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Bringing Safety and Responsiveness Into the Forefront of Care for Pregnant and Parenting Aboriginal People

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Poor access to prenatal care for Aboriginal people is well documented, and is explicated as an unethical barrier to care resulting from colonial and neocolonial values, attitudes, and practices. A postcolonial standpoint, participatory research principles, and a case study design were used to investigate 2 Aboriginal organizations' experiences improving care for pregnant and parenting Aboriginal people. Data were collected through exploratory interviews and small-group discussions with purposefully selected community leaders, providers, and community members. The study found that safety in healthcare relationships and settings, and responsiveness to individuals' and families' unique experiences and capacities must be brought into the forefront of care. Results suggest that the intention of care must be situated within a broader view of colonizing relations to improve early access to, and relevance of, care during pregnancy and parenting for Aboriginal people. **Key words:** *ethical practice and policy*, *Indigenous peoples*, *maternal/child healthcare*, *participatory research*, *postcolonial*, *pregnancy and parenting*, *responsiveness*, *safety*

PROVIDING care that is safe and competent is a minimum moral obligation for nursing. This longstanding obligation is enshrined in Codes of Ethics, with safety being a key feature of codes such as those developed by the International Council of Nurses [ICN] and the American Nurses Association [ANA].[1] Increasingly, nurses have recognized that all forms of marginalization and discrimination are ethical issues.[2,3] Codes of Ethics explicitly directs nurses to attend to such issues in the provision of safe and competent care. For example, the ICN Code of Ethics directs nurses to "initiate and support action . . . particularly

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for vulnerable populations."[4(p2)] The Canadian Nurses Association specifies that nurses "must not discriminate . . . based on a person's race, ethnicity, culture, spiritual beliefs, marital or social status, sex, sexual orientation, age, health status, life style, mental or physical ability and/or ability to pay,"[5(p15)] further directing that nurses should advocate for fair and inclusive practices, policies, and resource allocation.

As in most Western countries, Aboriginal* people in Canada have not fared well under colonialism, with poor health being but one consequence. Late or no access and poor use of prenatal care, as well as poor pregnancy outcomes among Indigenous† women globally[6–10] demonstrate the problems and lost benefits incurred by colonial-style healthcare delivery systems. In Canada, many healthcare programs and practices continue to reflect the oppressive values and attitudes that underlie colonization[11] and create demeaning, disrespectful, or dismissive environments and interactions between providers and Aboriginal people.[12–14] The often taken-for-granted, problematic legacy and enduring presence of colonial values, ideologies, and structures serve to disenfranchise Aboriginal people in the context of healthcare interactions and relationships. This has created a dynamic in healthcare in which Aboriginal† people may avoid healthcare services or use services only at the point of crisis. Although these dynamics may be unintended, they nevertheless contribute to unethical barriers to care. As a result, individuals and populations lose the benefits of preventive interventions during pregnancy and parenting. Thus fostering safe and competent care for Aboriginal people is a priority ethical concern for nursing and for healthcare more generally.

The purpose of this study was to describe community-based stakeholders' perspectives on their experience improving care for pregnant and parenting Aboriginal women and families. "Community-based stakeholders" were defined as Aboriginal people, providers, and organizations mandated to provide care tailored to the needs of the Aboriginal people. Results are being reported in a series of papers.† In an earlier article,[15] we described Aboriginal parents' views of the importance of pregnancy and parenting. Focusing on perspectives of Aboriginal parents in the study sample, findings suggested that pregnancy and parenting must be understood on the one hand relative to Aboriginal people's unique individual and family life experiences, and on the other within a broad understanding of the intergenerational impact of residential schools as an instrument of collective violence. The results highlighted the need to recognize colonizing policies as one of the root causes of inequities in health and access to services experienced by Aboriginal people. Participants' views that healthcare interventions must flow from the perspective and values of the people they serve set the context for answering the remaining research questions.

In this article we report on results for the research question, "What are community-based stakeholders' views on care during pregnancy and parenting?" Results extend current use of the concept of safety in healthcare, and describe how experiences of safe

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*The term Aboriginal "refers to organic political and cultural entities that stem historically from the original Peoples in North America, rather than collections of individuals united by so-called 'r acial' characteristics" (Royal Commission on Aboriginal Peoples, 1996). These include the First Nations, Inuit, and Métis Peoples of Canada.

†The term *Indigenous* is a globally inclusive term, while the term Aboriginal is used primarily in Canadian contexts. Both terms are used in this paper, depending on the context to which we are referring.

†A final set of papers will report on results for the final 3 research questions: (1) How does safe and responsive care developed by innovative Aboriginal organizations make a difference to Aboriginal women and families; (2) What was the process of transforming care for pregnant andparenting Aboriginal people; and (3) What was the influence of context on Aboriginal communities' experience of innovating care for pregnant and parenting Aboriginal people?

and responsive care may improve early access to and relevance of care during pregnancy and parenting for Aboriginal people. The importance of *safe* care is understood within a socio-historically situated understanding of unsafe healthcare encounters resulting from systemic disenfranchisement or "othering" of Aboriginal people. Imposed models of healthcare intervention based on racialized explanations and prescriptive solutions for health concerns experienced by Aboriginal people create an unethical paradox of care. At best, imposed models of care incongruent with clients' values, beliefs, and personal strengths and resource diminish the relevance of care. At worst, imposed models of care violate human rights and create unethical race-based barriers to effective care.[16] In contrast, *responsive* care and practice begins with understanding of the fundamental right to practice one's cultural beliefs and values, and respect and appreciation for the strengths each person develops through their unique life experiences. Implications for extending current use of the concept of patient safety, and improving responsiveness in healthcare, are considered. Importantly, this analysis supports an understanding of safety as reflected in nursing codes of ethics—a broad ethical mandate that extends well beyond narrow concerns with physical safety—and emphasizes the emotional and cultural dimensions of safety.

