumatic stressors. However, there is a lack of understanding of Indigenous women's social support utilization, and if psychosocial assessment is part of their prenatal care.

My research also highlights Indigenous women's levels of postpartum depression and younger Indigenous mothers, women aged 15 to 19 years of age were at higher risk. First Nations and Métis women were more likely and Inuit women were less likely to be prescribed antidepressants and be diagnosed with depression prior to becoming pregnant. While this finding suggests that First Nation and Métis women are at higher risk, the lower rates of Inuit prenatal depression and diagnosis contributes to the discussion on the lack of utilization and access to mental health resources and supports. My research highlights the need to identify and support Indigenous women who may be at risk for poor mental health outcomes before, during and following pregnancy and birth.

In addition to adverse social circumstance, and higher frequency of stress and postpartum depression, my analysis provides incontrovertible evidence of the need to address and end violence endured by Indigenous women and mothers. Violence against women and mothers requires immediate preventative action, care and intervention. Lack of research, understanding and support for Indigenous women's experiences of violence urges action on the monitoring and intervention of abuse before, after and during pregnancy, as well as providing cultural safe information and support for Indigenous women, their partners and families need to become more available.

My MES analysis highlights the need for additional public health applications and assessment of reproductive health needs, access to family planning information and birth

control, as well as experiences of and access to abortion. In addition, my research emphasizes the need to address Indigenous women's prenatal health care utilization and needs, as well as multi-vitamin/ folic acid supplement intake and awareness. My research underscores higher rates of maternal smoking and exposure to second-hand smoke environments. As modifiable health behaviours, my research exemplifies the need for public health education, awareness and prevention. An Indigenous women/family/community centered and culturally safe approaches are needed to address maternal smoking and exposure to second hand smoke cessation and reduction, folic acid intake, violence cessation and supporting Indigenous mothers, their infants, children, families and communities.

7.1.1 Limitations of the MES Research

7.1.1.1 Exclusion

The MES excluded First Nation women living on reserve, institutionalized (incarcerated) women and women whose children were not living with them at the time of the survey. The exclusion and the underrepresentation of Indigenous mothers in the MES clearly illustrate the need for additional research that is inclusive and representative of First Nation, Métis and Inuit mother's experiences across Canada. The exclusion of First Nation women living on reserve was the result of jurisdictional debates and divides between status and Inuit women who fall under the mandate of Firth Nation and Inuit Health Branch (FNIHB), and of non-status and Métis women who fall under the mandate of Health Canada and the Public Health Agency of Canada. There are gaps in cross-jurisdictional and cross-cultural research collaboration between and among Indigenous and non-Indigenous organizations, scholars, institutions and government. Jurisdictional debates and processes among all levels of government—federal, provincial, territorial, municipal—and Indigenous governments and institutions have resulted in fragmented

research, services and programming (Health Council of Canada 2011). Through collaborative relationships and cross-cultural, cross-jurisdictional dialogue, community based and participatory action research, research and researchers can ensure the representation of Indigenous women's voice, perspectives and experiences.

Although the exclusion of subpopulations of Indigenous women is due to jurisdiction divides and operational limitations, a critical Indigenous feminist lens demonstrates how the historical exclusion and marginalization of Indigenous women and their perspectives has been the result of mainstream patriarchal (and Euro-Christian) definitions and ideologies of the "good" or "typical" mother. In such an ideology, the "norm" in western society is defined as white, feminine, able bodied, middle-to-upper class, heterosexual, preferably married, women (Anderson 2008:61). First Nation women on reserve, incarcerated, non-biological mothers, and mothers whose children have been apprehended do not fall within the *scope* and mandate, which has led to the exclusion of mothers who do not fit mainstream definitions and ideologies. By challenging mainstream definitions and ideologies, we can expand the scope and inclusion of diverse experiences to better inform public health research which has historically excluded and silenced the voices and experiences of Indigenous women and mothers.

7.1.1.2 Internal and External Validity: Cross-Cultural Maternity Experiences Survey Research

In the MES sampling, Indigenous respondents were not adjusted to address for small sample sizes or for lower than expected response rates. The women received an introductory letter and survey pamphlet prior to participating. Once contacted, each woman had a forty-five minute telephone interview with a Stat Can interviewer, between 23 October 2006 and 31 January 2007 (PHAC 2009). Given the history of colonization and Indigenous peoples' relationship with and distrust of research, this method of data collection may have contributed to

a lower than expected response rate and may also have influenced women's responses. For example, in chapter one, I discuss Indigenous women's fear of accessing maternity services due to their feeling of being judged and their fears of child apprehension. Although participants would be aware of participant confidentiality and anonymity, fear and distrust of Statistics Canada employees may have influenced Indigenous women's responses and willingness to participate. Therefore, it is important to be sensitive to Indigenous peoples' history and experiences of colonialism and to utilize culturally appropriate and relevant research methods.

7.1.1.3 Disaggregated Data

Although it was my intention to disaggregate First Nation, Métis and Inuit women's responses to the MES, the lower than expected response rate and small sample size limited my ability to disaggregate responses because Statistics Canada control rules state that cell sizes less than five cannot be reported on. I was not unable to disaggregate First Nation, Métis and Inuit women's responses for each question, nor could I further disaggregate Indigenous women's responses by province, specifically for results in British Columbia. As my analysis illustrates, Indigenous women's maternity experiences are diverse and are unique to their historical and sociopolitical situation. Not only do their experiences differ from the non-Indigenous population, but also differ among First Nation, Métis and Inuit populations, thus illustrating the need to disaggregate data.

Although the MES is a pan-Canadian representation of women's maternity experiences, a "pan-Indigenous" approach is discouraged (Wilson et al. 2013: S10) given that First Nations, Métis and Inuit women have varying historical, social, political, and economic, health and geographic realities and priorities. Lumping all Indigenous women into a single 'Aboriginal' category does not address

> differences in health determinants and health status outcomes between First Nations, Inuit, and Métis across geographic regions and for First Nations, across Indian Act defined grouping (i.e. registered compared to non-registered). This is linked to different histories, cultures, social and political systems and health service infrastructure depending on the Aboriginal subpopulation. These differences mean that solutions for resolving disparities in health usually should be tailored to meet the needs and structures of a particular First Nations, Inuit or Métis group at the local or small region level. For these reasons, it is very important that health information can be separated out or "disaggregated" in data subsets that are specific to First Nations, Inuit, or Métis subgroups. It is also essential that these "disaggregated" First Nations, Inuit, and Métis datasets are available at different levels of geographic aggregation, so that health stakeholders can access national, provincial/territorial, regional, and community level health data (Smylie 2010:2).

The importance of disaggregating data for subpopulations of Indigenous peoples (Smylie 2010) is important for the identification of issues and priorities within vulnerable populations and to ensure the issues and disparities are addressed within policy, legislation and programming specific to those communities, their needs, priorities and available resources and capacity. By disaggregating the data for Indigenous women's maternity experiences, we can begin to understand the responses that are needed to create effective policies and programs from a culturally congruent point of view (NCCAH 2010). As we move forward, it is important to improve the data collection and analysis of Indigenous women's maternity experiences to allow for governments, organizations, communities, families and women to increase support and capacity building through policies or community specific and relevant pilot programs.

7.1.1.4 Community Relevance

Community/regional relevance involves the inclusion of subgroups in the identification, development and creation of research projects, as well as the collection, analysis and dissemination of research data through knowledge translation initiatives. Not only did the MES exclude subpopulations of Indigenous women from participating in the survey, the survey itself was not inclusive of Indigenous peoples or their perspectives in the identification, development,

creation, collection analysis or dissemination of research findings. The MES design and methods were adapted from similar studies conducted in the United States, Australia, United Kingdom, Scotland and Russia (PHAC 2009:21). In Canada, the MES questionnaire was gathered in 2002-2004 from three urban pilot study sites in Moncton, Vancouver and Yellowknife (Dzakpasu et al. 2005). The survey questions were designed according to Eurocentric experiences of white-middle-upper class urban, married, heterosexual women living with their infants. The survey does not take into consideration the diverse and complex context and experiences of Indigenous women in Canada. Indigenous women's maternity experiences were made to fit into non-Indigenous women's experiences, like trying to "fit a round peg into a square hole" (Edwards 1984:479). This raises question and concerns about the internal validity of the survey questions and whether or not the questions capture Indigenous women's perspectives and the complexity of their experiences.

