
Culturally Competent Care for Aboriginal Women:

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

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ABSTRACT

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

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

KEYWORDS

Aboriginal women, culturally competent care, hospital birth, obstetrics



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

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

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

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

Models of culturally competent care

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

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



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

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

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

Implications from recent research

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

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

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

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



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

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

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

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

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

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

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



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

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

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

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

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

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

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



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

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

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

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

RECOMMENDATIONS

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

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

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



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

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

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END NOTES

1. For the purposes of this study, women's health is defined as mental and emotional health, physical health, and social well-being. When health is defined as mental, physical and social well-being, and not merely the absence of disease and infirmity, cultural and social practices become critical contributing factors to health (Arctic Council, 2004).

2. Obstetric evacuation is a mandatory practice in most Nunavut communities, except for Iqaluit where there is a hospital, and Rankin Inlet, where a low-risk delivery birthing centre is located.

3. Inuktitut word meaning "people of Nunavut."

4. Inuit is the Inuktitut word for "people." Inuk is the singular form meaning "person."