BACKGROUND

Aboriginal women and families need more culturally appropriate maternal/child healthcare that is relevant to their needs and strengths.[17-20] Some evidence for intervention suggests that culturally appropriate perinatal services improved Indigenous women's satisfaction with care and early initiation of care, and increased rates of breastfeeding initiation and duration, although interventions deemed to be culturally appropriate varied. Research programs[21,22] and evaluation studies[23,24] with Indigenous communities have found that community involvement in program design, implementation, and evaluation improved participant satisfaction, promoted early access and participation in care, enhanced women's health behaviors, resulting in improved nutrition and decreased tobacco and alcohol consumption; and engendered feelings of mastery about infant care. These findings support the argument that "until the effects on the healthcare system of inequalities in power between groups in society are addressed,"[25(p453)] significant improvement in healthcare for Aboriginal people is unlikely.[26] Racism-driven inequities in health between populations, exacerbated by institutionalized inequities in access to safe care, are ethical issues for nurses, organizations, and societies.

Impact of colonization on healthcare for Aboriginal people

About 3.33% (approximately 1,000,000) of Canada's total population self-identify as First Nations, Métis or Inuit. Delivery of healthcare to Aboriginal people in Canada crosses provincial and federal jurisdictional responsibilities for healthcare. However, colonization of Aboriginal people in Canada has resulted in complex arrangements for jurisdiction, administration, and governance over healthcare, which in turn fostered inequities in health and social conditions and inconsistencies in design and capacity to deliver maternal/child healthcare. Since the Indian Act of 1876,[27] the federal government has had jurisdiction over primary healthcare services for those in First Nations' and Inuit communities.* About 30% of the Aboriginal people live in 602 communities under federal jurisdiction for provision of health services. Responsibility for providing healthcare to the majority (70%) of Aboriginal peoples is a provincial responsibility

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*Métis peoples were not included in theIndian Act. However, growing awareness of M Métis issues, improvements in recognition of Métisrights, and better enumeration has brought recognition of Métis tis needs for appropriate healthcare.

south of the 55th parallel, and a territorial responsibility north of it.*[28,29] Many Aboriginal communities are geographically isolated, having either no road access or access for only part of the year.

In federal jurisdictions, the First Nations and Inuit Health Branch [FNIHB] delivers health services to First Nations communities either directly, or through transfer agreements with First Nations–controlled health authorities. Health transfer has enabled First Nations to exert more control over health priorities and solutions, and has assisted the federal government to meet its fiduciary responsibilities. As of September 2005, 80% of eligible First Nations communities were involved in the transfer of some level of health services to First Nations control (FNIHB, 2005). Poor participation in and outcomes of healthcare have been attributed to inequities in access to services, an imposed biomedical rather than holistic approach to interventions, lack of responsiveness to differences in cultures and community realities, and federal government rather than Aboriginal authority and community control over health systems.[30-32]

Inequities in health and social conditions between Aboriginal and mainstream Canadian populations have been well documented.[33,34] For example, 46% of the people in First Nations communities live in inadequate housing,[35] compared to 20% of non-Aboriginal people in rental accommodation. Poverty is widespread, with 60% of all Aboriginal children from birth to 6 years of age living in low-income families (compared to 25% in the Canadian population).[36] Forty-four percent of people residing in Aboriginal communities live below the low-income cut-off point (compared to 20% in the Canadian population).[36] Aboriginal people experience significant perinatal and infant health challenges such as teen pregnancy (9% of Aboriginal children live with teenage mothers as compared to 1% in the non-Aboriginal population), Fetal Alcohol Spectrum Disorder (estimates of prevalence among Aboriginal people range from 2.8 to 9.1/1000 live births, vs 0.3/1000 in the Canadian population)[37] and infant mortality from injuries (4 times the rate in non-Aboriginal populations).[38] A growing body of evidence suggests that these inequitable health and social conditions have their root in the "othering" of Aboriginal peoples that began with colonization, which directly challenges discriminatory and socially unjust racialized explanations that have underpinned many health intervention programs for Aboriginal people.[39]

Design and delivery of maternal/child healthcare

The FNIHB's maternal/child health program comprises prenatal and postnatal care, including evacuation from rural and remote settings to provincial tertiary care facilities for birth.[40] Prenatal and postnatal programs are delivered primarily by registered nurses who work with community health representatives [CHRs†],[41] and alongside several related programs such as the Canada Prenatal Nutrition Program, the Fetal Alcohol Syndrome/Fetal Alcohol Effects Prevention Program, and the Aboriginal Head Start on Reserve Program. Nursing services across the regions are predominated by individualistic, biomedically oriented tertiary interventions. However, single regions have adopted particular emphases such as evidence-based prevention and population health approaches, prenatal screening, or family-centered care. The presence, size, and scope of the related programs also vary among the 602 First Nations communities since small

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*Health care for populations living north of 55 was outside the focus of this study.