7.2 Contributions to Maternity Narratives: Experiential Focused Ethnography

Understanding maternal and child health from the perspectives of Indigenous women is important to understand their health needs, experiences, perceptions and the barriers associated maternal and child health disparities (Oster et al. 2014; Whitty-Rogers et al. 2016). Previous research on Indigenous peoples experiences with healthcare and maternity health care emphasizes Indigenous women's voices, perspectives and experiences (Benoit et al. 2003; Browne et al. 2000; Downey and Stout 2011; Varcoe et al. 2013). Building off this research, my sister-participant's experiences echo the importance of addressing socio-political factors and social determinants of health (Browne et al 2000; Varcoe et al. 2013). My research takes into consideration and elaborates on social circumstances by providing a more in-depth exploration of social contexts (Johner 2006). My dissertation draws attention to social circumstances and highlights the need to understand and address poverty, lower socioeconomic status and adverse

social determinants of health and how these affect Indigenous women, their infant and families, as well as how it impacts postpartum depression and levels of maternal stress.

Originating in 1987, the PRAMS is a fourteen item scale developed in the United States and adopted by Canada as a way to identify at-risk mothers and reduce infant mortality and low birth weight by addressing women's need for social support (Gilbert et al. 1999). My qualitative research in chapter five demonstrates how the Pregnancy Risk Assessment and Monitoring System (PRAMS) does not address stressors specific to Indigenous women's contexts. The PRAMS does not include adverse social determinants of health, such as poverty, urban migration and access to safe and affordable housing, food insecurity and single parenting. In addition, the PRAMS does not include stress and experiences related to a history of colonization, residential school, foster care or intergenerational trauma discussed in chapter six. PRAMS is neither inclusive nor comprehensive of stressors experienced by Indigenous women and my research contributes to the assessment needed to inform risk assessment tools. Culturally relevant assessment tools are needed to understand and apply best practices to address Indigenous women's psychosocial stress. I also question the cross-cultural validity of the Edinburg Postnatal Depression Scale (Cox et al. 1987), a ten-item scale that determines vulnerability to PPD. There is no research on the cross-cultural validity of PPD assessment tools, such as the EPDS (Clarke 2008) and as we move forward, it is important to examine assessment tools and determine their applicability to Indigenous health.

My research also contributes to the literature on cultural safety and Indigenous women's invalidating encounters with healthcare, including being dismissed, feelings of being judged based on negative stereotypes, discrimination, racism and healthcare employees disregarding their personal circumstances and situations of vulnerability such as a history of residential school attendance (Browne et al. 2000; Dion Stout 1996; Stout and Kipling 1999; Varcoe et al.

2013). My sister participants expressed fears of accessing healthcare because they feared being judged and labelled as an unfit mother, which contributed to their fears of child apprehension (Denison et al. 2014). As demonstrated in chapter six, my research also contributes to understanding and addressing the historical and ongoing intergenerational effects of racism, sexism and colonialism (Benoit et al. 2003; Bourassa et al. 2015; Varcoe et al. 2013). My research makes significant contribution towards explaining the inter-generational impacts of colonization on maternity experiences, mothering and Indigenous women by including Indigenous women's narratives of residential school, foster care and ongoing impacts of racism.

The majority of maternity experiences research focuses on Indigenous women's experience with mainstream healthcare and there is a need to move beyond healthcare experiences in order to gain a holistic understanding of Indigenous women's maternity experiences as women and mothers. Indigenous women's experiences and perspectives can be understood in the literature on Indigenous women's stories, life stages and self-determination (Anderson 2000, 2011; Anderson and Lawrence 2003; Kelm and Townsend 2006; O'Driscoll et al. 2011; Valaskakis et al. 2006), as well as Indigenous mothering and other mothering spaces (Anderson 2007; Bédard 2006; Lavell-Harvard and Anderson 2014; Lavell-Harvard and Lavell 2006; Simpson 2006; Sunseri 2008). Strong women stories shape and give voice to Indigenous women's identities, histories, and perspective, including Indigenous ideologies of Indigenous mothering. Building on this research, my doctoral work provides a space for Indigenous women's voices and perspectives that moves beyond healthcare experiences by including Indigenous women's narratives of resistance and resilience as women warriors.

7.2.1 Limitation of Ethnographic Research and Thematic Content Analysis

7.2.1.1 Indigenous Health Research

One of the challenges I faced within my dissertation was representing Indigenous women's maternity narratives in a holistic way while trying to balance dissertation page number limitations and issues related to participant confidentiality. All of my sister-participants requested a pseudonym and their names be kept confidential. While I would like to have had limited analysis and written my sister-participant's narratives in their entirety, leaving them whole, some of the narratives would have violated confidentiality by providing in-depth narratives that have identifiable information. Given the sensitivity of my sister-participant's maternity narratives around stressors related to adverse social determinants of health (ie: poverty and not having enough money for food or rent), expressed fears of being labelled a bad mother and child apprehension, and experiences of violence, depression and suicide, I chose thematic content analysis as a way of balancing confidentiality while at the same time creating a space for Indigenous women's voices and experiences. My dissertation is a brief overview of Indigenous women's maternity experiences and by no means does it completely encompass the complexity or entirety of their maternity narratives.

Another limitation in my research is the narrow scope of health and wellness, and can be viewed as individualistic. Within Indigenous epistemologies, health is "not merely the absence of illness or disease, nor is it a set of statistics or measurement. Health is understood to be the physical, spiritual, mental, economic, environmental, social and cultural wellness of the individual, family and community" (BC Ministry of Health 2002: 10). Indigenous epistemologies of health and well-being are holistic (Douglas 2013:23) and based on the interconnected relationships between the physical, emotional, mental and spiritual wellbeing of the individual, family, community and Nation (Dumont 1993; NAHO 2015; NCCAH 2013). By

no means does this fully capture the diversity of Indigenous health epistemologies or suggest that all Indigenous people have the same or similar beliefs. However, a limitation of both the MES survey and my ethnographic research is that it was individualistic and focused primarily on social and physical health, and did not encapsulate the spiritual, mental and cultural health and wellness, definitions or include the perspectives of birth partners, families, communities and Nations.

7.2.1.2 Interpretation, Scope & Generalizability

As in any qualitative study, my research limitations are related to interpretation, scope and generalizability. My research does not objectify and describe Indigenous women's realities; rather it is an interpretation (e.g. Geertz 1973; Valeri and Keesing 1987:355). My thematic content analysis and organization is based on themes from my own subjective interpretation and is not a firm and steady truth about Indigenous women's maternity experiences or their lived realities (Denzin et al. 2008). Although I collaborated with my participants throughout the interviews, I did not collaborate in the interpretation, analysis and write-up of my research findings. This is a limitation of my research, whereby I situated myself, as an Indigenous feminist researcher yet, did not include my sister-participants throughout the entire research process.

Although the interviews provided a thick and rich description related to the context of Indigenous women's maternity experiences, the ten interviews are not representative of First Nation, Métis and Inuit women or their experiences. Given the heterogeneity of Indigenous peoples in British Columbia and Canada, my small sample size (N=10) is neither numerically nor qualitatively representative. Therefore, my finding cannot be generalized to Indigenous populations or subgroups of First Nation, Métis, and Inuit women who reside on or off reserve or in rural, remote or urban areas.

7.2.1.3 Recall

Another limitation to my research is recall issues. Studies have suggested that women's recall of some pregnancy and birth events, and their evaluation of maternity care, may change over time. Therefore, it is possible that for some questions, the accuracy of women's recall and their perception of past events may have been influenced by the timing of the interviews, which ranged between five and 18 months postpartum. The varied timing of the interview also means that information on issues may have been unavailable for women who were interviewed later compared with those interviewed earlier.

7.2.1.4 Focused on Mothers

Another limitation is that my research focused on the health and wellbeing of mothers and was not inclusive of birth partners and fathers. In Indigenous cultures, it is said "the eagle flies with a female wing and a male wing, showing the importance of balance between the feminine and the masculine in the human condition" (Valaskakis et al. 2009:9). In comparison to Indigenous women's maternal child health research, there is a lack of theoretical and applied scholarly work about Indigenous men and masculinities (Innes and Anderson 2015; men are also adversely by the impact of colonialism and the residential school system which finds expression in health disparities, social determinants of health and men's experiences of violence and their higher rates of incarceration. A more balanced perspective and approach is needed to account for how gender and race intersect and impact Indigenous men, including their masculinity and masculine gender roles, such as husbands, fathers, birth partners, providers and protectors who 'help carry their families.

