Defining and Evaluating Cultural Safety at Seventh Generation Midwives Toronto: Exploring Urban Indigenous Women's Perspectives on Culturally Safe Maternity Care

by

Mackenzie Elaine Churchill

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Author's Declaration

Abstract

In recent years, Indigenous midwifery has reemerged as a vital form of maternity care in Canada. With the majority of practices being situated in rural and remote areas, Seventh Generation Midwives Toronto (SGMT) remains the only urban-based Indigenous focused midwifery practice in the country. Looking to develop a culturally relevant performance measurement system for the practice, SGMT partnered with the Well Living House (WLH) – an Indigenous action research centre in Toronto – to undertake a community-based, participatory, realist, and utilization-focused evaluation study. This thesis project was nested in one of the qualitative branches of this evaluation. Semi-structured interviews were conducted with nine former clients of SGMT who self-identified as Indigenous to determine (1) how Indigenous women conceptualize cultural safety and (2) the extent to which their experiences at SGMT aligned with these conceptualizations. The interviews were transcribed verbatim, and the transcripts were analyzed using collaborative, consensus-based, iterative, and decolonizing methods. Twelve core themes that were grouped into four thematic pillars or containers emerged from this process. Even though the women participants were unique in their backgrounds, insights, and experiences, when taken together, culturally safe Indigenous midwifery care meant (1) "culturally continuous care”, (2) being able to access both Indigenous knowledge and practice and practical reproductive health information, (3) being connected to the community, and (4) feeling “at home” in a health care setting. There was also widespread support for SGMT as a practice; most – although not all – women felt that their pregnancy, birthing, and reproductive needs were fully met, and that they were made to feel culturally safe. All of the women offered constructive and loving feedback for the practice, even if they had experiences that fell short of their expectations. This confirms that SGMT can and does provide culturally safe care, and that cultural safety both has benefits and a place in the mainstream health care system. This project also sheds light on the roles and responsibilities of contemporary Indigenous midwives and the ways in which they can be supported. Altogether, herein lies a compelling argument for the continued support and expansion of urban-based Indigenous midwifery, and the application of cultural safety in a Canadian context.

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Chapter One

Background

According the *United Nations Declaration on the Rights of Indigenous Peoples,* all Indigenous peoples have the right to actively participate in the development and determination of their own health programs, to administer such programs through their institutions, to maintain their traditional medicines and health practices, and to access any and all health services without discrimination (United Nations General Assembly [UNGA], 2007). At first, the Canadian government refused to sign the *Declaration* on the grounds that it jeopardized treaties, failed to balance individual and collective rights, and was incompatible with the 1982 *Constitution Act,* among other things (Joffe, 2010). Based on ideological biases instead of credible, legitimate, and legal evidence, these claims were heavily criticized by scholars, Indigenous peoples, and the international human rights community (Joffe, 2010). Eventually, the Conservative government agreed to endorse the *Declaration* in 2010, but not without reiterating its place as a "non-legally binding document that does not reflect international customary law nor change Canadian law" (Aboriginal Affairs and Northern Development Canada [AANDC], 2010, para. 4). Even though this decision signified a public commitment to upholding, respecting, and implementing the rights of Indigenous peoples, the government's initial opposition and ambivalence around the *Declaration* reflects the government's continued reluctance to fully affirm Indigenous rights such as that to control their own health care services. This is concerning, as Indigenous peoples in Canada – and Indigenous women in particular – continue to experience an unacceptable disproportionate burden of poor health (Adelson, 2005). These inequalities in health are due in part to the underlying social determinants of health (SDOH) such as income, housing, and education (Adelson, 2005; Reading & Wein, 2009) and to health inequities, which are uneven distributions of health that are "unnecessary and avoidable as well as unjust and unfair" (World Health Organization [WHO], 2014a, para 2). As such, it is essential that statistics depicting the health status of Indigenous populations be interpreted within the context of colonialism, racism, social exclusion, and other existing sociopolitical dynamics. For example, when compared to non-Indigenous women, certain groups of Indigenous women have been shown to experience higher rates of sexually transmitted infections, infant mortality, post-partum depression, complicated deliveries, and sexual violence (Dion Stout, Kipling, & Stout, 2001; Luo et al., 2004; Luo, Wilkins, & Heaman, 2010; Yee, Apale, & Deleary, 2011). These inequalities in reproductive health can be directly linked to the impacts of colonization and continued colonialism, examples of which include the uneven distribution of health care resources due to institutionalized racism (Allan & Smylie, 2015), the unresolved intergenerational trauma brought about by residential schools and forced adoptions (Roy, 2014), and the displacement of traditional Indigenous knowledge around reproduction and women's health by biomedical forces (Carroll & Benoit, 2004; Reading & Wein, 2009; Waldram, Herring, & Young, 2006).

In recent years, the Indigenous population in Canada has become increasingly urban, adding yet another dimension to Indigenous health (Statistics Canada [StatsCan], 2008). Even though historical and contemporary forces have portrayed the "urban Aboriginal person" as everything from assimilated to "out of place" to deeply impoverished, the reality is that urban-dwelling Indigenous peoples occupy a diversity of socioeconomic, geographic, and cultural spaces (Peters, 2011). However, due to the interplay of several historical, social, and political factors that will be discussed below, there is a tendency for urban-dwelling Indigenous populations to be predominantly female. Unfortunately, many urban settings have failed to accommodate, create safe space for, and meet the diverse needs of Indigenous women (Peters, 2006). The Canadian health care system is a prime example of an institution that has been instrumental in excluding and discriminating against Indigenous women. By privileging Western and biomedical perspectives on health, facilitating the delegitimization of Indigenous knowledge and ways of knowing (Carroll & Benoit, 2004; National Aboriginal Health Organization [NAHO], 2004; NAHO, 2008a), promoting the medicalization of childbirth (FNC, 2009; Shaw, 2013), and failing to address the negative, discriminatory, and racist attitudes and behaviours of its providers that have been documented across Canada (Benoit, Carroll, & Chaudhry, 2003; Browne, Fiske, & Thomas, 2000; Kurtz, Nyberg, Van Den Tillaart, Mills, & the Okanagan Urban Aboriginal Health Research Collective, 2008; Peters, 2006; Senese

& Wilson, 2013), the health care system is often not an environment wherein Indigenous women can feel "culturally safe".

Cultural safety is a concept that was developed by Indigenous nurses in New Zealand/*Aotearoa* in an attempt to resolve the mainstream health care system's failure to address the needs of the Māori peoples (Ramsden, 2002). Distinct from "cultural sensitivity" and "cultural awareness", cultural safety is the opposite of "cultural *un*safety", which is "any actions [or omissions that] diminish, demean, or disempower the cultural identity and well being of an individual" (Wood & Schwass, 1993, p. 5). Culturally "unsafe" care is harmful to the health and wellbeing of those who receive that care and expensive for the health care system in general. There have been several reports of Indigenous clients avoiding primary care until it is absolutely necessary (i.e. their condition worsens and becomes critical) due to previous negative and devalidating encounters with the provider or system (Dodgson & Struthers, 2005; NAHO, 2006; Smith, Edwards, Varcoe, Martens, & Davis, 2006). Positive and affirming encounters can be empowering, validating, health promoting, and culturally safe for Indigenous clients. What distinguishes cultural safety from other approaches to culturally relevant care is that "culture" is broadly defined. Here, culture is not confined to singing, dancing, food, art, language, or customs, but rather, it is a "complex network of meanings enmeshed within historical, social, economic, and political processes" (Anderson & Reimer-Kirkham, 1999, p. 63). Culture is understood as a fluid, relational, and politically charged construct that cannot be reduced to a simple checklist of beliefs ands norms (Woods, 2010). Within the context of cultural safety, this critical interpretation of culture shifts the focus away from the "Other" (i.e. the Indigenous client) and onto the health care provider (Browne & Varcoe, 2006). Cultural safety begins with the provider reflecting on how their own assumptions, biases, beliefs, stereotypes, and sociopolitical locatedness affect their practice and their relationships with clients. Providers must then respond in ways that challenge the power imbalances that exist between providers and clients (Browne & Varcoe, 2006; Woods, 2010). Central to this response is the transfer of power from the provider to the client, wherein the provider allows the client to self-define the quality and safety of his or her own care experience (Ramsden, 2002).

The definition of cultural safety that was used to guide this project was developed in collaboration with the researchers at the Well Living House (WLH) and the midwives at Seventh Generation Midwives Toronto (SGMT). Drawing on the foundational works of Ball (2007, 2008), Browne and Varcoe (2006), and Ramsden (2002), the following definition was created to reflect the findings from the literature, the existing survey tools, and the project's research questions.

> Cultural safety is an *outcome* experienced by the recipient of a particular service. It is a state of being that can only be defined and measured by those who have experienced a culturally safe encounter. In a culturally safe encounter, service recipients are made to feel comfortable, respected, able to be themselves, and assisted in terms of having their cultural location, values, and preferences taken into consideration. As such, cultural safety is as much about supportive relationships as it is about supportive spaces.

Even though cultural safety has yet to be widely applied and studied within a Canadian health care context, the National Aboriginal Council of Midwives (NACM) recognizes the significance of the concept and lists it among its core values (2012c). According to Indigenous midwife Carol Couchie, "we practice cultural safety. This means that a woman can be who she is in any way she chooses to be" (as cited in National Aboriginal Council of Midwives [NACM], 2012c). Although Indigenous midwives have always helped Indigenous women and communities bring new life into the world, their practices and ways of knowing were largely displaced and delegitimized by colonialism and biomedical dominance (Carroll & Benoit, 2004). However, following the legislation of midwifery in Ontario in 1994 and generations of resistance and advocacy, Indigenous midwives have recently experienced a remarkable resurgence in their numbers, organization, and education (Carroll & Benoit, 2004). With this revitalization has come a renewed push to return birth to Indigenous communities located in rural, remote, and northern areas in particular (RRN; Olson & Couchie, 2013).