†CHRs are lay health workers with variable amountsof formal and/or informal education who assist individuals, families, and groups of people in the community to take responsibilityfor their own health; to work with other healthcare teams to improve and maintain the spiritual, physical, intellectual, social, and emotional well-being of the individuals, families, and community.

geographically isolated communities often do not have the population, resources, or capacity to support infrastructure or staffing for full program delivery. The result is a collection of maternal/child health services with disparate administrative, governance, and implementation systems. Furthermore, service continuity and depth of care over the childbearing continuum are disrupted by evacuation for birth, geographical barriers to delivery of care, and high rates of staff turnover. These shortcomings and challenges contribute to the inequities in access to relevant and responsive maternal/child health services for Aboriginal people[42] set up by colonization.

Over the last decade, some improvements have been noted, such as greater congruence between healthcare services and local values and beliefs; increased emphasis on the role of family, culture, and prevention; and more effective integration between traditional and Western approaches.[43,44] However, the process and characteristics of the innovations have not been systematically documented or disseminated. Furthermore, models addressing social determinants of health and each community's unique cultural, social, economic, and political circumstances have yet to be described.

METHODS

A critical postcolonial stance and participatory research principles[45,46] shaped the study methods. Postcolonial and participatory research perspectives are inclusive of different value systems and sensitive to differences, view all forms of knowledge as valuable, and seek to generate knowledge that is relevant to stakeholders and useful for solving practical problems.

Postcolonialism is concerned with "the unequal relations of power that are the legacy of the colonial past and neocolonial present, and the ways in which the cultures of dominant groups have redefined local meanings, and dictated social structures, including healthcare delivery systems."[47(p197)] Postcolonial scholarship aims to expose, describe, and change ideological and social structures that maintain inequities between Aboriginal and non-Aboriginal populations. A critical postcolonial perspective recognizes Aboriginal people as central agents of this change, and moves beyond us-them ways of thinking, toward recognition and valuing of the strengths made available through integrating diverse ways of knowing, doing, and being.[48,49]

Participatory research methodologies acknowledge and aim to redress the troubled history of research *on* Aboriginal people. "Many Aboriginal people have been the subjects of research that they had little say in or no control over, that misrepresented or misinterpreted their experiences, and failed to create knowledge that was useful to the community."[50(p4)] Participatory research views all forms of knowledge as valuable, and maintains that knowledge should be useful for solving practical problems and be relevant to stakeholders. Participatory research is particularly suited to exploring the potentially disparate knowledge, values, and worldviews of stakeholders (eg, community members, providers, and policy makers) for the purpose of acquiring the practical knowledge needed to improve care for pregnant and parenting Aboriginal people.

A 2-phase case study design enabled collection of in-depth contextual data to understand the determinants and processes of individual and organizational participants' experiences improving care for pregnant and parenting Aboriginal people in each setting.[51]

Phase 1

The study was set in the province of British Columbia, Canada. The study setting was chosen on the basis of the following: (*a*) the goal of learning from Aboriginal organizations with successful approaches to prenatal care; (*b*) the goal of exploring the interplay between complex jurisdictional, administrative, and governance arrangements for healthcare for Aboriginal people; and (*c*) recognizing that the depth of data collection and analysis would depend on development of partnerships with organizations and trusting relationships with participants. The researcher had preexisting professional relationships with several Aboriginal organizations in this setting, expediting the initial steps of identification, recruitment, and development of agreements with the organizations and communities in phase 2.

Concurrent data collection and analysis for phase 1 began in February of 2004 following approval from the University of Ottawa Health and Social Sciences ethics review board. Sixteen key informants working in policy, leadership, and provider positions in maternal/child health within the province of British Columbia were purposefully selected using network sampling techniques.[52] Policy makers and providers who worked in early childhood services, infant development programs, nursing, and pregnancy support were included. Leaders were from policy organizations, First Nations communities, and Aboriginal health service organizations. During either telephone or face-to-face interviews, key informants shared their perspectives about issues and influences on Aboriginal women's and families' pregnancy experiences, and identified healthcare delivery organizations with a reputations for high rates of early access and participation in prenatal care by Aboriginal women. Consequently, several communities from both provincial and federal jurisdictions were identified and approached regarding their interest in participating in phase 2.

Phase 2

One urban and one rural Aboriginal healthcare delivery organization geographically located in one health region agreed to participate in the community-based case study in phase 2. The 2 sites represented complementary jurisdictional, geographical, and program development characteristics. Ethical approval for phase 2 was obtained from the University of Ottawa Health and Social Sciences ethics review board, the ethical review committee of the participating Tribal Council, and Chief and Council of the participating communities. Fieldwork was conducted from June to September of 2004 in the 2 settings. Participants in each setting were purposively selected using network sampling techniques to obtain a variety of perspectives from community members, providers, and leaders. Sampling decisions were made to juxtapose stakeholder group perspectives (eg, leaders, providers, and community members) on the research questions. Data were collected by the first author using one-to-one exploratory interviews and small-group discussions according to the preference of each participant. Interviews lasted from 45 to 120 minutes depending on the communication style and the stories and perspectives the participant wished to share. Time was taken at the beginning of the interview to create a safe, trusting, respectful environment and dynamic in the researcher-participant relationship and to emphasize the importance of many ways of knowing, particularly feelings or embodied knowledge.[53,54] Many participants held multiple stakeholder positions, such as parent, provider, and community leader, so a longer period of time was required to discuss their related experiences. Interviews were taped with participants' consent* and transcribed. Supplementary documents and field notes were also included in the data set.