7.3 Future Research Directions

7.3.1 Indigenous Women's Maternity Experiences Research

Previous research, such as the MES, has excluded First Nation women on reserve and is non-representative of Indigenous women's maternity experiences and context. There is a need to indigenize health research and "health and social policy, need to be 'indigenized' so that both are truly reflective of Aboriginal women's lives and grounded in their personal experiences and life challenges (Dion-Stout et al. 2001:30). Additional research is needed to inform the creation of a maternity experiences survey that encompasses Indigenous women's voices, perspectives, experiences and contexts. Like the development of the National Longitudinal Aboriginal Health Survey (O'Neil et al. 1998), additional cross-cultural survey research collaboration and Indigenous community pilot sites can help inform a more culturally relevant maternity experiences survey. By engaging regional steering committees, Indigenous maternal child health researchers, and Indigenous women's organizations, a set of core and adaptive maternity experiences questions could potentially "produce information that would be both trustworthy at the community level and credible to government officials" (Trostle 2005:158). Through collaborative and community based research, an Indigenous maternity experiences survey can help inform more social and culturally relevant interventions, preventions and supports aimed at addressing and alleviating Indigenous maternal child health disparities and inequities.

It is my goal to foster research relationships with various Indigenous health researchers and build collaborative research with the First Nations Health Authority and regional First Nation health directors, Métis Nation BC and the BC Native Women's Association to create and pilot an Indigenous Maternity Experiences Survey (IMES). In addition to the survey research, additional follow up qualitative research is needed to contextualize Indigenous women's maternity experiences, maternal health pathways and Indigenous mothering epistemologies.

7.3.2 Indigenous Women's Maternal Health Research

Based on key findings from my dissertation, further research is needed to examine and addresses Indigenous women's pre- and postpartum depression, violence and stress associated with adverse social determinants of health. My findings from the MES analysis also illustrate the need for additional research to address Indigenous women's folic acid intake and awareness and women's higher rates of smoking while pregnant and their exposure to second hand smoke.

7.3.3 Indigenous Women's Experiences of Intimate-Partner Violence Before, During and After Pregnancy

There is a crucial need to examine, challenge and eliminate the ongoing effects of negative stereotypes, prejudice, discrimination, racism and sexism against Indigenous women. My research on Indigenous women's experiences of violence prior to, during and following pregnancy illustrates the emerging need to address the historical, systemic and ongoing violence against Indigenous women. This is further echoed in the report *Stolen Sisters: A Human Rights response to the Discrimination and Violence against Indigenous Women in Canada* (Amnesty International Canada 2004). On 8 December 2015, the Government of Canada announced that it would invest $40 million during 2016-2017 toward a national Inquiry on Missing and Murdered Indigenous Women. There is a need for research and a national dialogue because "it is up to everyone to put an end to violence and work together to ensure Canada is a safe place for Indigenous women and girls (Lavell-Harvard and Brant 2016: 12).

7.3.4 Indigenous Men, Masculinity and Fathering

Previous maternal child health and maternity experiences focuses on women and mothers. There is a gap in the literature on Indigenous men, masculinity and Indigenous birth partner experiences. It can be said that the current maternity experiences research marginalizes and

silences men's voices and experiences. Additional research is needed to include the voices and perspectives of Indigenous men as birth partners, as well as the role of masculinity and ideologies of Indigenous fathering. Perhaps exploring Indigenous men's perspectives, masculinity, gender roles and the impact of colonization on men's paternity experiences can give us insight into understanding, addressing and alleviating intimate partner-violence, lone parent families and improving maternity experiences, parenting, and relationship supports for Indigenous men as birth partners.

7.3.5 Indigenous Peoples Health Indicators and Assessment Tools

There is a need to examine medical and clinical assessment tools that fail to identify and recognize colonization, ongoing colonizing practices, and multigenerational trauma as legitimate traumatic events or effects (Bombay et al. 2014; Evans-Campbell 2008). As discussed above, PRAMS is a 14 item scale developed in the United States and adopted by Canada as a way to identify at-risk mothers and reduce infant mortality and low birth weight by addressing women's need for social support (Gilbert et al. 1999). My qualitative research in chapter five demonstrates how PRAMS does not include stressors specific Indigenous women and their adverse social determinants of health, such as poverty, urban migration and housing, food insecurity and single parenting. In addition, PRAMS does not include stress related to a history of colonization, residential school, foster care or intergenerational trauma as I discussed in chapter six. Research is needed to assess and inform risk assessment tools and additional research is needed to determine if Indigenous women are receiving psychosocial assessment as part of their prenatal care.

7.4 Recommendations

7.4.1 Reconciliation

As we move forward, there is a need to build anti-racism and understanding within mainstream Canadian society that challenges misconceptions, prejudices, discrimination and racism. As a society we need to build compassion, respect and understanding for Indigenous peoples and reconcile our colonial history (Maclean's 2016; Young-Ing et al. 2009). Experiences of racism, feeling judged, and being put down can adversely affect Indigenous peoples.

> I've been down and out in my life and been put down [endured an abusive relationships and ongoing racism] and that can be the last thing you say to somebody [she is elaborating on her experiences of being called names such as drunken Indian or easy squaw] can be the last nail in the coffin and they could end their life [commit suicide] and I've been to that point. All these people [Canadian society] need to have respect for [Indigenous] people. The drunks and the drug abusers they all have feelings. They're all going through something in their life. Never, ever, put them down. Never, ever, judge them. Because I've been that person and I know what it's liked to be judged.

7.4.2 Address Indigenous Maternal and Child Health Disparities

In chapter one, the literature reveals the current state of Indigenous maternal and child health. The research available illustrates the gaps in Indigenous health research. Therefore, one recommendation is to improve maternal and child health information. There is a need to identify and alleviate health disparities such as higher rates of perinatal and infant mortality, and adverse maternal health indicators such as higher rates of gestational diabetes mellitus for pregnant mothers. My research also highlights the need for support maternal smoking cessation and reduction, and increase the number of smoke free homes to improve maternal and child health, improve folic acid intake and awareness, and address Indigenous women's maternal stress, adverse social determinants of health, as well as higher rates of violence and postpartum depression. My recommendations are echoed in the TRC Calls to Action report (TRC 2015).

> We call upon the federal government, [and the larger Canadian society; Indigenous and non-Indigenous peoples alike] in consultation with Aboriginal peoples to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities, and to publish annual progress reports and assess long-term trends. Such efforts would focus on indicators such as: infant mortality, maternal health, suicide, mental health, addiction, life expectancy, birth rates, infant and child health issues, chronic disease, illness and injury incidence, and the availability of appropriate health services (TRC 2016: 2)

7.4.3 Alleviate Social Determinants of Health for Indigenous Women

In order to address maternal and child health disparities, my research emphasizes that particular attention must be given to the unique and complex contexts of Indigenous women's maternity experiences that are embedded within the proximal, intermediate and distal determinants of health (NWAC 2007; Smylie 2009). Indigenous mother's maternity narratives illustrate that they face barriers to education, employment and income, food security and issues related to housing and homelessness. Therefore, there is a need to address Indigenous health disparities by addressing socio-economic inequities. On 21 March 2016, the ministry of Indigenous and Northern Affairs Canada announced an investment of $8.4 billion from 2016-2021, to

> improve the socio-economic conditions of Indigenous peoples, their communities and bring about transformational change. The proposed investments in education, infrastructure, training and other programs will directly contribute to a better quality of life for Indigenous peoples and stronger, more unified, and prosperous Canada (INAC 2016).

While the funding commitment is a step in the right direction to improve the quality of life for Indigenous peoples, my research demonstrates that Indigenous women face unique barriers that are the result of historical racism, sexism and colonialism. Particular attention must be given to the unique experiences, barriers and needs of Indigenous women and mothers. For example, Indigenous women's narratives in chapter six illustrate the direct and indirect results of residential school and foster care that are the direct consequence of colonization.