For decades, legislation has mandated that pregnant women in rural, remote, and northern communities be transferred away from home to larger and more urban health centres for delivery (Native Women's Association of Canada [NWAC], 2014). Initially introduced as an attempt to improve maternal and infant health outcomes (Lawford & Giles, 2012), the practice of "maternal evacuation" has been heavily criticized for its impacts on the health and well being of the mothers, infants, families, and communities involved. Families are not only forced to endure unintended financial costs (e.g. accommodations for travel; lost income while travelling), but also, unintended social (e.g. separation from community), emotional (e.g. separation from family; prevention of fathers, partners, and extended family sharing in birth, delaying bonding), and health costs (e.g. maternal and infant health risks associated with travel; Grzybowski, Stoll, & Kornelsen, 2011; Kornelsen, Stoll, & Grzybowski, 2011; NAHO, 2008a; NWAC, 2014). Maternal evacuation has also been critiqued for advancing the colonial agenda by disrupting Indigenous women's abilities to adapt to motherhood (Lalonde, Butt, & Bucio, 2009), perpetuating the misconception that Indigenous communities and homes are "unfit for childbirth" (Tedford Gold, O'Neil, & Van Wagner, 2007, p.12), and privileging biomedical knowledge at the expense of the marginalization of Indigenous knowledge and practice around childbirth and parenting (Lawford & Giles, 2012; NWAC, 2014; Shaw, 2013). In addition, by preventing Indigenous communities from exercising their right to determine, control, and access the reproductive health services that they need, evacuation can be interpreted as an infringement upon the right to self-determination (Lalonde et al., 2009).

Equipped with the knowledge and skills that are required to provide specialized, culturally relevant, and high quality maternity services to all types of women, Indigenous midwives have reemerged as pinnacles of community health and well being. In Nunavik, the reestablishment of Indigenous midwifery has reduced the number of evacuations (Van Wagner, Osepchook, Harney, Crosbie, & Tulugak, 2012) and strengthened local health service capacity (Epoo, Stonier, Van Wagner, & Harney, 2012). Indigenous midwifery has also supported positive maternal and infant health outcomes and experiences (Couchie & Sanderson, 2007; Epoo et al., 2012; Houd, Qinuajuak, & Epoo, 2004; Van Wagner et al., 2012), enhanced family and community support networks (Cook, 2011), and facilitated the revitalization of traditional Indigenous knowledge (Carroll & Benoit, 2004; Cook, 2011; Epoo et al., 2012; First Nations Centre [FNC], 2009). Indeed, these works only offer a glimpse into the potential of contemporary Indigenous midwifery practice; this field remains under-researched in Canada (Carroll & Benoit, 2004; NAHO, 2004; NWAC, 2007; Skye, 2010; NAHO, 2004).

Even though communities and knowledge keepers may have a longstanding and evidence-based understanding of the value of Indigenous midwifery, communities need to formally investigate and evaluate Indigenous midwifery in order to ensure its expansion and secure financial support from sources such as the Ontario Ministry of Health and Long Term Care. Research is especially needed in urban areas, where Indigenous midwifery, cultural safety, and the combination of the two have seldom been explored (Brascoupé & Waters, 2009). Given the increasing urbanization of the Indigenous population, the burgeoning research interest in Indigenous midwifery, and the need to deliver culturally safe maternity care to urban Indigenous women, now is the time to support initiatives like Seventh Generation Midwives Toronto that are returning birth to urban Indigenous communities, privileging the voices and needs of Indigenous women, and honouring the *Declaration* through research and practice.

The Purpose

Seventh Generation Midwives Toronto (SGMT) is a group of Aboriginal and non-Aboriginal midwives that have been providing reproductive health care to women in the Greater Toronto Area (GTA) since 2005 (for use of Aboriginal versus Indigenous, see Appendix A). Even though they offer midwifery care to all women in the GTA, SGMT has a particular interest and skillset in serving families within the Aboriginal community (SGMT, 2014). By allowing clients to choose where their baby will be born, how their baby will be born, and what traditional practices, ceremonies, and/or knowledge will be incorporated throughout these key stages, SGMT has been praised for its culturally sensitive approach to maternity care (Association of Ontario Midwives [AOM], 2012). However, as mentioned above, the only way to determine whether a health service is in fact culturally *safe* is by consulting the users of that service (Ramsden, 2002).

As such, the purpose of this project was to establish what "culturally safe maternity care" meant to Indigenous women living in the GTA, and to determine whether the care provided by SGMT met, exceeded, and/or fell short of their expectations. These perspectives were accrued through semi-structured interviews that were conducted with nine SGMT clients who self-identified as Indigenous and/or Aboriginal and gave birth with the practice within the past year. By interviewing these women, it was anticipated that SGMT, the WLH, and other stakeholders would obtain a deeper understanding of what constitutes culturally safe midwifery care and what Indigenous women living in the GTA want and expect from their reproductive and maternity care providers. It is hoped that these findings will help shape the practice of SGMT midwives as well as other urban-based health care providers who work with Indigenous clients.

This project was nested within a larger community-based, participatory, realist, and utilization-focused evaluation of SGMT that was co-led by midwives at SGMT and researchers at the Well Living House (WLH). The WLH is an Indigenous action research centre for Indigenous infant, child, and family health and wellbeing that is led by Dr. Janet Smylie and is located at the Centre for Research on Inner City Health (CRICH) in Toronto. As such, it is also anticipated that the findings from this project would be used to inform and enrich the "cultural safety" component of the evaluation study, which is looking to develop and implement a culturally relevant performance measurement system for SGMT. The results of the larger evaluation will also be used to enhance service delivery, improve Indigenous and non-Indigenous maternal and infant health outcomes, and ensure that SGMT meets its long-term goal of strong women, infants, families, communities, and nations. Finally, because SGMT is the first urban-based Indigenous midwifery practice in Canada, the results of the larger evaluation and this project in particular will be invaluable to midwives, providers, and communities interested in expanding and improving their services (FNC, 2009; NACM, 2012b; Skye, 2010).

Research Questions

This project was concerned with responding to two key questions: 1) *How do Indigenous women living in the GTA conceptualize "culturally safe maternity care"* and 2) *To what extent did their experiences at SGMT align with these conceptualizations?* In keeping with the principles of community-based participatory action research (CBPR) (see Israel et al., 2008), *Ownership, Control, Access, and Possession* (OCAP) (see FNC, 2007), and of those outlined within the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (see Canadian Institute of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council [CIHR, NSERC, & SSHRC], 2010), these research questions were developed in collaboration with SGMT and the WLH research team to be congruent with the larger SGMT evaluation study. The answers to these questions were sought through in-depth, semi-structured interviews with nine self-identified Aboriginal clients who previously gave birth with SGMT. The participants were asked a number of questions about their experiences at SGMT; their pregnancy, birthing, and reproductive needs; their views on cultural safety; the role of their identity; and, the incorporation of traditional knowledge, teachings, and ceremonies into their care. It was hoped that their responses would offer insight towards the strengths of the practice and the areas that need improvement with regards to cultural safety. Each interview was digitally or manually recorded with permission from the participant, and subsequently transcribed, coded, analyzed, and interpreted in partnership with members of the WLH research team and a peer reviewer from the community (for an example of collaborative, iterative, and consensus-based analysis methods, see Smylie et al., 2009).

Chapter Two

Literature Review

Indigenous Peoples and the Urban Landscape

Sources of urban-based Indigenous population data. Recent trends in Census data have lead Statistics Canada, government organizations, scholars, and the media to believe that the Aboriginal population has become “increasingly urban” (StatsCan, 2008, p. 21; see also AANDC, 2014b; Browne, McDonald, & Elliot, 2009; Peters, 2004; Senese & Wilson, 2013). For example, in their analysis of Census data, Norris and Clatworthy (2011) found that between 1961 and 2006, the proportion of the Aboriginal-identified population that were living in “total urban areas” rose steadily from 13% to 53%. Even when delineated by Aboriginal “group” (under Section 35(2) of the 1982 *Constitution Act*, “Aboriginal peoples” includes the Indian, Inuit, and Metis peoples of Canada, see Government of Canada, 2014), the data shows general increases in the percentages of First Nations, Inuit, and Métis peoples living in “total urban areas” (StatsCan, 2008). The majority of urban-dwelling Aboriginal peoples appear to identify as First Nations (50%) or Métis (42%), with the latter increasing at the fastest rate of all three groups (StatsCan, 2008). As a highly popularized and widely used source of population-level data, these Census trends have inspired a number of researchers and policymakers to prioritize the needs of urban Indigenous peoples (AANDC, 2014b).