Documents reviewed reflected both the program design and the process of health system change. Examples of documents reflecting the process of health system change included the following: government reports; proceedings from community meetings; memoranda of understanding; strategic policy documents; organizations' mission and mandate, and terms of reference for tribal councils, boards, and advisory committees; newspaper articles; and annual reports. Documents capturing program design and/or innovation included consultant and pilot project reports, program descriptions,

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* Three participants preferred to have notes taken during the interview.

utilization statistics, staff job descriptions, and reports of audits and external evaluations.

Criteria for enhancing methodological rigor included critical reflexivity, maintaining integrity of participants' voices in context, taking direct action on the research problem,[55] confirmability, credibility, and fittingness.[56] Peer debriefing, member checking, prioritizing trust and relationship building in research encounters, reflective writing, and engagement were used to enact these criteria. Critical reflexivity is a process of deliberately noticing, recording, and reflecting on the research process and experience, and the nature of knowledge being constructed. It is a method for observing, making explicit, and continuously revising the influence of the researcher as the primary instrument in research, and records influence of the researcher's voice and perspectives vis-à-vis those of participants.[57] Critical reflexive strategies included regular reflective writing and peer debriefing as a way of "mining" the subjective experience of doing the research for potential problematic situations, perceptions, values, and attitudes. Integrity of participants' voices was facilitated through giving control of time, place, and format of interviews to participants; making time and space to develop a comfortable and safe interaction; member checking during analysis to deepen understanding of themes and subthemes; and privileging verbatim quotes in presentation of results. For example, participants chose to do interviews alone or with a trusted peer or colleague. Hard copies of preliminary results were distributed to participants in the study sites, and workshops and luncheons were hosted by the researcher (first author of this article) to discuss and critique themes and subthemes and their presentation.

Data were analyzed by the first author using an interpretive descriptive method[58] supported by NVIVO software during a prolonged period of immersion in the data. Analysis proceeded from a wholly inductive approach, and became increasingly deductive as important themes were identified. Analysis included iterative cycles of coding, collapsing, and reorganizing coding structure, and consideration of thematic patterns across different sites and different participant groups (eg, community member, providers, and leaders). Once preliminary results were drafted, all participants were invited to discuss them in 3-hour workshops held in the study communities in April of 2005.

RESULTS

A total of 73 key informants and community-based leaders, providers, and community members participated. Table 1

Table 1. Sample composition by phase, Aboriginal identity and gender

Study phase and setting	Sample subgroup	Total*	Aboriginal identity No. (%)	Female No. (%)
Phase 1		16	8 (50)	15 (93.7)
Phase 2		57	36 (63)	51 (89.5)
Case A: remote setting		29	21 (72.4)	25 (86.2)
	Leaders	8	7 (87.5)	6 (75)
	Providers	10	2 (20)	9 (90)
	Community members	11	11 (100)	9 (81.8)
Case B: urban setting		28	15 (53.6)	26 (92.9)
	Leaders	9	4 (44.4)	9 (100)
	Providers	15	7 (46.7)	14 (93.3)
	Community members	4	4 (100)	3 (75)
Study Totals		73	44 (60.3)	66 (90.4)

*Although many participants fit into more than 1 category, they are only counted once in this profile.

Table 2. Themes and subthemes in results

Themes	Subthemes
Pregnancy as an opportunity for change	• Wanting children to have the gifts but not the pain of the intergenerational impact of residential schools • Children are highly valued • Parents are highly motivated to heal past hurts, and reconnect with self, family, and culture
Safe healthcare places and relationships	• Nonjudgmental • Respectful • Strengths-based • Facilitating healing and trusting relationships
Responsive care	• Holistic • Client-directed • Integrating multiple ways of knowing, with greater emphasis on experiential and cultural knowledge
Making intervention safe and responsive	• Reaching out—being visible • Empowerment education • Including fathers and family • Feeding body, mind, and soul

shows a profile of participants in each phase of the study. Over 60% of the sample self-identified as Aboriginal and 90% were women. Nearly half of phase 2 participants were providers ($n = 25$); and 20 of these had more than 10 years ($n = 20$) of experience working in an Aboriginal health service delivery organization. Providers included registered nurses ($n = 9$); lay providers ($n = 7$) such as nutrition counselors, community health representatives, or family support workers; and other health and social service professionals ($n = 9$) such as nutritionists, social workers, and professional counselors. The remainder were community members, including mothers, fathers, grandparents, and elders; and leaders such as band administrators, chief and council members, health center administrators, and advisory committee members. Participants were assigned to the group according to the criterion by which they were to chosen to participate. However, most Aboriginal participants held multiple stakeholder positions: for example, participants may have been both a leader and a provider, or both a parent and a provider, or both a leader and a parent (as well as other family roles), and in some cases held all 3 roles (leader, provider, parent). Many of these participants brought critically reflexive understandings gained through multiple roles, thus enriching the insights into the research questions.

Table 2 shows the themes and subthemes resulting from our analysis. Each of these themes and subthemes are described below, followed by discussion of implications for policy, practice, and education of health providers.