> We call upon the federal, provincial, territorial, and Aboriginal government [and the larger Canadian society; Indigenous and non-Indigenous peoples alike] to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential school, and to recognize and implement health-care rights of Aboriginal people as identified in international law, constitution law, and under the Treaties (TRC 2016:2).

7.4.4 Disctinct Health Needs

In the MES, jurisdictional disputes and divides between the First Nations and Inuit Health Branch and the Public Health Agency of Canada and Statistics Canada led to the exclusion of subpopulations of Indigenous women, including First Nations women residing on reserve. There is a need to be inclusive and respectful of First Nation, Métis and Inuit women who reside on and off-reserve, in rural, remote and urban areas (NAFC 2010)..

> In order to address the jurisdictional disputes concerning Aboriginal people who do not reside on reserve, we call upon the federal government [and the larger Canadian society; Indigenous and non-Indigenous peoples alike] to recognize, respect, and address the distinct health needs of the Métis, Inuit, and off-reserve Aboriginal peoples (TRC 2016: 2).

7.4.5 Cultural Safety

In chapter six, I discuss Indigenous women's affirmative and destructive experiences with mainstream healthcare. While most experiences were positive, additional attention must be paid to cultural safety, intercultural competence, conflict resolution and incorporating Indigenous peoples health perspectives in curriculum through culture-based literacy (Smylie et al. 2006).

> We call upon all levels of government [and the larger Canadian society; Indigenous and non-Indigenous peoples alike] to:
> i. Increase the number of Aboriginal professionals working in the health-care field.
> ii. Ensure the retention of Aboriginal health-care providers in Aboriginal communities.
> iii. Provide culturally competent training for all health-care professionals.
>
> 24. We call upon all medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the

> history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal right, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights and anti-racism (TRC 2016:3).

7.4.6 Support and Resources

Not every mother has knowledge or access to programming and community services and there is a need to explore models of quality care for Indigenous women (NAHO 2006; Smith et al. 2007). One recommendation Mary made here is to increase programming and awareness of available programs and services, as well as address barriers such as lack of transportation.

> I think more programs. There has to be more programs in this area. In prenatal help there isn't enough and there's a lot of moms. They need to access these programs. I don't know if it's because of lack of transportation or the timing and I think that there needs to be more culturally safe programs such as healthy eating programs. Learning about birth and birth plans, as well as access to doulas and midwives and all these other options out there (Mary).

In addition to expanding parental care and programming, there is a need to alleviate financial barriers such as costs associated with prenatal classes and providing free meals and childcare.

> Moms just need a place where they can have a good lunch. Some of them just need a healthy meal and somewhere where they feel comfortable with childcare. The Friendship Centers have a little bit of prenatal there. Métis society has none. Bridges does one every Thursday in Kelowna—that's a non-profit non-native program. But there's a need to provide a free prenatal program. When I was trying to access, it was like $150. It was too expensive so I didn't go. So now it's free, thank goodness (Mary).

Another recommendation is to support women through outreach programs and in-home visits, such as an "aunties" program. Lisa, Susan, Donna and Michelle recommended this:

> I would like to see like an aunties program for someone to come drop in and see how I'm doing. A lot of our services we have to go there and it's difficult. We need more outreach (Lisa).

One sister participant pointed out that programming needs to extend beyond the individual and include families and partners.

> I think families need to be educated too [on postpartum depression and how to support mothers] so they can help. I think there needs to be programs for families, not just women. Family programs for everybody and not just individually (Karen).

Other recommendations centred on supports for men. In addition to an aunties program and mentorship program for women, one sister participant stated that there also "needs to be an 'uncles' program for Native men and programs for single moms and dads. There is a need to include Indigenous women's partners and men's maternity and paternity experiences that address the maternity and parenting needs for men, such as issues related to anger and violence.

> We went to the prenatal program and it centred on me and having the baby, which was good 'cause he got to know about the process. But afterwards, it's mostly women at the mom's programs. I guess 'cause they're home with the baby. But where do men learn parenting skills? Where do men go to talk about dealing with their anger and violence and all that stuff? (Mary).

As Susan related: "I totally believe native men need so much more support. They have their struggles too. Just like me, but I think our native … they need it just as much, if not more, because they need help to carry their family." One of the women stated that there is a gap in support and programming for children over age six and there is a need to support mothers with teen children and provide programming for teens.

> There are a lot of family programs out there for moms and babies and kids up to six, but we also have our other kids over age six and teens who need support too. There's nothing for them (Lisa).

7.4.7 Intergenerational Trauma Resources

In chapter six, I discussed the distal context of colonization and the impacts of residential school and foster care. When speaking to my sister participants about violence, depression and intergenerational experiences of trauma and residential school or foster care, they indicated that they would like to see more counselling and therapy aimed at addressing

intergenerational trauma. Previous research has demonstrated the importance of culturally appropriate counselling (McCormick 1995).

> We call upon the federal government [and the larger Canadian society; Indigenous and non-Indigenous peoples alike to make a commitment] to provide sustainable funding for existing and new Aboriginal healing centers to address the physical, mental, emotional, and spiritual harms caused by residential schools, and to ensure that the funding of healing centers in Nunavut and the Northwest Territory is a priority (TRC 2015:3).

Lisa recommends that,

> we need to have some kind of safe place to talk so that you can address it [residential school and history of violence]. I think there needs to be more counselling and treatment, whether it is connected to culture or not. Because it [the cycle of poor health and violence] has to stop somewhere.

This was also reiterated by Patricia, who said:

> I would like see more therapists, people who have the skills to deal with important issues and who know about some of our history [residential school, the 60's scoop and foster care].

7.5 Conclusion

I began my journey with the story of Sky Woman. Her story teaches us the power, roles and responsibilities women have as mothers of the Nations, sisters of the land and daughters of Sky Woman. In the story, Sky Woman loses her balance and falls through a dark hole, which leads to her, decent to earth. While on turtle's back, she faces a number of challenges and obstacles including being pregnant, alone and afraid. However, she is resilient. She teaches us how to transform distortion and corruption, adversity and suffering into healing and reconciliation. Sky Woman reminds us of our identities as great-granddaughters and that we all connected, we all have a history, a family, and a place where we all belong. "We are her and she is us" (Horn Miller 2016: 32).

Despite maternal and child health disparities and socio-economic inequities, adversity,

challenges and obstacles, Indigenous women continue to persevere to birth, raise and nurture the next generation. As we move forward, it will be these warrior women who continue to resist and persist, challenge and change, transform and create a better future for our children today and the following seven generations.

7.5.1 Epilogue

As I reflect on my dissertation journey, it is difficult to describe where and who I was in May 2010 and the transformation that unfolded throughout the seven years of my graduate degree. My journey into Indigenous peoples' health research has been a life changing ceremony (Wilson 2008: 61). It has been a process of conscientization, decolonization and transformation, peeling layers of awareness, sparking resistance, struggle, critical action, transformation, as well as reclaiming my voice and vision (Smith 2000).

I have struggled trying to create and maintain *gwayahkooshkaywi*n, a balance between the many tensions I encountered throughout my academic journey. It has been a difficult process trying to balance my lived experience as an Indigenous woman with the objective academic, particularly because the statistics and data presented and discussed herein are not merely faceless numbers; they represent my family, my history. The theory is not based in hypotheses and the methods are not just instructions; rather, they are embodied. Conducting Indigenous health research is not to observe or write about 'the other,' but has been a journey into the hearts, minds, homes and histories of my family, my community and my own lived experiences. I have and suspect I will continue to walk a fine line between two worlds, searching for *gwayahkooshgawin*, 'balance' between and among disciplines; the tensions between Indigenous and Western methodology; being grounded in community while walking the halls of the academy; being a mother and an academic; researching and writing while living the realities. But perhaps the larger and ongoing challenge to creating and maintaining a balance within my

own life comes from peeling the layers of our colonial history, finding and using my voice by no longer sitting on my hands.