While the number of Indigenous peoples living in urban areas has certainly increased, conclusions drawn from Canadian Census data must be interpreted with caution. The Censes – both past and present – have been known to underrepresent and under-cover the Aboriginal population (StatsCan, 2007). Not only do the methodologies exclude those who live in institutions (e.g. hospitals, prisons, senior citizen’s homes, etc.) or outside of Canada (StatsCan, 2007), the Census is limited in its ability to capture those who struggle with literacy, qualify as homeless or housing insecure, or who are mobile in their place of residence (Belanger, Awosoga, & Head, 2013; Smylie et al., 2011). Owing to the burden of inequity, Indigenous peoples are often forced to contend with one or more of the aforementioned social issues that exclude them from enumeration. The Census also fails to capture every First Nations reserve community. While some communities refuse to participate in the Census for historical reasons – a refusal that has been growing over time (Hubner, 2007) – others are excluded because the enumeration process was interrupted prior to completion (Gionet & Roshanafshar, 2013; StatsCan, 2007). With these factors in mind, it is likely that the Census underestimates the size of the Aboriginal population, and inaccurately captures its diversity (Smylie et al., 2011).

Another issue with Census data is its changing definition of "Aboriginal." Between 1991 and 2001, the identification of Aboriginal peoples by Statistics Canada changed from measures of ancestry and ethnicity to Aboriginal identity and origins that are obtained through participant self-identification (Walks & Bourne, 2006). For example, before 1996, Aboriginal identity was measured in the Census using questions about the cultural/ethnic background of an individual's ancestors (StatsCan, 2005b). Thereafter, questions about whether or not an individual self-identifies with an Aboriginal group, is a Registered or Treaty Indian, and/or is a member of a First Nation or Indian Band were added (StatsCan, 2005b). The wording and formatting of these questions have since evolved, changing alongside the legal definition of "reserves" and the number of Registered Indians under the *Indian Act* (StatsCan, 2013a). Thus, it is imperative that analysts consider the influence that these factors and changes have had on Aboriginal population data. Analysts must also consider how "ethnic mobility" – that is, the transitory nature of how Indigenous or Aboriginal peoples self-identify – can make it difficult to confirm whether changes between Census periods are in fact population-level changes (Anderson, Smylie, Anderson, Sinclair, & Crengle, 2006). One useful aspect of the 2006 Census was that it identified and distinguished between types of residences (e.g. rural, small urban, suburban, census metropolitan areas, etc.) instead of classifying, for instance, First Nations individuals as "off reserve" or "on reserve" (for examples of the latter, see Aboriginal Peoples Study and Canadian Community Health Survey; Browne et al., 2009). The latter can be problematic for those who are trying to characterize urban populations of Indigenous peoples without any urban-specific information. Where the 2006 Census fell short yet again, however, was in its failure to discern residence by Indian Status. Status has been identified as a key determinant of First Nations migration patterns (StatsCan, 2011c) and will be discussed below.

The most recent survey that attempted to capture urban Aboriginal peoples at a national level was the 2011 National Household Survey (NHS). Unlike the Census, the NHS was voluntary and included Registered or Treaty Indian Status as well as Aboriginal identity, Aboriginal group, Membership in a First Nation or Indian band, and Aboriginal ancestry as key indicators (StatsCan, 2011c). Even though it was criticized for its low sampling rate (3 in 10), response rate (68.6%; StatsCan, 2013b) and coverage of Aboriginal populations (e.g. a total of 36 First Nations reserves or settlements were “incompletely enumerated”; StatsCan, 2013d), the NHS did generate results that were fairly consistent with the Census (StatsCan, 2011c). For example, of the 37.6% of First Nations peoples who were living on reserve, 98.2% of them had registered Indian Status. Of the 62.4% of First Nations peoples who were living off reserve, only 60.8% have registered Indian Status (StatsCan, 2011c). While these statistics should not be taken at face value, they shed light on the influence that Status has on First Nations migration patterns. Inuit peoples, on the other hand, were primarily situated within the Inuit Nunangat territory (StatsCan, 2011c). Still, the NHS suggests that the population of urban Inuit has been increasing; 4 in 10 Inuit who lived outside the territory were located in large urban centres such as Edmonton (StatsCan, 2011c). Métis people were shown to occupy even larger proportions of western census metropolitan areas, with 84.9% of their population residing in either Ontario or the western provinces and 25% living in Winnipeg, Edmonton, Vancouver, or Calgary (StatsCan, 2011c). Inuit and Métis migration patterns can also be explained in part by the interplay of existing historical, social, political, economic, and legal forces. Even though the results of the Census and the NHS are limited in their application to the Aboriginal population in its entirety and do not draw enough attention to the contextual factors influencing the patterns observed, they have been instrumental in promoting further research, programming, and policy to meet the needs of urban-based Indigenous peoples.

Without a reliable or accurate source of Indigenous population-level data, there are no sampling frames available for urban-based Indigenous communities in Canada (Environics Institute, 2010a; Smylie et al., 2011). This poses a particular challenge for public health researchers, who rely on high-quality, longitudinal population health studies to develop, implement, evaluate, and improve effective programs and policies. To address these gaps, researchers have made several attempts to characterize the health status of Indigenous populations living in urban areas. Notable examples include the Urban Aboriginal Peoples Study (UAPS; Environics Institute, 2011a), the Toronto Aboriginal Peoples Report (TARP; McCaskill, Fitzmaurice, & Cidro, 2011), and the *Our Health Counts* Urban Aboriginal Health Database Research Report (OHC; Smylie et al., 2011).

The UAPS was informed by the results of in-person interviews that were conducted with over two thousand First Nations, Inuit, and Métis peoples living in 11 Canadian cities (Toronto included), telephone surveys that were conducted with over two thousand non-Aboriginal peoples living in the same cities (except Ottawa), and a pilot online survey for current and past National Aboriginal Achievement Foundation (NAAF) scholars (Environics Institute, 2010b). The findings were fairly positive, documenting a general connectedness among urban Aboriginal peoples to both their urban environment and their cultural identity, a shared aspiration towards higher education, and a pride in their Aboriginal and Canadian identities. Yet, upon examination of the methods, it is likely that the results of the UAPS overestimate the quality of the lived experiences of urban Aboriginal peoples. Not only was the sampling frame developed using the already-biased 2006 Census data, but also, income was not included within the sampling frame, and participants were recruited by referrals/advertising from Aboriginal organizations, post-secondary institutions, and community foundations (Environics Institute, 2010b). As such, the UAPS sample is likely biased towards urban Aboriginal peoples with education, housing security, and/or affluence, skewing the results and underestimating and under-covering the impacts of poverty. The UAPS's small sample size also limits its generalizability to other urban Aboriginal populations, and its quantitative approach to data analysis/interpretation may have distorted the extent to which the results reflected the participants' lived experiences (McCaskill et al., 2011).

In the same year, the Toronto Aboriginal Support Services Council published the findings of the TARP study (McCaskill et al., 2011). Community surveys, key respondent interviews, focus groups, life histories, case studies, and Photovoice were used to engage Aboriginal youth, men, women, seniors, and Elders living in Toronto. These methods were used to explore Aboriginal culture and identity, governance, law and justice, housing, poverty and social services, and homelessness, as well as the Two-Spirited community and the Aboriginal middle class. Key findings of the TARP study included the persistence of widespread poverty and social challenges despite improvements in education, employment and income; a growing Aboriginal middle class; the pervasiveness of racism against Aboriginal people; and, the importance of culture within the urban landscape (McCaskill et al., 2011, p. 18). Even though the community-based, outcomes-oriented, mixed methods TARP study had a large sample size (N=1424) and avoided the use of Census data, there is still a possibility that the results were subject to sampling bias, with participants being recruited from networks instead of the population at large. The authors made note of this given the underrepresentation of Métis participants within their sample (McCaskill et al., 2011).

What set the *Our Health Counts* (OHC) study apart from the UAPS, TARP, and its predecessors was its use of respondent-driving sampling (RDS) to compensate for the lack of a population-based sampling frame (Smylie et al., 2011). RDS combines snowballing recruitment techniques with a mathematical system that estimates and weighs respondents' network sizes and information about who recruited whom, so these factors (i.e. biases) can be measured and accounted for (Schonlau & Liebau, 2012; Smylie et al., 2011). It has been considered ideal for hard-to-reach populations such as urban Aboriginal peoples (Schonlau & Liebau, 2012). With RDS, OHC reached 554 First Nations adults and 236 First Nations children living in Hamilton. All participants were required to complete paper or electronic "respectful" – rather than rapid – health surveys. These surveys were developed to reflect priority health and social issues identified by community representatives, and refined (e.g. feedback on adjusting language, length of survey, flow of questions) by First Nations community members who were ineligible for the survey (e.g. lived outside of Hamilton). 92% of participants consented to providing their health card numbers and survey data to the Institute for Clinical and Evaluative Sciences (ICES) to be anonymously linked to income quintile, number of emergency room visits, mammography participation rates, and other population-level health indicators. The results of the OHC study were staggering, with approximately 70% of the First Nations cohort in Hamilton being placed within the lowest income quintile. Given the robustness of RDS statistics and the completeness of the ICES database, these results are arguably the most accurate representation of the health status of an urban-based First Nations community in Canada to date (Smylie et al., 2011). The study's unique blend of research, practice, and community partners is already being applied in a larger context; the *Our Health Counts* Toronto project kicked-off in the spring of 2015. As the number of First Nations, Inuit, Métis, and other Indigenous peoples living in urban areas continues to grow, so too does the need for health research initiatives that are as creative, rigorous, reliable, culturally safe, and Indigenous as *Our Health Counts.*

Understanding patterns of urbanization. Due to the persistence of colonial stereotypes and the popularity of Census data, there are a number of misconceptions about why Indigenous peoples migrate to urban areas and what they experience upon arrival (Peters, 2004). According to Peters (2004), four of the most commonly held myths about "urban Aboriginal people" include (1) that they are leaving reserves, rural Métis communities, and Arctic communities to live in cities, (2) that they are forming impoverished, inner-city ghettos, and (3) that they face an overwhelming number of barriers to building culture and community in the city. Even though Peters (2004) debunks these myths by manipulating Census data, she does raise some key points about the mobility of urban-based Aboriginal peoples and challenges the assumed incompatibility between Indigenous peoples and urban environments. She also speaks to the complexity of the "migration picture", which has been shown to vary by place, gender, socioeconomic status, generation, and Aboriginal group (i.e. registered Indian Status, non-registered Indian Status, Métis, Inuit; Iwasaki, Bartlett, & O'Neil, 2004; Peters, 2004; Restoule, 2008). Given the diversity that exists both within and between these Aboriginal groups, understanding Indigenous urbanization patterns requires a thorough understanding of the *push* and *pull* factors that influence or have influenced each group.