Pregnancy as an opportunity for change

"Successful" intervention approaches were described by participants as acknowledging individual and collective history, and responding to pregnancy and parenting as a significant opportunity to facilitate and support Aboriginal peoples' efforts to create a better future for their children. Respondents described pregnancy as a powerful opportunity to support and facilitate people to choose a healing path. Participants indicated that pregnancy was often a time when prospective parents examined the influence of the intergenerational impact of residential schools on their values, beliefs, and capacity for healthy parenting. Speaking from her experience as a parent, this provider explains:

> I've found having children really makes you question the spiritual, your spirituality. . . . So if you're ambiguous before, you weren't sure what you believed, it's pretty hard to talk about that with your kids. . . . I think questioning as you become a parent is a normal part of becoming a parent, but there probably are a lot more conflicting issues I think, if you have the residential school issues. Even if you weren't there yourself, but a child of someone who went to residential school because it's passed down for sure. But they were never taught how to be a parent. They were never parented. (Provider P2-A3)

As well as revisiting a painful childhood, becoming a parent represented a time of significant hope for a better future for their children.

> I was abused. I was neglected, I was physically abused by my parents, by my friends. This is something I don't want to happen to the next generation of children. I want things to be different for my kids. I want them to succeed—I can see they are going to succeed. They are doing well in school and they are going to have a chance. (Community member P2-A10)

Participants described high value placed on children by families, culture, and community as an "enormous" motivator for parents to make and sustain healthier choices.

> The real cultural belief is that all children are a gift from God. So no matter what the circumstances . . . if the woman is drinking, if she's doing drugs . . . it doesn't matter [to the importance placed on the child], that child is a gift. And that has an enormous influence on the women. (Provider P2-A2)

Safe and responsive care

Safety and *responsiveness* were seen by participants as central to an approach to care that fundamentally changed the nature of their relationships with healthcare organizations and providers. They saw attention to safety and responsiveness as enabling healthcare to facilitate Aboriginal peoples' efforts to "turn around" the intergenerational impact of residential schools. The subthemes involved in design, implementation, and evaluation of safe and responsive care for pregnant and parenting Aboriginal people are described below.

Safe places and safe relationships

Safe places and relationships were described as essential to support Aboriginal parents in their efforts to turn around the intergenerational impact of residential schools. Safe places are important from multiple perspectives. Participants described how mainstream healthcare environments were often perceived and experienced as unsafe. Speaking about experiences in mainstream healthcare setting, one leader said:

> Lots of the time they don't feel comfortable [at the mainstream health agency]. It's not a culturally acceptable place. The rules are very rigid. You have to come at a certain time. They [agency staff] don't understand the difficulty of getting rides, they don't understand how appointments can be missed . . . and also they [Aboriginal parents] feel they're being judged on the way the baby looks, or how they talk or . . . health nurses assume they're stupid or they're slow and they can't read, or, you know, these sorts of things. (Leader P2-B1b)

Participants described how the risks associated with past care-seeking experiences have made safe places and safe people in the Aboriginal health organization critical. Safe places require a nonjudgmental attitude on the part of the whole program and organization.

> It took a long time for trust to be established. That this was a safe place and that it had benefits versus the risks of coming into this place. I think we have to acknowledge for people who have been marginalized, the risks need to be weighed out versus those benefits. And you know, some of the risks might be that it puts on the table that you are using a substance that could cause harm to the fetus or if you have other children at home and you identify that you are using a drug of some sort . . . , I

> mean just coming out of the closet and telling people that you have a problem has its own risks. And that's where the trust factor comes in. You know if, if the way that that problem solving is handled is respectful, effective, and client focused, then that's why people will come. The word of mouth is going to put it out there that it's okay to take that risk. (Leader P2-B6)

Participants described the characteristics of a safe place, emphasizing the importance of the energy, or the feeling, of a place:

> It's also the environment, the place; it's warm, friendly and caring and we have time for people. There is a different energy in programs built from an Aboriginal perspective . . . the pace is different . . . the environment is more relaxed, friendly, casual . . . it is a comfortable place to be with couches and the coffee room. There is a mix of staff that is similar to the mix of participants [including some] First Nations staff. We dress differently. . . . I don't dress up to see participants. . . . We are people-friendly, not appointment book–friendly . . . it feels like home here. (Provider P1-16)

Aboriginal parents said that to heal, you have to face up to the pain, to the weaknesses and the problems, which can be very difficult. Therefore, you need supportive relationships with people who will not judge you, but will walk beside you, who will listen and acknowledge your pain and your strengths along with the mistakes you may have committed as a human being. Respect in everything that is said and done, whether consciously or unconsciously, influenced people's feelings of emotional safety.

> But I think the more First Nation's groups I know, the more I know just to treat everyone like individuals. It truly is. You know, you make these assumptions based on what they should be culturally and then you get challenged and told that's wrong. So, I find it's always best to work with them as individuals and say . . . and treat them as people, with respect, and then you get amazing results. (Provider P2-B1a)

The client-provider relationship was seen as an opportunity to build understanding and capacity for healthy relationships. Participants emphasized facilitating healthy reconnection and relationships with self, significant others, and family, rather than creating dependencies on providers.

> You have to have, I feel, for me to even connect with them and to be open and honest so that we can work with that, is to say, "What has life shown you?" "What's your biggest issue, what's you biggest concern?" And when it's coming from them, then probably 95% of the time, people come out and say what their issue is . . . and [ultimately] they wanted a healthy relationship and they wanted to treat each other respectfully so that their children could come into a world where they were treated respectfully. (Provider P2-A22)

Safe relationships meant providers being open, and seeking to understand and acknowledge, rather than to judge. Along with acknowledging the pain and struggles people have experienced, participants thought it critical to recognize the gifts and assets that people have developed through their struggles.