7.5.1.1 Who's gonna listen to us? We're just a bunch of Indians.

When I began my graduate degree in 2010, the first question I asked myself and my mother was: why don't we speak Saulteaux like Nanny (Eva Chartrand) and her siblings? My mother responded that we didn't need our language anymore and that the Catholic nuns told Nanny not to teach it to her children because they (my mother Patty, her sister Shirley and brother Kenneth) would be better off. In an attempt to learn Saulteaux I began a journey to learn as much as I could. In 2012, I went with my mother and my family to Duck Bay, Pine Creek and Camperville, Manitoba. While it was my intention to research my family genealogy and learn as much of the language as I could from my aunts and uncles speaking, I was unprepared for the history that unfolded. I learned that my grandmother, Eva Cecile Chartrand attended Christ the King Catholic School, a day/residential school taught by nuns and priests at Our Lady of Seven Sorrows Roman Catholic Church in Camperville Manitoba. Although I am uncertain of the details of my grandmother's experience because she died in 1995, I have been told that she experienced immense trauma. In addition to her unresolved trauma, violent relationships, undiagnosed and untreated mental health conditions(s) and addictions, she died from stomach cancer at the age of 63. My mother also experienced childhood trauma and as a result of her undiagnosed/untreated mental health conditions(s) and addictions, she died from a massive heart attack at the age of 59 on 21 May 2013.

As I returned to my history and roots, did I then understand the intergenerational impacts of colonization. The intergenerational impacts of colonization can best be understood through visual anthropology and photography as a research method (Collier 1967). Illustration 7.1 below is my grandmother's class photo at Christ the King Residential/Day School in Camperville,

Manitoba (approximately 1940). Illustration 7.2 below is my mother sitting in the basement of Our Lady of Seven Sorrows Church, Camperville Manitoba, August 2013.

Illustration 7.1 Christ the King Catholic (Day and Residential) School class photo circa approximately 1940, Camperville Manitoba. Photo Credit: Confidential. Shared August 2013.

Illustration 7.2 Patricia Valerie Marie (Fagnant) Leason sitting in the basement of Our Lady of Seven Sorrows Roman Catholic Church, Camperville Manitoba. Photo Credit: © Jennifer Leason, August 2013.

The remarkable thing about the two photos is that the students in the first photo are sitting on their hands with the Nun/Sister standing in the background. In the 2013 photo my mother, nearly 75 years later, is also sitting on her hands with the priest in the background. The intergenerational impacts of colonization and residential schools created generations of Indigenous people who feel they must sit on their hands, be quiet, do what they are told, do not question authority and accept what they are given, even if is it unfair, inequitable and unjust because the consequences of retaliation would far outreach the benefits. My grandmother and mother lived in a time where society devalued Indigenous people, particularly Indigenous women who thus did not have a voice. No one listened to, believed, or trusted an Indian, especially an Indian woman.

What cannot be seen in the 2013 photo is that my mother is crying, because it was the first time she had seen her parent's original signatures from their wedding day and we were not allowed to scan our family archives because the files are sacred and confidential documents of the church. While my mother sat on her hands crying, I continued to press for permission to scan our family archives. Although I was not given permission, I continued to search for our family genealogy. Later, I wrote in my journal:

> I'll never forget that day, sitting in the church basement while the names of the people we loved were displayed upon the pages. People I had never met or briefly knew; but who you knew well. You sat there, shoulders shrunken with tears rolling down your cheek. I was angry at how upset you were. I was angry while you sat there and did nothing. I was angry that you said nothing. I was angry at you and more so at the priest- you can't tell me no! You don't own our history and who are you to tell me I can't have access to those records! As we headed up the stairs, I held your hand and said 'don't worry mom, we'll get a copy.' And I'll never forget what you said to me. You said: 'who's gonna listen to us? We're just a bunch of Indians.' You were defeated before we even started. Your legs hurt. Dad held you up because you could barely walk the cemetery boundary as I mapped out our ancestors and found your dad's unmarked grave. Why was there no record of where they were buried? Why were they forgotten? Why were you silent? (Personal Journal, 18 July 2012).

The two photos, as well as my mother's body language, her tears and her comment about who is going to listen to a bunch of Indians are the embodiment of social injustices and the imbalances of colonial and patriarchal power, as well as the epistemic, structural, relational, institutional and internalized racism and oppression. I struggle to try to make sense of colonization and assimilation and how it has impacted my family as well as other Indigenous Canadians, particularly Indigenous women. I struggle with feelings of anger and despair, trying to understand my mother and grandmother even now that they are both gone. Although I cannot speak for them and can only interpret their experiences to the best of my ability, it is my opinion that the photos illustrate two generations of women who felt hopelessness, helplessness and disempowered. They had no voice and no one to listen.

When I reflect on my mother's words in my journal entry, I am reminded of the purpose and power of my dissertation. Although I may not have captured the entirety of the complexity of Indigenous women's maternity experiences and may have distorted their words and experiences in my interpretation, my dissertation provided a space for Indigenous women's voices through sharing their stories and experiences. Providing a space and an opportunity for women to share and to talk about their maternity experiences is an act of empowerment whereby women can validate their experiences and empower other women to do the same. Sharing stories and experiences breaks the cycles of silence and feeling alone, and as Lisa said:

> It's going to be healing for me… I just get to talk about my pregnancy. I didn't really get to talk about it [before this interview] because I did so much of it on my own. Research is healing. If it helps other moms, then it's totally worth it. Experiences, pregnancy, and after—thinking I'm not the only one who's been through it—if my story can teach someone else to keep going, then that's what it's for. Be an example. You don't have to teach, just be, that's how you'll help, just by being (Lisa 2015).

My research has been a healing journey and perhaps my greatest gift was just by being. In response to my mother's question: "who's going to listen to us? We're just a bunch of

Indians," my reply is: I listened, I am listening, and I will continue to listen. I will not be defeated or allow your voices and mine to be shadowed in the darkness of silenced. Your experiences will not be forgotten. Following Mary-Ellen Kelm, I will try my best to

> be faithful to the stories told to me, and I offer them back to the communities who provide me with their intellectual sustenance. I do not pretend this is the final word on the subject; there is much that has eluded my scholarly gaze. But it is a step in the transformative process of decolonizing our history, a start towards undoing the colonial legacies that still characterize the relationships between Native and non-Native people in this country. Too often, researchers have heard these stories without listening, listened without acting, acted without listening again. It is time to break that cycle (Kelm 1998: xxiii).

My doctoral dissertation has been a journey into the intergenerational decolonization of the mind and breaking the cycles of silence. My dissertation has been a process of finding and expressing my own voice, as well as listening to and advancing the experiences and voices of other Indigenous women and mothers. As I move forward, I am optimistic about the intergenerational transformation and the upcoming generations that no longer sit on their hands but join hands to work together to improve Indigenous peoples' health.

But perhaps the larger piece of my life, my hope and optimism, as well as the larger transformation and inspiration comes from being an Indigenous mother. The greatest gifts I have received are my two beautiful children, Lucas and Lucy (aka Jackson). I was pregnant with Lucas when I was accepted into graduate school and gave birth to Lucy during the second year of my Ph.D. My children have taught me the importance of life, *gwayahkooshgawin*, and that another way is possible. My hope is that my children as well as all children throughout the next seven generations stand proud and continue to fight the injustices and disparities that remain. I hope that we reconcile our differences, join hands, hearts and minds and create a society that lives in *gwaahkyooshgawin*. This is not to say it will be easy. Remember that "Creator gave us

something extra and when we need an extra bit, we can dig deep and we know it's there. Don't give up!" (Susan 2015). Just keep going.

7.5.2 In Closing

In closing and keeping with tradition, I would like to honour all those I had the privilege to meet and learn from, especially my sister-participants, whose courage has motivated me to become part of the larger dialogue and solution in Indigenous maternal and child health. I am grateful to all my teachers: young and old, past, present and future who have taught me the importance of honouring each individual's and each community's journey. I am further inspired by the dedication and commitment of all the "warriors," the women, families, communities, Nations, scholars and caring professionals who continue to fight for the improved health and wellbeing of Indigenous peoples all over the world.

Miigwech!

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Appendices

Appendix A Socio-Economic Indicators for Indigenous Peoples in Canada.

Table 10.1 Comparison of Socio-Economic Indicators for Aboriginal (First Nation, Métis and Inuit) and Non-Aboriginal peoples in Canada, 2001-2008.