First Nations. Several scholars have studied the migration patterns of First Nations populations. According to Peters (2004) and Norris and Clatworthy (2011), the general trend towards urbanization has been accompanied by high "mobility." When compared to non-Aboriginal populations, First Nations groups appear to experience higher rates of residential mobility (movement *within* an urban centre), migration (movement between more than one community), and churn (movement between city and reserve-based communities; Norris & Clatworthy, 2003; Peters, 2005). Although largely based on Census data, these trends discredit myth (1) above. However, given the links between mobility, housing instability, and homelessness (Belanger et al., 2012; Browne et al., 2009; Norris & Clatworthy, 2003; Smylie et al., 2011), these trends may also be indicative of larger social issues (e.g. lack of affordable housing) that urban-based First Nations populations are forced to contend with.

These high levels of mobility can be explained in part by the interplay of *push* and *pull* factors. Factors that may *push* First Nations peoples away from one of the 617 distinct reserve-based communities (AANDC, 2014a) include a lack of employment and/or educational opportunities, poor social conditions, inadequate housing, insufficient health services, and/or the need to escape abuse or violence (Cooke & Belanger, 2006; Norris & Clatworthy, 2003). Factors that may *pull* First Nations peoples towards cities include better opportunities for employment and education, the need to access health/social services, and/or – for some – the allure of city life (Browne et al., 2009; Cooke, 2002; Cooke & Belanger, 2006; Norris & Clatworthy, 2003; Peters, 2004). In addition, contrary to myth (1) above, there are factors that "pull" First Nations peoples towards reserve-based communities. As per Peters (2004), moving away from the city may not reflect a failure to adjust, but rather, a need to access social support networks (e.g. family, friends, kinship ties), culturally relevant services and benefits (e.g. health care), and/or the "cultural hearth" that is home (Heaman et al., 2010; Norris & Clatworthy, 2003, p. 66). That being said, not all reserve-based communities serve as "cultural hearths" and not all First Nations peoples perceive them as much. Communities that have been and continue to be deeply affected by colonialism and its legacies (e.g. Pikwakanagan First Nation, as explored in Smylie et al., 2009) may have different priorities, dynamics, strengths, challenges, and conceptualizations of culture than communities that are larger and/or more closely (or more distantly) located from an urban centre.

Many of these *push/pull* factors can be attributed to the profound and ongoing effects of colonialism. One colonial tool that is of particular importance to migration patterns is "Indian Status." In

1876, the government passed the *Indian Act* – a consolidation of all of the previous laws that related to Indigenous peoples in Canada. Among its key tenets was the creation of "Indian Status," a legal designation that entitles "eligible" Aboriginal peoples to certain rights and benefits in Canada. Although the term "Indian" has been broadly interpreted in legal contexts to encompass Status and Non-Status First Nations peoples, Inuit, and in one case the Métis (Bonesteel, 2008; Bourassa & Peach, 2009; Teillet, 2003; The Canadian Press, 2013), Indian Status almost exclusively applies to First Nations peoples. This exclusivity has created legal divides between Status and Non-Status First Nations, Métis, and Inuit groups that have been normalized by the public and internalized by some Indigenous peoples as attributable to "cultural differences" (Lawrence as cited in Bourassa et al., 2004, p. 25). The understanding that Status was and continues to be separate from one's "Nativeness" is constantly challenged by the idea that "the only *real* Indians are those who have Indian Status" (Lawrence, 2004, p. 230). As such, Status was and continues to be:

> … A system that enabled Canada to deny and bypass Indigenous sovereignty, by replacing 'the Nation' with 'the Indian' […] in ways that have alienated whole communities from any access to a land base and permanently fragmented Native identity through an extremely patriarchal and racist system that has torn large holes in the fabric of Native societies. (Lawrence, 2004, p. 229)

Recent statistics show that 37.6% of First Nations peoples live "on reserve" and 62.4% live "off reserve" (StatsCan, 2011c). Of those living on reserve, 98.2% have Registered Indian Status; of those living off reserve, only 60.8% have Status. Evidently, not all First Nations peoples have Status. Some First Nations peoples are identified as (and/or may self-identify as) "Non-Status Indians" or "not registered Status Indians" due to personal choice, ineligibility, or a loss of Status (AANDC, 2010). Others may also be "Treaty Indians" if they belong to a Band that signed treaties with the Crown (AANDC, 2010). These statistics also offer a glimpse into the relationship between Status and migration patterns.

Since 1876, the *Indian Act* has undergone a series of amendments and revisions. Within the context of Status and migration, the most important changes took place in 1951 and 1985. In 1951, the ban on cultural practices (e.g. Potlatch Law) was repealed, Status Indian women were given the right to vote in band councils, and Status Indians no longer required permission from the Indian Agent to travel (RCAP, 1996b; Stevenson, 2011). However, these changes also extended provincial/territorial jurisdiction on reserves (e.g. on matters not covered by the *Indian Act* such as child welfare), and tied the Indian Status of women to the Status of their husbands (Lawrence, 2004; RCAP, 1996b). Under Section 12(1)(b), if a Status Indian woman married a non-Indian or non-Status Indian man, she and her children would lose their Status, Band membership, and all accompanying rights (e.g. right to live on-reserve, participate in local activity, receive on-reserve health and education services, etc.; Lawrence, 2004). Through this process, Indigenous women and their children were systematically removed from their lands (Stratford, 2007). Indian Status could also be lost if a child was born out of wedlock to a Status mother and a non-Status father, or if an individual was away or unavailable during registration (Bourassa, McKay-McNab, & Hampton, 2004; Jamieson, 1978; Lawrence, 2004; Smylie, 2009). Because Non-Status Indians were not permitted to live on Indian Reserves, many had no other choice but to venture to cities or smaller urban centres to survive, influencing migration (Bourassa et al., 2004; Bourassa & Peach, 2009). The 1951 legislation also introduced the “Double Mother Rule,” which stripped children of their Indian Status at age 21 if their mother and grandmother had only gained Status through marriage. These discriminatory and sexist provisions remained in effect until 1985. Lawrence (as cited in Bourassa et al., 2004) estimates that there were only 350,000 Status Indians left in Canada at this time.

Bill C-31 was passed in 1985 in the hopes of resolving and reversing the gendered impact of the *Indian Act* (Senese & Wilson, 2013). Key changes included the addition of Sections 6(1) and 6(2) and their respective subsections, and the separation of Indian Status from Band membership (Clatworthy, 2001). Sections 6(1) and 6(2) made significant changes to rules governing entitlement to Status, creating new categories that were determined by parenting arrangements (Clatworthy, 2001). Women who lost their Status due to Section 12(1) provisions could register under Section 6(1), and their children could register under Section 6(2). 6(1) individuals have parents who are (or are entitled to be) registered and can automatically pass Status onto their children. 6(2) individuals have one parent who is (or is entitled to be) registered under 6(1), and can only pass on their Status if they have children with another Status Indian.

This inevitably leads to a “second-generation cut-off” where Status is lost after “two successive generations of parenting with a non-Indian of either sex” (National Aboriginal Law Section, Canadian Bar Association [NALS], 2010, p. 1). Scholars fear that these inheritance rules – when combined with the increased likelihood of out-marriages that accompany urbanization (Cannon, 2011) – will lead to a dramatic decline in the population entitled to register for Status (Clatworthy, 2001; Hurley & Simeone, 2014). The second-generation cut-off has also been criticized because it occurs one generation sooner for descendants of Status grandmothers than descendants of Status grandfathers, as the latter can *always* register under Section 6(1) (Stratford, 2007). This discriminatory measure was the focus of *McIvor v. Canada,* a case that has been relevant for over twenty years and has yet to be completely resolved (Hamill, 2011).

The separation of Band membership from Indian Status is another point of controversy. Indeed, allowing First Nations communities to determine their own membership via blood quantum, the *Indian Act,* one- or two-parent descent rules, and/or other criteria can be viewed as a positive step towards self-government (Clatworthy & Smith as cited in Furi & Wherrett, 2003; Furi & Wherrett, 2003). However, this clause has created new divides. Many Status Indians were forced to reapply for band membership only to be denied due to a lack of community resources and/or space (Furi & Wherrett, 2003). Over 117,000 Indigenous peoples and their descendants have regained Indian Status since 1985 (Hurley & Simeone, 2014), but the government has not provided Bands with additional resources to accommodate the influxes in membership (Anderson & Denis, 2003). As such, many Status Indians have become Band-less. Hamill (2011) believes that the majority of these individuals are descendants of women who lost their Status between 1951 and 1985 and were forced into towns and cities. The reinstatement of Status to these individuals may partially explain the sharp increase in the number of “countable” urban First Nations peoples observed in recent years (Browne et al., 2009). Hamill (2011) also points out that this separation will increase the number of Indigenous peoples with Band membership, but no Indian Status. Because Band funding is dependent on the number of members who are Status Indians, the long-term consequences of the second-generation cut-off may have serious implications for the prosperity and health of reserve-based communities (Hamill, 2011). Bill C-3, the most recent set of amendments to the *Indian Act,* offers little recourse on this issue, and on the gender-related disparities that emerge from the second-generation cut-off rule (Hamill, 2011; NALS, 2010).