> That's all people want, is that acknowledgement. I think we all want that as people, trust that I can make my own decision and trust that I will do the best that I can with the skill set that I have. And when you give me that credit . . . then I'm going to aspire for more. (Provider P2-A22)

Connecting with people at a "heart" or "spirit" level through developing safe, trusting relationships was described by all groups of participants (eg, leaders, providers, community members) as the most important difference between the approach developed by the Aboriginal health organizations compared to conventional care. This became increasingly clear as the interviews progressed, so the question was posed, "What happens if you don't connect with people at a heart level?" Responses to this question ranged from "You might as well pack your bags and head home," to "Nothing. Absolutely nothing happens." One participant put it like this:

> If [connecting at heart/spirit level] isn't there, they're not there. That's what happens. People just don't feel comfortable. My take . . . is that they're not going to come back, because that's the feedback that I have got from people . . . when they feel

> respected and when they feel accepted, when they feel that you care and they'll test you out . . . and they know . . . they've been through an experience for so long that they know from their teachings and also from their experience and all the kinds of painful things that have happened what works and what doesn't. (Leader P2-B7)

Responsiveness

Responsiveness of care is a fundamental shift by providers and organizations. Rather than entering into care relationships with unexamined and often unconscious worldviews, values, and priorities for health-related experiences, care is offered in a way that seeks to understand, respect, and respond to those of communities' and clients'. Responsiveness encompasses being holistic, being client-directed, and integrating ways of knowing into relationships and care. Participants in this study described *holistic* as

> There is that kind of spiritual dimension in everything that takes place . . . the spiritual, mental, emotional, physical aspects of life all need to be considered and in balance for us to really be able to participate fully in who we are and in our families and in our communities. And that's a juggling act. Anybody who has tried to become balanced knows that. But, so we need all kinds of support to do that . . . we need understanding, we need encouragement. (Leader P2-B7)

Client-directed care was differentiated from client-centered care and was described as the client setting the agenda, making the decisions and taking responsibility for living with the consequences. For example,

> Most of it, I truly believe, if I look back over the years . . . it's about 50 to 60% emotional support. I might have an agenda that I'd like to talk about breastfeeding today, but that might be the last thing on their agenda, so if we can't do what's on their mind and their focus, then how can we really reach what we need to do. (Provider P2-A22)

Responsiveness means that many ways of knowing are respected and integrated into care. Ways of knowing included the traditional knowledge, experiential knowledge, "heart knowledge," and clinical knowledge from both clients and providers. However, there was a consistent emphasis on bringing traditional and experiential knowledge, and "heart knowledge," into the forefront of care. Participants explained why:

> We're trying to work with women to invite them to explore some of the traditional practices, like before they give birth, and try to incorporate it into a birth plan. And even through the pregnancy, to try to use some of those belief systems and have that guidance instead of white society telling you what you should and shouldn't do. (Provider P2-A3)

An emphasis on personal and cultural knowledge reverses the pattern of care, from imposing and shaming based on mainstream knowledge and practices, to connecting with clients, and acknowledging and affirming their cultural knowledge and identity:

> Well I think that to be strong on the culture is such a good tool to try to turn it around because, you know I talked to a lot of women and there's a lot of anger, there's a lot of being made to feel ashamed of yourself that sort of results in sex and abuse issues. And I think going back to the traditional ways of giving pride and food can help to undo some of that. I see that as the answer. And I think it will come. It's going to be slow. But I think that's the answer, going back to the traditional teachings and beliefs. (Provider P2-B16)

The importance of an approach that incorporates many ways of knowing is evident in descriptions of experiences of moving back and forth between living in small isolated First Nations communities and larger mainstream communities. The difficulties of trying to fit into the values and lifestyle of mainstream society heightened some participants' awareness of their unique way of being and knowing as an Aboriginal person:

> It was like two collisions . . . this world with that world . . . and it took many years to realize . . . how do I fit into this society? How do I adjust to this society? How do I meet up to their standards, their education, their lifestyle, their raising of their children was so different from the way . . . we were raised as children . . . and ah, it was hard. It took me many years to adjust. (Community member P2-B3)

Providers, leaders, and community members were clear that up-to-date scientific and expert clinical knowledge is important, and integrated as needed. Providers indicated that deciding how and when to use different ways of knowing comes from reflective engagement with their own emotional wisdom, as well as being emotionally "tuned-in" and respectful of the choices and priorities of the people with whom they are working.

Making intervention strategies safe and responsive

Safe and responsive care meant that providers and organizations reoriented their role and relationship with the community and clients. Paramount was understanding and embracing the local cultural values, norms, and practices as an organizing framework for engaging with clients and community, with other ways of knowing such as professional nursing standards, evidence-based knowledge or expert clinical knowledge being woven in. This is in direct contrast to clients' and providers' experience of working within an imposed model of care:

> In the past, the emphasis had always been on perceived rigid rules and regulations coming from the outside. [Though] we wanted to honor our professional code (eg, nursing standards for practice), we also wanted to honor the cultural codes and protocols of the [local] people. We needed to understand the [local cultural] code, to respect it, to abide by it, and to be guided by it. So that the cultural code was the main code, and the professional code was the add-on piece, rather than the other way around. (Provider P2-A4)

Safe and responsive care for Aboriginal parents during pregnancy and parenting involved a collection of innovative strategies that are qualitatively different from conventional care. These strategies were identified as critically important by all 3 groups of participants in both communities (ie, community members, providers, and leaders). Examples illustrating this difference include reaching out and being visible, empowerment education, inclusion of fathers and families, and an emphasis on the role of food. Examples highlighted below demonstrate how the imperatives of safety and responsiveness shaped providers' practice.