Socio-Economic Indicators	Aboriginal	First Nation	Métis	Inuit	Non-Aboriginal
Education (StatCan 2001) %					
Less than highschool	48	50.6	42.2	57.7	30.1
Highschool graduate	9.9	9.0	11.9	6.2	14.2
Some post-econdary	12.6	12.7	12.4	12.8	10.8
Trades certificate/diploma	12.1	11.5	13.6	11.1	10.8
College certificate/diploma	11.6	10.7	13.4	9.5	15.1
University certificate (below bachelor)	1.4	1.4	1.4	0.8	2.6
Bachelors degree	3.4	3.2	4.0	1.6	10.8
Univeristy certificate above bachelors	0.4	0.4	0.5	0.1	1.6
Masters	0.5	0.5	0.7	0.2	2.8
Doctorate	0.1	0.1	0.1	0.04	0.6
Employment (StatCan 2001)					
Age 15 and over					
Participation Rate	61.4%	57.3%	69.1%	62.5%	66.5%
Employment Rate	48.6%	59.4%	44.6%	49.7%	61.8%
Unemployment rate	22.2%	14%	22.2%	19.1%	7.1%
Income (StatCan 2001)					
Avg full time employment income ($)	36,152	34,778	32,176	33,416	43,486
Avg part time employment income ($)	12,866	15,386	12,837	13,795	19,383
Government transfers as income (%)	20.3	15.7	24.3	20.8	11.5
Median (total)	13,699	16,342	12,263	13,525	22,431
Incidence low income in families (%)	21.9	24.5	37.3	31.2	12.4
Incidence low income individuals (%)	56.8	51.7	59.8	55.9	37.6
Child Poverty (Anderson 2003)	52.1%				23.4%
Housing (STATCAN 2008)					
Living in crowded dwellings		15%	3%	31%	3%
Dwelling in need of major repair		28%	14%	28%	7%
Homelessness					
Nutrition %					
Food Insecurity	27%				10%
Compromised Diet	24%				8%
(Che and Chen, 2001: 143)					
Residential School Attendance		On reserve:	Off reserve	Off-	
Off reserve (STATCAN 2003)		20.3%	2.5%	reserve	
On reserve (FNC 2005)		Off Reserve: 8.4%		13%	

Appendix B Call for Participation

a place of mind
THE UNIVERSITY OF BRITISH COLUMBIA

EXPLORING ABORIGINAL WOMEN'S MATERNITY EXPERIENCES IN THE OKANAGAN, BC.

A research project

The purpose of this doctoral research project is to gain an understanding of Aboriginal women's maternity experiences. By sharing your experience, you can help guide the identification of key issues, needs, gaps and priorities pertaining to Aboriginal women's maternal health.

If you self identify as an Aborginal (First Nation, Métis or Inuit) woman, are you pregnant or have you given birth between January 2012 and October 2014 and you are 16 years of age or older, would you like to participate in the project by sharing your maternity experiences with me?

If so, you are invited to participate in a one-on-one interview for about two to four hours to share your maternity experiences. The interview will include your experiences during the prenatal, labour and birth and the 6 months after you gave birth. All interviews and conversations with me are strictly confidential and you will not be identified by name in the notes, summary and/or thesis unless you direct otherwise.

You will receive $50 honorarium for your time, travel and associated daycare costs.

If you are interested in participating or wish to find out more about this research project (including a list of interview questions), please contact:

JENNIFER LEASON, PhD candidate
Email: jennifer.leason@ubc.ca

Appendix C Letter of Initial Contact

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EXPLORING ABORIGINAL WOMEN'S MATERNITY EXPERIENCES IN THE OKANAGAN, BC.
A research project

Thank you for contacting me and expressing your interest in participating in the Aboriginal Women's Maternity Experiences research project. Your participation is greatly appreciated and by sharing your experience, you can help guide the identification of key issues, needs, gaps and priorities pertaining to Aboriginal women's maternal health.

I would like to introduce myself. My name is Jennifer Leason and I self-identify as a Saulteaux-Métis Anishinabe kwe and my Indigenous roots originate from Duck Bay, Pine Creek First Nation and Camperville Manitoba. I now reside in Vernon with my two sons Lucas (age 5) and Jackson (age 2 ½). As an Indigenous woman, mother, daughter, sister, aunt, friend and scholar- I am interested in understanding Aboriginal women's maternity experiences and addressing any barriers that impede Aboriginal women (their children, families and communitites) from obtaining their full health potential.

You are invited to participate in a one-on-one interview which will last aproximately two to four hours (over one or two separate interview dates) to share your maternity experiences during your prenatal period (while you were pregnant), labour and birth and the 6 months after you gave birth, as well as questions pertaining to stress and post-partum depression. All interviews and conversations with me are confidential and you will not be identified by name in the notes, summary and/or thesis unless you direct otherwise. You are under no obligation to participate and you may withdraw your participation at any time.

We will now arrange a date, time and location to meet within the next week.
When we meet, you will be asked to sign a letter of consent that gives your free and informed consent on the benefits and risks of the study prior to the interview.
The initial interview will take place and may be 2-4 hours (maximum 4 hours). After 2 hours, I will ask if you would like to continue or we can reschedule for a second interview date. You will receive $50 honorarium for your total time. Should you require additional support for daycare or travel cost, please contact me to make arrangements.
After I interview 10 women, I will analyze my data and write up my findings. I will present my findings back to you and ask for your feedback, insight, edits or omissions (which is optional).
Upon completion of my PhD dissertation, I will provide you and the supporting community organizations a summary of my findings, and if you are interested then I will provide you with a copy of my dissertation.
The findings of this research may be used in knowledge translation activities such as papers, conference presentations and community presentations. If at any time you have any questions, comments or concerns please do not hesitate to contact me at any time. I look forward to meeting with you and sharing in your maternity journey.

JENNIFER LEASON, PhD candidate, UBC Okanagan Email: jennifer.leason@ubc.ca

Appendix D Research Consent Form

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Title of Project: **EXPLORING ABORIGINAL WOMEN'S MATERNITY EXPERIENCES IN THE OKANAGAN, BC.**

Principal Investigator*:*

Naomi McPherson, PhD Professor Emerita, Cultural Anthropology Rm 270, Community, Culture and Global Studies, UBC Okanagan, 3333 University Dr, Kelowna BC V12V 1V7 Email: Naomi.mcpherson@ubc.ca	**Jennifer Leason,** PhD Candidate Interdisciplinary Graduate Studies, College of Graduate Studies, UBC Okanagan Email: jenniferleason@ubc.ca

Purpose:
The purpose of this project is to gain an understanding of Aboriginal women's maternity experiences during the prenatal, labour/birth and 6 months postpartum periods.
By sharing your experience, you will help:

- Identify key issues, needs and priorities pertaining to Aboriginal women's maternal health,
- Identify gaps and/or areas of improvement for Aboriginal mothers and,
- Inform support and/or prevention/intervention initiatives.

Procedures:
I will conduct a 2-4 hour interview with you at a location of your choosing. The interview will include 24 open-ended questions on your experiences during the prenatal, labour/birth and 6 months postpartum period, as well as questions pertaining to stress, postpartum depression and mothering. If you are in agreement, the interview will be audio-recorded and the recording will be transcribed into notes. If you prefer not to have your interview audio-recorded, I will attempt to keep detailed field notes.
Project outcomes:
A copy of the research analysis and findings will be shared with you to provide additional feedback, clarity and/or removal of anything you do not wish to include in the dissemination. A copy of the research analysis and findings (with all identifiers removed) will also be shared with the other participants, organizations and stakeholders to support their initiatives pertaining to Aboriginal women's maternal health.
The research findings will be disseminated in my PhD dissertation. Following the completion of my PhD programme, I intend to pursue publication of my findings in relevant journals and present findings at local, regional, provincial, national and international conferences.
Potential risks:

There are no anticipated risks to participating in this project. However, some of the questions asked are sensitive or personal. Some of the questions include sharing your experiences (positive and negative), life circumstances and barriers. These questions may or may not bring about negative feelings, emotions and relived negative experiences. Should you feel uncomfortable at any time, please know that you do not have to answer any question if you do not want to answer and your input does not need to be included in the summaries and/or dissertation if you so choose. You can withdraw your participation and/or input at any time. I have attached a list of community supports and resources that you may access for additional support if needed.

Potential Benefits:

Your participation will provide insight and understanding into Aboriginal women's maternity experiences and the areas that require focus for improvement (priority). Your participation will provide an important learning experience for myself as an Aboriginal woman, mother and scholar.