Inuit. Approximately three-quarters of Inuit peoples live in Inuit Nunangat, a territory that spans regions of the Northwest Territories, Nunavut, Nunavik, and Newfoundland and Labrador (StatsCan, 2011c). Even though there is a lack of recognition that Inuit reside outside of Nunangat, the number of urban-dwelling Inuit has been on the rise (StatsCan, 2011c). Tomiak and Patrick (2010) argue that urbanization has “contributed significantly to new forms of Inuit cultural production, as urban Inuit mobilize for resources and recognition in cities” (p. 134). Although not as mobile as their urban-based First Nations counterparts, the Inuit have a long history of movement. Traditionally, Inuit communities were mobile, migrating with the seasons (Stuckenberger, 2006). However, following the arrival of European explorers, Inuit ways of life underwent significant changes, with outsiders challenging the legitimacy of their knowledge systems, and the Canadian government relocating communities to permanent settlements (Inuit Tapirii Kanatami [ITK], 1999; Tester & Kulchyski, 1994). Even though the resettlement process did create some opportunities for educational attainment and employment, it undermined traditional knowledge and practices and disrupted existing social structures (Billson, 1990; Tester & Kulchyski, 1994).

The arrival of European settlers was also accompanied by the arrival of infectious diseases such as tuberculosis (Grygier, 1997). The tuberculosis epidemic among the Inuit became so severe in the mid 20th century that by 1956, “approximately one out of every seven Inuit was in a sanatorium in the south” (Grygier, 1994, p. 71). These evacuations were equally damaging, disrupting families, communities, and traditional practices, and creating new welfare issues (Tester & Kulchyski, 1994). The intergenerational impacts of these multiple resettlements, relocations, and evacuations on Inuit health and well being (e.g. links to food insecurity, alcoholism, family violence, poor health, etc.) have been likened to those from residential schools (Billson, 1990; Grygier, 1997). Climate change, housing shortages, and sovereignty disputes – other issues related to colonialism and its legacies – are also important determinants of health in the North (Patrick & Tomiak, 2008; Richmond, 2010). In spite of these challenges, many Inuit communities have preserved and adapted their languages, beliefs, and knowledges. Some families leave their permanent locations during the spring and summer to set up camps (ITJ, n.d.), while others celebrate Christmas in a way that reflects Inuit worldviews and practices (e.g. 10-day celebration; practice custom of cooperative games; Stuckenberger, 2006).

The contemporary migration picture for the Inuit is somewhat complex. For example, Inuit residing in Ottawa reported that they migrated to the city to attend post-secondary education programs, access better-paying forms of employment, be closer to family members, escape abuse, and/or improve the opportunities for their children (Patrick & Tomiak, 2008). Thereafter, they chose to stay. Not all Inuit may be in the city by choice, however. With the majority of Inuit living in remote areas, many are required to travel great distances to receive medical care (Tedford Gold, O’Neil, & Van Wagner, 2007). The unforeseen financial, physical, emotional, and/or psychosocial costs may be unmanageable, leaving them trapped in the city. Inuit involved in the federal corrections system may experience a similar sense of entrapment. After completing their penal terms, some Inuit are forbidden by the courts from returning north, or are not welcomed back into their communities (Makivik Corporation, 2012). When placed in these transitory positions, many can “quietly drift into homelessness” (Makivik Corporation, 2012, p. 6).

What sets the Inuit apart from First Nations populations within the context of urbanization is the ease of mobility. Travelling to and from the territory can be extremely cost-prohibitive (Tomiak & Patrick, 2010). Even so, many urban-based Inuit find ways to stay “rooted” to their Arctic communities (Kishigami, 2002; Tomiak & Patrick, 2010). This can mean communicating with family members/friends via telephone (Kishigami, 2002), social media like Facebook, and/or web-cam (McShane et al., 2013), and/or maintaining and adapting traditional practices in urban centres (Kishigami, 2002). Tensions have been identified between southern- and northern-raised Inuit (Patrick & Tomiak, 2008) as well as between land-dwelling and town-dwelling Inuit (Searles, 2010). Cultural and linguistic differences (Patrick & Tomiak, 2008) and the idea held by some Inuit that urban-dwellers are less “authentic” in their cultural identities (Searles, 2010) might make it difficult for the groups to connect. However, within cities, there is a sense that urban Inuit are “relatively unified” (Patrick & Tomiak, 2008, para. 11), valuing community cohesiveness (Smylie et al., 2009) given their shared experiences with migration and Inuit life.

Métis. The Métis are a group of peoples who are distinct from Inuit and First Nations peoples in their cultures, traditions, ways of life, and nationhood (Métis National Council [MNC], n.d.). Their origins are diverse, with some descending from Indigenous/European relations during the fur trade, and others not (e.g. Acadian and Cajun roots, or mixed ancestry; Fenwick, 2004; Métis Family Services (MFS), 2015). Even though many reside within the Métis Nation Homeland (i.e. Manitoba, Saskatchewan, and Alberta, as well as parts of Ontario, British Columbia, the Northwest Territories, and the United States), Métis communities exist all across Canada (MNC, n.d.; Wesche, 2013). That being said, each community is unique, with Central and Eastern Canada Métis clearly distinguishing themselves from their Western counterparts (Bourassa & Peach, 2009). As such, a singular “Métis experience” does not exist, even in urban centres where Métis peoples have been living and positively contributing to for generations (Wesche, 2013). Similarly, given the diversity within First Nations and Inuit groups, it is arguable that a singular “First Nations experience” or “Inuit experience” does not exist either.

Scholars predict that Métis migration to urban areas began as early as the 1800s, following the dispossession of the Homeland by military forces and the encroachment of white settlers (Shore & Barkwell as cited in Kumar, Wesche, & McGuire, 2011). Over time, migration to urban centres became the norm as the federal government continued to ignore and fail to affirm the rights of Métis peoples. For example, despite being including in the 1982 *Constitution*’s definition of “Aboriginal peoples”, Métis peoples have not been consistently entitled to the same rights and privileges as other Indigenous groups. They are ineligible to receive services (e.g. health care) that are delivered to on-reserve Status First Nations and Inuit communities and they lack settled land rights claims (Anderson et al., 2006; Bourassa & Peach, 2009; Kumar et al., 2011). As a result, in urban areas and beyond, Métis peoples often feel “caught in the middle” between identifying as White or First Nations (Iwasaki, Bartlett, & O’Neil, 2004). That being said, Métis rights have been gaining more attention and recognition in Canada. In *R. v. Powley,* the Supreme Court ruled that the hunting rights of two Métis men living near Sault Ste. Marie were protected under Section 35 of the 1982 *Constitution Act* (Teillet, 2003). Although hunting- and community-specific, experts predict that *R. v. Powley* and the "Powley Test" (i.e. the criteria for defining Métis rights and who is entitled to them) will function as precedents for future cases concerning Métis rights (Fenwick, 2004; Teillet, 2003). Chartrand (2003) agrees, but calls for a more careful interpretation of the influence of the *Indian Act* and the definition of "Métis" in future cases. Métis rights have also been affirmed more recently, with the Federal Court ruling in 2013 that Métis are in fact "Indians" and thus a federal responsibility (The Canadian Press, 2013). In spite of these promising legal advances, Métis-specific policies, programs, and services are scarce and/or under-funded (Wesche, 2013). Too often, Métis needs are grouped in with broader "Aboriginal" needs or excluded from research/programs/services altogether, leaving gaps in areas such as health care (Kumar et al., 2011; Wesche, 2013).

Understanding Métis migration patterns also requires an understanding of Métis identities. Even though organizations such as the Métis National Council have developed their own definition of "Métis", there is no statutory definition of "Métis" to be universally applied under the law (Anderson et al., 2006; MNC, n.d.). As such, it can be difficult to capture local Métis populations and meet their needs. In addition, Métis identities and geographies experience substantial ethnic mobility (Peters as cited in Wesche, 2013). For instance, prior to Bill C-31, many First Nations women who lost their Status were accepted into urban Métis communities and subsequently identified their children as such (Bourassa & Peach, 2009). Statistically, this period would read as an increase in the Métis population and decrease in the First Nations population. Ethnic mobility also comes into play when First Nations, Inuit, or Métis peoples move to a city and either a) hide/mask their Indigenous identities to protect their children and themselves from discrimination (Iwasaki et al., 2004), or b) manipulate their identities (e.g. for Métis, selectively identifying as "White" or "Native") to best adapt to situations (Wesche, 2013). As Indigenous identities – and Métis identities in particular – continue to diversify, so does the need for services, programs, and policies in urban areas that meet their specific needs.

Indigenous health in an urban context.