Reaching out and being visible

Reaching out acknowledges the barriers that the history of unsafe environments, people and relationships may have on care seeking. Reaching out was also seen as an indication of being with people because you genuinely cared about them. Reaching out was an example of following the local cultural codes, rather than imposing or limiting care to the norms of mainstream society. Reaching out was the "way we do things around here—it's our way." For example,

> There is, I think, very positive support with [the community health nurse], who is able to get out into the homes and do a one-on-one, and that's what really works. There is a very big weakness, in a sense, with people and their safety and their issues to walk into the health clinic. They don't feel safe. They don't feel that they can trust the staff [who] work there. They don't feel trust in, not just the people, but in the whole entire government structure. . . . Fear is a big thing—fear to talk to somebody about sex and sexual education [for example]. (Provider P2-A9)

Being visible went hand in hand with reaching out.

> To me, one of the most important things is being visible. I found that being visible in the community, consistently . . . I'll see Elders, I'll work with the mothers, I'll go to the school, I'll do baby shots . . . a lot of stuff, where people come in and they're looking for something or they want some screening done, and then I'll talk to them about that . . . about anything. I found that the women come much earlier. (Provider P2-A2)

Empowerment education

In contrast to the straight information-giving approach of conventional and less well-received programs, an empowering approach to education was a distinct aspect of supportive programs. Providers described a one-to-one responsive style of teaching and learning that was noticeably different than simply providing people with verbal or written information. They described an ongoing dialogue with clients that integrated client's knowledge of themselves, and their goals and constraints, with provider's knowledge of such things as bodily functioning, the healthcare system, and client's rights.

> Now they're thinking about it. They know that if they want to get pregnant they want to be healthy. They want to have healthy babies. . . . I teach them [about their menstrual cycle]. . . . Pretty much all those women know when they are ovulating now. And we all should. I tell them, don't feel bad if you don't know, 80% of the population doesn't. I mean, it's the truth. So, they all know. To me, that's empowering them. They are empowering themselves with that awareness of when they need to . . . not have sex when . . . you know, if they are going out for the weekend, there is more planning involved than I have ever seen before. (Provider P2-A22)

Including fathers and family

Safe and responsive care recognized the disconnections resulting from the intergenerational impact of residential schools, and seized the positive opportunity presented by pregnancy and parenting to encourage families to develop stronger connections and build healthy relationships. Providers encouraged family members to participate directly in care. For example,

> When [the nurse] is doing the prenatal, she welcomes them. . . . I don't think I've seen a dad come through here that wasn't just beaming when he left after the prenatal session. I think that even that early involvement and that early education about what's happening with the wife's body is an important step for, for men to have, for all people to have. And it's teamwork, it's not just all mom's job because the baby's in mom . . . you need that support. (Provider 14)

Participants also described how clients were encouraged to reach out to family members to explore how the tasks and issues of pregnancy and childbearing, such as dietary habits and naming have been managed in previous generations. This served to reconnect family members over a positive common interest that often provided an opening for healing past hurts.

Feeding the body, mind, and soul

Food was described as a positive, culturally based method of connecting, building relationships, and passing on knowledge and a traditional way of imparting knowledge.

> Culturally our way is to, when you feed someone, what you're feeding them is, you're feeding them information once you're feeding them nutritionally also. You know, what I mean, is you're feeding their mind. You're feeding their body and you're feeding their soul when you're giving them the respect. And you're giving them the honor that they deserve. Everybody needs to be well-respected when they walk in that door regardless of who they are. That's the way I envision it. Feed the mind. Feed the body. Feed the soul. (Provider 15)

However, food security and food literacy were also described as urgent concerns for pregnant and parenting families. Food insecurity was identified as a consequence of poverty, and a gap in knowledge and skills resulting from the loss of traditional food sources and the consequences of the intergenerational impact of residential schools:

> We also have to recognize that the parents of today's pregnant women may have been in residential schools. And so they didn't learn how to cook. Therefore, they didn't do what you're doing with your family. They didn't make from scratch or teach their children what is a balanced meal. So we've got some [food] illiteracy. (Leader P2-B6)

In summary, the stakeholders in this study saw pregnancy as an important opportunity for change. However they emphasized that in order for such change to be realized, healthcare organizations and relationships must be safe and responsive, Safety and responsiveness require taking history and inequities into account, and working partnership among all stakeholders.

DISCUSSION

These results expand notions of safety as currently used in healthcare. Patient safety broadens the concepts of medical or physical safety as criteria for quality in healthcare.[59] Patient safety, defined most broadly, supports the argument that a "major objective of any healthcare system should be the safe progress of consumers through all parts of the system. Harm from their care, by omission or commission, as well as from the environment in which it is carried out, must be avoided and risk minimized in care delivery processes."[60](p2) This understanding of safety includes the concept of harm due to negligent or intentional action or inaction.[61] However, the risk of *emotional* harm in healthcare settings and interactions is rarely discussed as a patient safety issue. Indeed, Storch has pointed out that current narrow interpretations of patient safety may distort and obscure broader needs such as those for emotional safety.[62] Results of this current study suggest that emotional safety is an important dimension of patient safety for Aboriginal people in healthcare interactions and settings and warrants further attention.