Confidentiality:

Your confidentiality will be respected. You will not be identified by name in the notes, summary and/or thesis unless directed otherwise. If you would like to share your name, rather than a pseudonym, please indicate your consent at the bottom of the consent form. Otherwise, participants will not be identified by name in any summaries, papers, and/or thesis prepared by the student to meet PhD requirements.

All documents, transcriptions, field notes and audio recordings will be kept in a secure, locked location accessible only to my supervisor, Professor McPherson and myself.

Contact for concerns about the rights of research subjects:

If you have any complaints about your treatment or rights as a research subject, you may contact the Research Subject Information Line in the UBC Office of Research Services at 1-877-822-8598 or the UBC Okanagan Research Services Office at 250-807-8832.

Consent:

Taking part in this study is entirely up to you. You have the right to refuse to participate in this study. If you decide to take part, you may choose to withdraw from the study at any time without giving a reason and without any negative impact on your persons.

- Your signature below indicates that you have received a copy of this consent form for your own records.
- Your signature indicates that you consent to participate in this study.

_____

Participant Signature Date

_____

Printed Name of the Participant signing above

Check off all that apply:

I agree that only notes can be taken of what I have to say.	
I agree that an audio tape recording can be made of what I have to say.	
I agree that my name (rather than a pseudonym) may be used in notes, summaries and/or thesis.	
I agree that photos may be taken of me and published in materials either in print or electronic purposes.	

Appendix E Photo Release Form

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PHOTO RELEASE FORM

I give the researcher of the **"EXPLORING ABORIGINAL WOMEN'S MATERNITY EXPERIENCES IN THE OKANAGAN, BC."** research project: Jennifer Leason from the University of British Columbia, to publish the materials and images taken today in print, or electronic format for research purposes – for example, pictures to be used in presentations about the research. I release all claims against the University with respect to copyright ownership and publication, including any claim for compensation related to use of the materials.

I hereby give all rights to all appearances made by me in the interviews, focus groups or personal photos and the right to use my visual image to share the findings of this research project.

_____ _____

N A M E (please print) **S I G N A T U R E**

_____

D A T E

GENERAL GUIDELINES: Signed releases should be used when adults are posed for photographs or staged to appear on videotapes. Signed release forms are not needed when subjects are in public places such as fairgrounds, parks, or public streets. Administering and maintaining records of this form are the responsibility of the photographer whether he/she is a professional university photographer or faculty or staff.

Appendix F Interview Script

Aboriginal Women's Maternity Experiences/ Health Narratives

Disclaimer this interview script is a preliminary guide. I anticipate that there may be changes (additions and revisions) as the research progresses and themes emerge or as issues arise within the interview.

I. Participant Information & Socio-Demographics

1) Name:
2) Date of Birth:
3) Is this your first baby?
   How many children do you have?
4) Name of baby (children):
5) Date baby was born:
6) Place baby was born:
7) Date questionnaire was completed:
8) Current address:
9) Self-identify as First Nation, Métis, Inuit, Dual citizenship, unknown, etc.
10) Highest level of education:
11) Marital status:
12) Total income:
13) Number of people in household:
14) Describe your (baby & family) overall health & wellbeing (past or present health conditions and rating):

II. Prenatal Experiences:

1) Tell me about your experience(s) when you first found out you were pregnant.
2) Describe how you felt throughout your pregnancy (from pre-conception to conception up until the birth of baby).
3) Describe what was occurring in your life at that time (circumstances or context).
4) Describe the care & support (or lack thereof) you received during that time (partner, family, friends, services, programs, healthcare, etc.).
5) Were there any barriers that prevented you to obtaining your optimal level of prenatal care?

III. Labour & Birth Experiences:

1) Tell me about your experience(s) when you went into labour and gave birth to… (Baby's name).
2) Describe how you felt throughout your labour and birth.
3) Tell me what was occurring in your life at that time (circumstances or context).
4) Describe the care & support (or lack thereof) you received during your labour & birth (partner, family, friends, services, programs, healthcare, etc.).
5) Were there any barriers that prevented you to obtaining your optimal level of labour/birth experience?

IV. Postpartum (6 months following birth of baby) Experiences:

1) Tell me about your experience(s) after the birth of … (baby's name).
2) Describe how you felt following the birth and/or when you returned home.
3) Tell me what was occurring in your life at that time (circumstances or context).

4) Describe the care & support (or lack thereof) you received during that time (partner, family, friends, services, programs, healthcare, etc.).
5) Were there any barriers that prevented you to obtaining your optimal level of postpartum care?

V. Stress

1) During your pregnancy, labor or postpartum period, did you experience any stress? If so, can you please tell me about your experience(s)?
2) Describe what was occurring in your life at that time (circumstances or context).
3) Tell me how the stressors affected you (your partner/relationship, parenting, baby, etc.)?
4) Describe the support (or lack thereof) you received during that time (partner, family, friends, services, programs, healthcare, etc.).

VI. Postpartum Depression:

1) During your postpartum period (6 months following the birth of your baby), did you experience any postpartum depression? If so, can you please tell me about your experience(s)?
2) Describe what was occurring in your life at that time (circumstances or context).
3) Describe how it affected you (and your family, baby, child/ren)?
4) Describe the support (or lack thereof) you received during that time (partner, family, friends, services, programs, healthcare, etc.).

VII. Additional Exploratory Questions

1) What does it mean to you to be an "Indigenous/Aboriginal" mother?
2) Throughout your experiences, what do you think needs to be improved upon or changed to create healthy mothers, babies, families and communities?
3) What strengths (personal- internal) and supports (external) do you draw upon as an Aboriginal mother?
4) Any other comments, feedback, suggestions, or changes/improvements you would like to see?

Appendix G Structured Participant-Observation Schedule

Structured Participant- Observation Schedule

Name of Project: **Aboriginal Women's Maternity Experiences in the Okanagan, BC, Canada**

Sister-Participant ID#:
Date of Interview: Start Time: End Time:
Interviewer: Jennifer Leason

FIELD NOTES

Pre-interview Goals for Interview:

Location of Interview:

People Present:

Description of Environment:

Nonverbal Behaviour: *(e.g., tone of voice, posture, facial expressions, eye movements, forcefulness of speech, body movements, and hand gestures)*

Content of Interview: *(e.g., use key works, topics, focus, exact words, or phrases that stand out)*

Analysis: *(e.g., researcher's questions, tentative hunches, trends in data and emerging patterns)*

Technological/Planning Challenges: *(e.g., lost 5 minutes when tape turned)*

Interviewer's Impressions of the Participant: *(e.g., discomfort of participant with certain topics, emotional responses to people, events or objects)*

Interviewer's Own Responses:

Comments:

Adapted from: Morse, J.M., & Field, P.A. (1995). *Qualitative research methods for health professionals* (2nd ed). Thousand Oaks: Sage. (p.115)

Appendix H Community Resources and Supports in the Okanagan Valley, BC.

Table 10.2 Community Resources and Supports in the Okanagan Valley, British Columbia

Community	**Community Resource & Support**	**Supports Offered**
Vernon, Spallumcheen, Enderby, Okanagan Indian Band	Family Resource Center: TEL:250-545-3390 FAX: 250-549-1548 EMAIL: info@vernonfrc.ca	Since 1992 we have been proudly serving the North Okanagan. We offer counseling in the following areas: Individual adult counseling Couples & Family counseling Sexual Abuse Recovery for Women Sexual Abuse Recovery for Men Family Support Sexual Abuse Intervention Program Therapeutic Counseling Healthy Families Programs Parenting Isn't Easy programs
	North Okanagan Community Resources Directory http://www.canwehelpyou.ca	Alcohol, Drugs & Addiction Community Information Clubs, Hobbies & Interest Culture & Recreation Education & Learning Resources Employment & Financial Environment Faith Groups Food & Food Security Health Related Services (mental health, no fee counseling, private practice) Housing Lay & Community Safety Supportive Health Services Services for Victims of Violence
	City of Vernon http://www.vernon.ca/community_links. html	Community Resource Directory
	Okanagan Indian Band 12420 Westside Road Vernon, BC V1H 2A4 Phone: 250-542-4328 Fax: 250-542-4990 www.okib.ca	Department of Health Sn'c'amalt?yn Daycare & School
	Vernon First Nations Friendship Centre 2904 29 Ave, Vernon, BC V1T 1Y7	Prenatal Program Moms & Tots drop in Hot lunch Thursdays Community Resources & Supports
	Vernon Métis Association President: Vince Van Wieringen	