Indigenous peoples and the Canadian health care system. According to the *Constitution Act,* the federal government is responsible for the "general care of Indians" and the provincial and territorial governments are responsible for health care (Browne et al., 2009). Unsurprisingly, there have been significant jurisdictional disputes around who provides health care services to "Aboriginal people." At the heart of these debates is the definition of "Indian," which until recently only included on-reserve First Nations peoples (i.e. Status Indians) and the Arctic Inuit (The Canadian Press, 2013). Although Métis and Non-Status First Nations peoples have been included in the definition of "Indian," the delivery of health care to Indigenous peoples in Canada has stayed much the same. Health Canada and local communities are responsible for the health of on-reserve Status Indians and Arctic Inuit, and an assortment of federal, provincial, territorial, and local organizations are responsible for the health of all other Indigenous peoples (Health Canada, 2012). The First Nations and Inuit Health Branch (FNIHB) is the department within Health Canada that supports the delivery of public health, health promotion, primary health care, and Non-Insured Health Benefits (NIHB) to eligible Inuit and First Nations peoples (Health Canada, 2008a). Eligible communities can also benefit from the signing of Transfer Agreements. When a community signs a Transfer Agreement, the federal government gradually transfers the control over health services to the communities themselves, creating opportunities for self-determination and self-government (AANDC, 2010). Because many off-reserve and/or Non-Status Indians as well as Métis peoples do not have access to these opportunities, benefits, and services, they are required to obtain their health care from provincially/territorially administered sources that may not cater to their specific needs (Anderson et al., 2006) and do not prioritize Indigenous rights. Interestingly, even those who are eligible have expressed their frustration in accessing FNIHB and NIHB care in urban areas due to a lack of provider awareness or respect (Anderson et al., 2006; Senese & Wilson, 2013).

Accessing health services in urban areas. It is often the prospect of gaining access to more diverse, appropriate, and/or relevant health services that draws Indigenous peoples to certain areas (Browne et al., 2009). As a key determinant of Indigenous health (Reading & Wein, 2009), health services can either promote health if they are safe and effective, or damage health if they are unsafe or ineffective. Unfortunately, it seems that the health services provided by the various provincial and territorial health care systems are hardly meeting the needs of Indigenous population. Not only have Indigenous peoples described the mainstream health care as “energy draining” (for example of First Nation’s womens experiences, see Browne, Fiske, & Thomas, 2000), “intimidating” (for example of Innu and Inuit experiences, see Hanrahan, 2002), and unresponsive to group-specific needs (for example of Métis women’s experiences, see Wesche, 2013), but also, the health inequalities that have existed between Aboriginal groups and between Indigenous and non-Indigenous peoples for centuries persist (Smylie, 2009).

Remedying these inequalities begins with an exploration and dismantling of the inequities that have facilitated their emergence and persistence. Rooted in Eurocentrism and colonialism, the mainstream Canadian health care system has failed to sufficiently meet the needs of Indigenous peoples. Central to this failure is the continued dominance of biomedicine (Adelson, 2005). While biomedicine has certainly lead to major advances in technology and population health and can work in concert with Indigenous approaches to health and well-being (Burnett, 2010), its guiding principles and philosophies operate in direct opposition to Indigenous principles and philosophies. Under the biomedical model, health is defined as the absence of disease, patients are perceived as “passive recipients” of care, and its objective and reductionist methods are considered superior. Indigenous worldviews, although diverse, generally understand health and well being as the balance between the physical, emotional, mental, and spiritual aspects of an individual within the context of their community, situating individuals as active participants in their own care and creating space for multiple ways of knowing (Adelson, 2005; Hunter, Logan, Goulet, & Barton, 2006). In a health care setting, it can be difficult to culturally and linguistically translate key concepts between these groups (Adelson, 2005). This difficulty is a consequence of what Leroy Little Bear (2000) famously described as “jagged worldviews colliding” (p. 77).

The clash between Indigenous and Eurocentric views on time, space, life, knowledge, power, health, etc. has had a particular impact on the health literacy of Indigenous peoples. The Public Health Agency of Canada (PHAC) defines health literacy as “the ability to access, comprehend, evaluate and communicate information as a way to promote, maintain and improve health in a variety of settings across the life-course" (2014, para. 1). Health literacy has been identified as an important determinant of population health (for full discussion, see Ronson & Rootman, 2009), with a recent study showing that those with low literacy scores were found to be 2.5 times more likely to perceive themselves as being in fair or poor health than those with higher health literacy scores (Rootman & Gordon-El-Bihbety, 2008). Other studies have drawn attention to the gaps in educational attainment, literacy, and health literacy that exist between Indigenous and non-Indigenous peoples in urban, rural, and remote areas (StatsCan, 2005a; Canadian Council of Learning [CCL], 2009; Korhonen, 2006). Health/service providers working with pregnant First Nations women in Ottawa noticed these gaps (i.e. lack of education/health literacy among clientele; inability to access or understand existing resources), identifying them as barriers to healthy pregnancies (Darroch & Giles, 2015). Lambert and colleagues (2014) took this idea a step further, asking health care professionals in Canada, New Zealand, and Australia to explore barriers that their Indigenous clients encountered with respect to health literacy. Participants listed Western dominance and a lack of Indigenous providers among the cultural barriers; poverty among the social barriers; and, service delivery limitations among the systemic barriers. Incidentally, the health care professionals knew very little about health literacy, its implications, and what they could do to empower their clients in this regard (Lambert et al., 2014).

While there are certainty inequalities in educational attainment and high-school drop out rates between Indigenous and non-Indigenous groups (CCL, 2009), the health literacy picture is further complicated by the definition of health literacy itself. In Canada, health literacy is often measured by assessing an individual's ability to read, write, and comprehend (Western) health information communicated in English (Antone & Imai, 2006; Darroch & Giles, 2015). This can be problematic for Indigenous peoples who do not speak English, use English as a second/third language, come from a strong oral tradition, or lack formal education. Flawed measures such as these can misrepresent the needs of the Indigenous population. As such, scholars and providers must adopt a culture-based definition of health literacy that operates at the interface between Indigenous and Western knowledge and languages

(Smylie, Williams, & Cooper, 2006). It must respect multiple worldviews, incorporate multiple literacies, and be developed alongside communities in order to facilitate empowerment (Smylie et al., 2006; Vass, Mitchell, & Dhurrkay, 2011). However, given the differences between Indigenous and Eurocentric worldviews, the continued dominance of biomedicine in the mainstream health care system, and the lack of research exploring Indigenous health literacy, this task has proven challenging – especially in urban areas. Many urban-dwelling Indigenous peoples do not have and are not given the opportunity to expand their health literacy.

This disconnect between Indigenous peoples and the mainstream health care system can be amplified by the abundance of non-Indigenous providers and the expectation that Indigenous peoples will seek care when it is needed (Adelson, 2005). As previously discussed, it may be difficult for urban-based Indigenous peoples who are not covered by the FNIHB to access culturally safe health care. Even for individuals with FNIHB coverage, reports of NIHB clients being declined or discriminated against by providers (Senese & Wilson, 2013) and restricted in their choice of knowledgeable and culturally safe providers (Anderson et al., 2006) is worrisome. In the Hamilton OHC study (Smylie et al., 2011), participants felt that federal coverage was a barrier to accessing health services. Considering that 25% of participants were not covered, this may partially explain why 26.8% reported an inability to afford the direct costs of care and 30.0% listed an inability to afford transportation among the barriers to care (Smylie et al., 2011). For the Métis – who only receive a fraction of federal Aboriginal health funding – the concerns about coverage surround the lack of Métis-specific services and Métis awareness among providers (Kumar et al., 2011). All things considered, the issue of accessing health services as an urban-dwelling Indigenous person "remains a muddy one" (Browne et al., 2009, p. 32).

Compounding the barriers to access is the longstanding misconception that Indigenous peoples and urban environments do not mix (Peters, 2004). Wilson and Peters (2005) argue that this false dichotomy has endured because of the government's continued attempts to physically and conceptually separate Indigenous space and urban space. For example, in addition to creating the reserve system, the government took measures to move reserves away from growing towns and cities to "remove all hindrances to the full settlement and exploitation of all potentially productive lands in the West" (Gaby, 1973, p. 49; key examples: Songhees Indian Reserve near Victoria, B.C.; several reserves in southern Saskatchewan). These relocations were legalized following 1911 amendments to the *Indian Act* that allowed authorities to expropriate reserve lands for public works without surrender, and relocate reserves away from municipalities if it was deemed "expedient" (referred to as "The Oliver Act"; Vancouver Status of Women Feminist Working Group, 2008). While "Indians" were being relocated but confined to reserves (e.g. via pass system, whereby First Nations peoples needed written permission from Indian Agents to leave the reserve; Smylie, 2009), the Métis were also being "swindled out of their rightful heritage" (MFS, 2015, para. 36) by government-issued land scrip certificates. Although the scrips entitled their bearers to land and money, they were seldom honoured, recognized, or evenly distributed among the Métis by government officials (MFS, 2015). Excluded from Indian reserves and eventually their own communities, many Métis had no choice but to live on "road allowances" – unused Crown land that was located along the sides of roads and road lines (Belisle, 2006). The "road allowance years" were generally marked with poverty as well as social exclusion, harassment, and racism from nearby settler-dominated towns/cities (Belisle, 2006; Logan, 2008). In some instances, Métis children were prohibited from attending town-based schools, creating significant gaps in education (Aboriginal Healing Foundation, 2006). Logan (2008) argues that the road allowance was a physical manifestation of the "Othering" that the Métis experienced.