Results identified the emotional dimension of safety as having a crucial influence on ***access*** to prenatal care. That is, experiences of unsafe care can deter access. Emotional safety has been discussed in the context of mental healthcare, and as an issue in care and healing from interpersonal and collective violence, rather than as an issue of patient safety that is central to all healthcare encounters. The extent to which one feels safe in healthcare encounters is affected by past experiences with safety or lack of safety. One's willingness to engage in healthcare encounters is also influenced by peer and social network views about how likely organizations and providers are to be safe and caring. This community-level influence is also a reflection of the influence of past experiences with unsafe healthcare interactions or institutions.[63] Further research is needed to understand the influence of emotional safety on both access to and experience of healthcare interactions and settings.

As described in the cultural safety literature, some healthcare settings and interactions are routinely unsafe for Aboriginal people.[64] Unexamined, demeaning, and disrespectful attitudes, values, and beliefs of healthcare providers and organizations of colonized societies have fostered behaviors that are hurtful for Aboriginal people.[65] Transforming this systemic impact of collective violence on Aboriginal peoples' experiences of both internal and external safety in healthcare has been termed *culturally safe care* and is described as "actions which recognize, respect and nurture the unique cultural identity of [Aboriginal people], and safely meet their needs, expectations and rights."[66] Identifying safety as an important influence on early access and use of care during pregnancy and parenting is an important finding, and complements the emerging body of evidence on cultural safety.

Results suggest that Aboriginal people are working on understanding, healing, and transforming their sense of safety and well-being in interpersonal relationships, including relationships in the context of healthcare. Participants described the approach taken by both providers and organizations to work *in partnership* with Aboriginal people to create relationships, places, and interactions that feel safe. Furthermore, healthcare organizations and providers must develop the skills and understanding to assess the extent to which they *are* providing safe care. The extent to which institutions responsible for the basic preparation of health professionals, such as undergraduate schools of nursing, are equipping graduates with the skills to understand and develop safe care must be examined. Research and education could build on the work of nursing organizations and educational institutions in New Zealand to develop competencies and organizational support for culturally safe practice.[68]

Findings highlight the importance of responsiveness to the diversity of individual and families' lived experiences, and the need to provide care that respects these differences. Responsiveness is qualitatively different from "sensitivity," particularly as it is used in relation to culture, in at least 2 ways. First, responsiveness is more active than "sensitivity" and places responsibility on healthcare providers to act. Second, responsiveness implies particular individuals and situations rather than sensitivity to groups based on generalized assumptions and stereotypes. Third, responsiveness is an ethical alternative to imposing a dominant model that dictates the rightness of a particular set of healthcare issues and priorities on the basis of a taken-for-granted worldview (Western) and values, priorities, and actions (eg, biomedicine). In contrast, responsiveness positions healthcare organizations and providers as responsible to (*a*) recognize their own positions, (*b*) seek to understand that of others, and (*c*) ethically make the resources and support available to address their priorities rather than judging difference as somehow wrong or inferior. Furthermore, a strengths-based orientation to responsive intervention seems critical to improve real access to care and to facilitate women's choices related to family planning and timing of pregnancies. These results illustrate how safe, trusting relationships are prerequisite to understanding individual circumstances and needs for basic determinants of health such as housing, food, advocacy with mainstream health and social systems, and encouragement to start and sustain further education. Results exemplify *how* the approach to care can enhance Aboriginal peoples' feelings of safety and relevance, thereby increasing early access, participation, and outcomes of care.

Finally, this study adds to awareness of discrimination, inequity, and safety as ethical concerns. Importantly, as Applebaum has argued, racism is a particularly serious ethical issue.[68,69] Furthermore, the findings suggest links among ethical concepts such as justice, competence, autonomy, and respect. Safety is a minimum ethical standard for nursing practice. A broader conceptualization of safety suggests that to practice ethically and competently, inequities and discrimination must be addressed in both individual and organizational practices.

CONCLUSION

This qualitative community-based study of the innovations developed by Aboriginal organizations in 2 unique geographical, jurisdictional, and demographic contexts explored perspectives of providers, leaders, and community members to describe their views of care during pregnancy and parenting. Although several strategies were used to capture the richness of their experience, and differentiate researcher and participant voice and interpretation, these results represent only a beginning understanding of community-based perspectives. Further research is needed across a greater number and diversity of settings to confirm or add to our understanding of salient aspects of approaches to and evaluation of care during pregnancy and parenting for Aboriginal people. Adequate time and resources are required to enable community-based participants with long-standing, trusting relationships to take a more active role in research design and implementation, thus enabling Aboriginal perspectives to guide and inform knowledge, policy, and practice development.

Pregnancy and parenting represent a culturally and developmentally significant opportunity for Aboriginal people to heal from and resist the ongoing impacts of colonialism. Results highlight the critical importance of building successful programs on an understanding of the history of colonization, and its impacts on Aboriginal people's relationships and experiences in healthcare. Results describe how the approach to care positions providers and organizations to work in partnership with Aboriginal people toward their vision to transform both the impact of this history and the nature of relationships. Situating care within a wider historical timeframe profoundly influences the goals, roles and relationships, resources, and expected outcomes of care. This study also underscores the importance of planning programs to recognize and respond to the unique experiences of individuals, families, and communities. These results warrant further exploration of the notion of safety in healthcare, particularly how experiences of emotionally safe care may improve early access to, and relevance of, care during pregnancy and parenting for Aboriginal people. We conclude that ethically, healthcare providers and organizations must work in closer harmony with Aboriginal people toward their vision, rather than reinforcing the colonizing relations that are a legacy of our past and often an ongoing feature of daily practices.

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