	#102 3207 30th Avenue Vernon B.C V1T 2C6 Phone: (778) 475-0823 **Website:** www.vdmametis.com	
Kelowna, West Kelowna, West bank First Nations	Kelowna Community Services: http://kcr.ca	Central Okanagan Services Directory Family Services: Kids Count, Family Friend Program, Family Group Conference Program Employment Services
	Kelowna Women's Shelter http://www.kelownawomensshelter.com Phone 250-762-8561.	
	Kelowna Women's Resource Centre Society http://www.weblocal.ca/kelowna-womens-resource-centre-society-kelowna-bc.html 1492 St Paul Ave Kelowna, BC V1Y 2E6 (250) 762-2355	
	Ki-Low-na Friendship Centre (250)-763-4905 reception@kfs.bc.ca www.kfs.bc.ca Edna Terbasket (Executive Director) executivedirector@kfs.bc.ca	Provides support for the mental, emotional, physical and spiritual well-being of all peoples, through the development of community based services, while encouraging the community to preserve, share and promote Aboriginal cultural distinctiveness * works to support the achievement of success and well-being for the individual, the family, and the community in each of the human life stages * offers health and wellness, community/family support services, children's programs, employment and education, youth services, and administration programing * operates three ESL classes through our ELSA program (we are the only aboriginal organization in BC that provides contracted services to the immigrant community)
	West Bank First Nations http://www.wfn.ca	Chief & Council Community Services Pine Acres Home Financial Services Human resources
	Kelowna Métis Association President: Larry Carriere #202 - 2949 Pandosy Street, Kelowna, BC V1Y 1W1 (250) 868-0351 EXT 107	
Penticton	Penticton & District Community Resources Society http://www.pdcrs.com/page.asp?PageID=1	Programs Counselling Services Employment News and Upcoming events

		Workshops & Conferences Community Directory
	Penticton Indian Band http://pib.ca/?page_id=5 Enowkin Centre	Community Website Departments: Social Development Health Housing Education Economic Development Programs & Services: Little Paws Children's Centre Comprehensive Community Plan Footprints Centre
Okanagan Nation Alliance	http://www.syilx.org/contact-page/ #101, 3535 Old Okanagan Hwy West bank, BC V4T 3L7 T: 250.707.0095 Toll Free: 1.866.662.9609 F: 250.707.0166	Health: Community Engagement Hub Okanagan Nation Health Plan Shared Care Pathway Navigating Mainstream Health: Cultural Safety Youth Mental Health Okanagan Nation Response Team R'Native Voice Aboriginal Child & Youth Wellness Program Child & Family: Children & Family Services Aboriginal Family Group Conferencing
Métis Nation BC	http://www.mnbc.ca 30691 Simpson Road, Abbotsford, BC V2T 6C7 **Toll free:** 1.800.940.1150 **Phone:** 604.557.5851 **Fax:** 604.557.2024	Employment & Training Health Natural Resources Industry Engagement & Partnership Sport Veterans Youth Women Children & Families

Truth & Reconciliation Commission of Canada	http://www.trc.ca/websites/trcinstitution/index.php?p=3 **Head Office** 1500-360 Main Street Winnipeg, Manitoba R3C 3Z3 Telephone: (204) 984-5885 Toll Free: 1-888-872-5554 (1-888-TRC-5554) Fax: (204) 984-5915 email: info@trc.ca	Reconciliation Statements Events & Projects About us Media Resources

Endnotes

[1] In Australia, Aboriginal and Torres Strait Islander population is estimated at 669,900 people or 3 per cent of the total Australian population, of which 34.8 per cent reside within major city areas, 22 per cent reside within the inner regional area, 21.8 per cent reside in the outer regional areas, 7.7 per cent reside within remote areas and 13 per cent reside within very remote areas (Australian Bureau of Statistics, 2011).

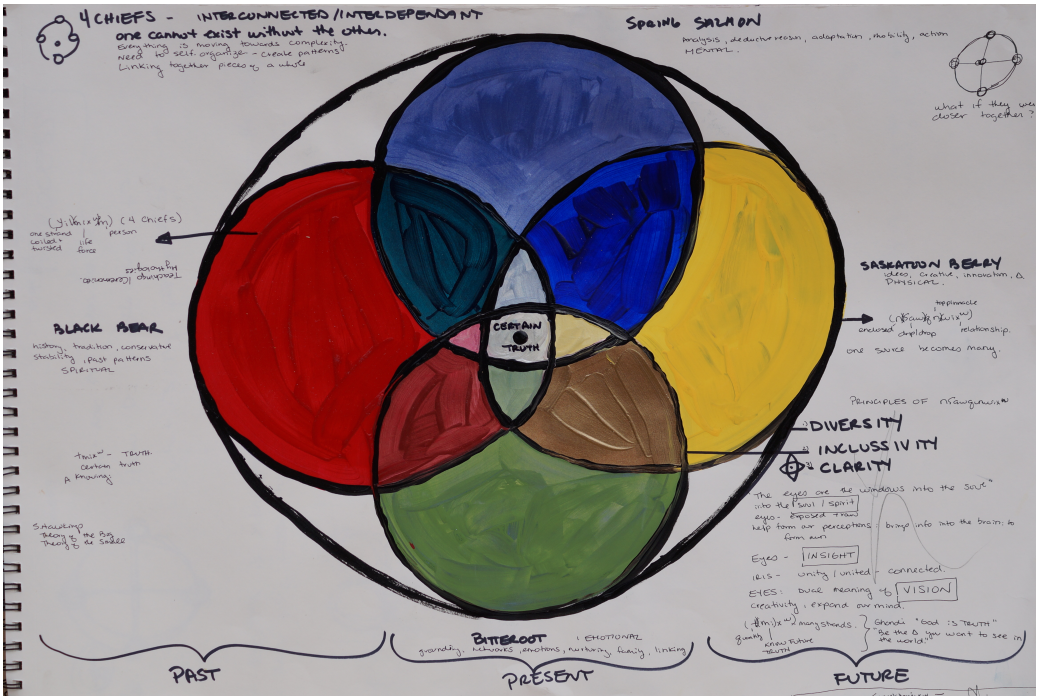
[2] In New Zealand, the Māori (population is estimated at 682,200 people or 15.4 per cent of the total population (Statistics New Zealand, 2012).

[3] In the United States, 1.7 per cent or 5.2 million self-identified Indigenous peoples: 2.9 million identified as American Indian and Alaska Native alone and 2.3 identified as American Indian/ Alaska Native in combination with other ethnicities (United States Census Bureau, 2010).

[4] *Gwayahkooshkawin* is a philosophy of the relationships between the four aspects of self (physical, emotional, mental and spiritual)
the four hills of life (birth, youth, adult, elder); four hills represent
the four gifts of medicine (sweet grass, sage, cedar and tobacco)
the four directions (north, south, east, west)
the four seasons (summer, winter, spring, fall)
the four living creatures (plants, animals, humans and the environment);
the gift of the elements that sustain life (earth, fire, wind, water);
the elements (sun, stars, moon and earth);
the four moral principles (caring, vision, patience and reasoning) and the interconnections represented through the dynamics of life—birth, growth, death and decay—and connections between the heart, mind, body and spirit.

Gwayahkooshkawin represents an Indigenous epistemology and is based on the values:
1) diversity: represented by the multiple layers and colours of the four circles;
2) holism and inclusiveness represented by the external circle;
3) connection and interdependence of each element such that, one cannot exist without the other: represented by the overlapping of the circles;
4) relationships: represented by the connection and overlapping of each circle;
5) equality and the sacredness of all beings where one is not greater or lesser than the other;
6) throughout the lifespan- past, present and future: represented by how the four main circles align;
7) sustainability: represented through the continuing cycles of each circle; and
8) truth, clarity and vision: represented by the two eyes in the center (one horizontal and one vertical).

Gwayahkooshkaywin: Interdisciplinary Theoretic Framework



The *gwayahkooshkaywin* model and framework places my ideas and approaches within a larger circle and, by doing so, it illustrates the relationships between, within and among the circles. The circles represent varying perspectives, resources and ideas, as well as unity in creating a shared vision through a process of inclusion and diversity.