The story is quite different for the Inuit, however. By the 1940s, the impacts of military, settler, and missionary activity on Inuit health and wellbeing grew increasingly difficult to ignore (Tester & Kulchyski, 1994). Not only were epidemics devastating entire communities, but also, following the 1939 *Re Eskimo* Supreme Court decision (i.e. Inuit were formally recognized as "Indians" under the law; see Bonesteel, 2008), the Inuit had become a federal responsibility (Tester & Kulchyski, 1994). The government's response to the poor health outcomes in the North was the relocation and removal of families and communities to permanent settlements that were more accessible to the south. These forced relocations were seen as advantageous because they gave Inuit the opportunity to access health care, social services, and education and escape the ostensibly "hostile climate" and "primitive conditions" of the Arctic (Tester & Kulchyski, 1994, p. 311). It was also expected that Inuit would gain Western credentials (e.g. nurse, physician, police, teacher) and return to the north with their skills, and/or start a "new life" in the city. The physical removal and relocation of Inuit from their communities was devastating; it divided and re-divided families and destroyed kinship ties and social systems. Even though the Inuit were physically incorporated into "urban" or southern space, this process relied on the depiction of Inuit space (i.e. communities and territories) as insufficient and in need of "modernization" from the West. In other words, there was *space* for Inuit in urban/southern regions, but only if they assimilated and fully integrated into Canadian society. All things considered, Indigenous peoples have endured various types of physical separation and rejection from urban areas.

Early settlers and European scholars were also under the impression that Indigenous urbanization reflected a conscious effort towards assimilation (Peters, 2004). Wrongfully believing that Indigenous culture was a static concept belonging to history or to a distant, exotic place, the cultural romantics of the 20th century viewed "the city" as a threat to the ostensible "authenticity" of Indigenous languages, cultures, and peoples (Goldie as cited in Peters, 2004). Cultural romanticism was damaging, contributing to the "racialized juxtaposition of civilization and savagery" and functioning as yet another paternalistic measure that told Indigenous peoples where they belonged (Harris, 2002, p. 268). The romanticization of Indigenous peoples continues, although it follows a different trajectory. When non-Aboriginal people were asked about their views on the Aboriginal peoples living Toronto, 55% expressed idyllic and optimistic responses, overestimating the health and well being of Aboriginal peoples and the quality of Aboriginal/non-Aboriginal relations (Environics Institute, 2010a, b). That being said, given the limitations of the UAPS and the prevalence of racism and discrimination in Toronto as revealed by Indigenous residents, it is likely that this statistic is a gross underestimate of the number of "dismissive naysayers" and "inattentive skeptics" in the city (Environics Institute, 2010a) and health care system (Allan & Smylie, 2015; Health Council of Canada [HCC], 2012; Livingstone, 2012; McCaskill et al., 2011; Senese & Wilson, 2013). This suggests that the narrative that casts urban space as exclusively European-Canadian space is still strong.

While there is certainly a need for high-quality population-level health data capturing the outcomes and needs of the urban Indigenous population, much can be learned from the existing evidence that documents First Nations, Inuit, and Métis experiences with the Canadian health care system. Some studies elected to use “Aboriginal” or “Indigenous” as a blanket term, rather than focusing on one of the three groups, which is done below. The first relevant study examined the relationships between “underclassism” and access to emergency services in a Western Canadian city (Tang, Browne, Mussell, Smye, & Rodney, 2015). Interviews with Indigenous patients, non-Indigenous patients, and health care providers revealed that the health care system often “feed[s] into the popularized images of [Otherized, racialized, marginalized, low-income, homeless] people as potentially dangerous, deviant, or less deserving members of society” (Tang et al., 2015, p. 8) and as such does not deliver care equitably. Many Indigenous patients felt that their providers treated them like second-class citizens, dismissing their concerns, and making clinical decisions (e.g. triage) based on stereotypes and assumptions (e.g. drug abuse). Accounts from providers support this idea, with their interviews suggesting that vulnerable inner city groups are constructed as less credible, less important, and less deserving of health care resources than groups with “higher” social positioning. The authors argue that the “social devalues attached to welfare” (Tang et al., 2015, p. 10) – which reflect neoliberal and classist assumptions – reinforce this differential treatment, and function as a means for the State to survey and control the social “Other.”

In a different study, thirteen Aboriginal women living in Okanagan Valley, British Columbia were interviewed about their experiences with the mainstream health care system and Aboriginal-run health services (Kurtz et al., 2008). In the mainstream health care system, the women had to contend with racism (e.g. stereotypes), discrimination (e.g. assumptions about alcoholism), and communication barriers (e.g. being silenced). In contrast, Aboriginal-run services such as Friendship Centres were supportive safe places where providers could be trusted. The thirty-six Aboriginal people who were interviewed about the ways in which urbanization, Aboriginal rights, and health intersect in Toronto shared similar stories

(Senese & Wilson, 2013). Even though the participants believed that their struggles to access services, assert their rights, and overcome discrimination negatively affected their health, many felt that opportunities to reconnect with their cultural identities allowed them to better negotiate these challenges. Organizations, although initially difficult to reach, were recognized as helpful buffers and support systems while in the city.

Each of these investigations offers some insight towards the complexities of Indigenous health within an urban context, while drawing attention to the areas that are ripe for improvement. Evidently, urban landscapes can be marked with both obstacles and opportunities for Indigenous peoples (Adelson, 2005). The task of public health researchers is to collaboratively develop strategies to eliminate existing barriers and create paths for First Nations, Inuit, Métis, and other Indigenous peoples to seize these opportunities.

First Nations experiences with the mainstream health care system. One of the recurring themes in the literature exploring urban-dwelling First Nations peoples' experiences with the mainstream health care system is the desire to access traditional healers and to maintain their traditional ways of knowing around health (Benoit et al., 2003; Browne et al., 2009; Hunter et al., 2006; McCaskill et al., 2011; Restoule, 2008; Silver, Ghorayshi, Hay, & Klyne, 2011; Smylie et al., 2009). That being said, not everyone who identifies as First Nations feels this way, or has the same level of interest or knowledge. Even so, what research and experience also indicates is that the urban environment does not always create space for traditional knowledge or First Nations-based health care. For example, in interviews with a group of Anishnabek-identified people who recently moved from their communities in Northern Ontario to a southern urban centre, the participants acknowledged that it was not always easy to openly practice or maintain their cultural identities (Wilson & Peters, 2005). Even though many were able to reconnect with their cultural identities and create new ones by creating small cultural spaces in the city (e.g. urban gardens; smudging in apartments), one participant shared her experience of being threatened with eviction when her landlord assumed her sage was marijuana.

Interviews with Carrier First Nations women who accessed care in the mainstream health care system painted a similar picture (Browne, Fiske, & Thomas, 2000). The women's stories were divided into invalidating encounters (e.g. being dismissed and stereotyped by providers; feeling like an outsider; having circumstances and vulnerabilities disregarded) and affirming encounters (e.g. actively participating in care decisions; feeling cared for; being supported and respected in their personal and cultural identities). Even though fifteen years have passed since the publication of this telling piece, many First Nations peoples – both Status and non-Status (Anderson et al., 2006; Senese & Wilson, 2013) - who access health care in urban areas are made to feel culturally "unsafe" (see literature review on "Cultural Safety" below). Clearly, colonialism, racism, sexism, and the other underlying determinants of Indigenous health have yet to be resolved (Reading & Wein, 2009). These types of barriers have lead to significant gaps in access to high-quality health care between urban-based and reserve-based First Nations peoples, and between First Nations and non-Indigenous peoples (McAskill et al., 2011; Browne et al., 2009). Often, the most vulnerable groups fall through the cracks. As revealed in the OHC Hamilton study (Smylie et al., 2011), poverty and its associated social consequences (e.g. homelessness) remain a very real yet grossly underreported aspect of many urban-based First Nations realities. Although First Nations communities must be recognized and commended for their resiliencies, action is desperately needed to reach and provide culturally safe support to these communities.

Many – although not all – urban-dwelling First Nations peoples seem to maintain some sort of physical, spiritual, emotional, and/or mental connection to their reserve-based communities and/or communities of origin (McCaskill et al., 2011; Peters, 2004; Silver et al., 2011; Wilson & Peters, 2005). This desire to stay connected may partially explain the relatively high mobility of urban First Nations peoples, although travel can be limited by geography and cost for those who live in "concrete nations" like Toronto (Wilson & Peters, 2011). In these cases, some First Nations peoples may put their differences aside and find kinship and community through First Nations groups or pan-Aboriginal organizations (Peters, 2011). However, other First Nations peoples have been shown to actively avoid pan-Aboriginal initiatives (Smylie et al., 2011) because these homogenized initiatives are incapable of meeting their diverse needs (Proulx as cited in Peters, 2011). Whether urban-based First Nations peoples seek pan-Aboriginal initiatives or not, what can be concluded is that Indigenous identities and definitions of cultural inclusiveness are not static; they are fluid, flexible, and adaptive and must be considered when planning programs and designing services (Restoule, 2008; Skye, 2006; Wilson & Peters, 2005). It is also important that First Nations peoples have access to Indigenous-run organizations, as they have been shown to promote health and empower women in urban settings (Browne et al., 2009; Silver et al., 2006; Skye, 2006).

Inuit experiences with the mainstream health care system. Being surrounded by non-Indigenous peoples, languages, and cultures in a fast-paced urban centre can be very overwhelming for Inuit who have recently migrated. Although the literature linking Inuit health with experiences of urbanization is sparse, existing studies speak to the prevalence of "culture shock" (Hanrahan, 2002; Patrick & Tomiak, 2008; Tomiak & Patrick, 2010). After conducting interviews with 107 Inuit and Innu peoples who had to travel to urban areas in Newfoundland and Labrador to access health services, Hanrahan (2002) found that four themes emerged: language, disorientation, accommodations, and diet. The participants expressed a need for more interpreters (e.g. Innu-eimun speakers), more suitable accommodations for short-term stays, and access to traditional foods in the hospital and city. Many recalled "freezing" – that is, feeling paralyzed out of fear – in the hospital environment. Although it would be ideal to expand the breadth of health services in the Arctic, this remains economically infeasible due to the remoteness and low population size of most communities (Lalonde et al., 2009; Tagalik, 2009). Social workers, midwives, doctors, and other health care providers are not always available year-round, or at all. As a result, it is imperative that decision-makers and health care providers develop strategies to ease the transition from Arctic communities to urban health care environments for the Inuit.

Even though many First Nations peoples may be able to relate, it is important to reiterate that urban Inuit are distinct in their health status (Simonet et al., 2010), needs, and preferences (Tomiak & Patrick, 2010). For example, in a report studying the pathways of health information dissemination and use in three Aboriginal communities near Ottawa, several themes were identified as unique to the urban Inuit subgroup (Smylie et al., 2009). While some First Nations peoples may be open to pan-Aboriginal strategies, the Inuit in this study perceived non-Inuit-specific services as inferior and less relevant. Participants also mentioned a tendency to consult Elders about health issues before approaching mainstream sources, even if they were separated by distance. Efforts to maintain connections with home communities up north have been reported elsewhere (McShane et al., 2013) and align with Patrick and Tomiak's (2008) conclusion that for some Inuit, "the promise of a better life… outweighed the shock of adjustment to life in the city" (para. 21).

*Métis experiences with the mainstream health care system***.** Métis peoples have had negative experiences in the mainstream health care system as well as with generic "Aboriginal" health services (Iwasaki et al., 2002; Smylie et al., 2009; Wesche, 2013). However, there are only a handful of studies that have explored these encounters. Iwasaki and colleagues (2002) compared Métis and First Nations experiences with stress related to diabetes. Their work confirmed the existence of Métis-specific stressors – in this context, examples included being "stuck in the middle" between White and Indian peers and being concerned about Métis status after marrying a Treaty Status First Nations man. Another key issue that was identified as specific to the Métis community in Ottawa was community dispersion (Smylie et al., 2009). Because there is "no closeness" in terms of cohesive community structures and networks (Smylie et al., 2009, p. 442), participants felt that it was difficult to identify and connect with other Métis in the city. They also shared how their identities and experiences made them feel like outsiders in both the mainstream Canadian health care system and when using Aboriginal health services. Identity also emerged as an important theme in Wesche's (2013) interviews with 12 Métis women living in urban areas of British Columbia. Here, the participants expressed an uncertainty in their Métis identity, sharing stories about feeling judged for their appearance (e.g. skin colour). Even though the women stressed the importance of procuring more funding for Métis-specific services, they also spoke to the power and strength in the cohesiveness of their families and communities. They unanimously agreed that culturally safe space has "an atmosphere and practitioners who are open, non-judgmental, inviting, warm, and nurturing" (Wesche, 2013, p. 194). Reflecting on the distinctness of the Métis and their unique experiences in the health care system, it is not enough for the Métis to be under federal jurisdiction; funding and support for Métis-specific policies and programs is much needed.

Indigenous Women, urbanization, and health. Indigenous women have always been important members of their communities. Historically, they were not only responsible for raising children, but also, for decision-making (e.g. politics, economics, land, etc.), conflict resolution, community health, and hunting, fishing, and gathering (Anderson, 2000b; McGrath & Stevenson, 1996; Pauktuutit Inuit Women of Canada [PIWC], 2006) – depending on their community. These responsibilities complemented those that were held by men, balancing the division of labour (Burnett, 2010; Carter, 1996; PIWC, 2006). Even though some of these traditional practices and responsibilities have endured (PIWC, 2006), Indigenous women experienced a "tremendous loss with the introduction of European political systems" (Anderson, 2000b, para. 17). Because the autonomy of Indigenous women was seen as a threat to the "Christian patriarchal order" (McGrath & Stevenson, 1996, p. 45), colonial forces made numerous attempts to disempower and assimilate Indigenous women. In the words of Mi'kmaq woman Cathy Martin (as quoted in Anderson, 2000b):

> In order to break down and destroy a culture, you have to get to the root it. The heart of Aboriginal cultures is the women. So it makes sense to start making policies that would banish the women, the givers of the language and the culture and the life. (para. 24)

The *Indian Act* was particularly detrimental to Indigenous women. For example, First Nations women who "married out" (i.e. to a Non-Status or non-Indigenous male) lost their Status, the Status of their children, and their right to live on reserve (Peters, 2005; Senese & Wilson, 2013). The Government also tried to control Indigenous sexuality by refusing to grant Band membership to children who were born out of wedlock, unless this was approved by the Superintendent General of Indian Affairs (McGrath & Stevenson, 1996). Women were also excluded from land ownership (McGrath & Stevenson, 1996). The consequences of these sexist provisions were multi-fold; families were disrupted and women were separated from their lands, stripped of their rights, and silenced politically (Anderson, 2000b).

The Christian patriarchal order was also forced on Indigenous women by the residential school system. The racist and sexist assumptions that ostensibly justified the imposition of this order lead to the creation of a system where violence and abuse was normalized; Indigenous women were objectified; Indigenous languages, cultures, and sexuality were attacked; and families were intentionally damaged (Anderson, 2000a; LaRocque, 1994). The historical and intergenerational trauma caused by many of these schools has contributed to the disproportionately high rates of violence against Indigenous women (LaRocque, 1994; Mathyssen, 2011; StatsCan, 2013c) and to their higher risk for experiencing alcohol and substance abuse, diabetes, poverty, violence, incarceration, and homelessness (Baskin, 2007; NWAC, 2007; Smylie, Fell, Ohlsson, & the Joint Working Group on First Nations, Indian, Inuit, and Métis Infant Mortality of the Canadian Perinatal Surveillance System, 2010; Wesley, 2012; Yee et al., 2011). While it is best to avoid deficiency-based perspectives, it is important to recognize that the burden(s) of inequity are very real for many Indigenous women.

Attempts to control Indigenous women and their families did not end with residential schooling, however. Between 1960 and 1980, there was a mass removal of Aboriginal children from their families referred to as the “Sixties Scoop” (Hanson, 2009; Sinclair, 2007). The children were largely adopted by non-Aboriginal families in Canada or overseas, or placed in the child welfare system. Even though these adoptions were not part of a program or policy, social workers began entering Indigenous homes (with or without permission) and apprehend children that they felt required protection (Sinclair, 2007). With no understanding of Indigenous ways of life (e.g. traditional foods) and the impact of colonialism (e.g. prevalence of poverty), the Canadian child welfare system disrupted thousands of Aboriginal families. Hanson (2009) argues that child apprehension has become the successor of the residential school system as a form of cultural genocide. Regrettably, the Canadian child welfare system “is no less prolific in the current era” (Sinclair, 2007, p. 67). As of 2011, 48.1% of all children under the age of 14 in foster care were Aboriginal children (StatsCan, 2013a). This represented 4% of all Aboriginal children, whereas only 0.3% of all non-Aboriginal children were in care. The majority were First Nations children, followed by Métis and Inuit. Research and experience indicates that the apprehension of Indigenous children has been traumatic for many of the women, families, communities, and children involved (for examples, see Sinclair, 2007). Many Indigenous women fear apprehension, and this fear – when combined with cultural *un*safety – has been shown to deter Indigenous women from seeking health care services for themselves, or from visiting their children when they are hospitalized (Denison, Varcoe, & Browne, 2014).

Evidently, the convergence of sexist, racist, and colonial forces has placed Indigenous women in what Bourassa and colleagues (2004) refer to as a "matrix of oppression" (p. 24). Because of this matrix, Indigenous women often experience a disproportionate burden of poor health (NWAC, 2007). That being said, Indigenous women have been fighting the "irony of colonialism" for generations; their resiliencies cannot go unnoted (Monture, 2008, p. 155; PIWC, 2006). For example, in the context of health care, Indigenous women have been deeply involved in the revitalization of Indigenous midwifery (see literature review on "Indigenous Midwifery"), the promotion of cultural safety in health care (see literature review on "Cultural Safety"), the practice of trauma-informed mental health care for Aboriginal peoples (Arthur et al., 2013), the development of guidelines for professionals working with Indigenous clients (Wilson et al., 2013), and the leading of Indigenous research projects (e.g. Well Living House). In one study, pregnant and parenting Aboriginal women acknowledged pregnancy as an opportunity to change, heal from trauma, and move forward as a family (Smith et al., 2006). Given the role that parenting has in transmitting trauma (Sotero, 2006) and the profound importance of birth and life, delivering culturally safe reproductive health care to Indigenous women can certainly improve the health and well being of women, families, and communities while combating sexism, racism, and colonialism.

One of the key prerequisites of delivering culturally safe care to Indigenous women is to recognize and honour their diversity, especially in urban areas. Below is a brief overview of the patterns of urbanization that directly pertain to First Nations, Inuit, and Métis women. What can be concluded from the following paragraphs is that the lived experiences of a first-generation urban (i.e. first generation living in the city) Métis woman will differ from those of a second generation urban First Nations woman and a third generation urban Inuit woman, and so on (Kumar et al., 2011). Despite being united by the collective experience of being Indigenous, each Indigenous woman is unique in her experiences, realities, communities, and histories.

Urbanization and First Nations women. As previously discussed, the implications of the *Indian Act* were gendered. Prior to 1985, it was not difficult for a First Nations woman to lose her Status and thus her right to live on reserve. As a result, many Non-Status First Nations women had to find new homes in urban centres. After the introduction of Bill C-31 in 1985 – which sought to reverse some of the more sexist clauses introduced in the 1951 *Indian Act* - thousands of First Nations women and their children were eligible to re-apply for Status (Browne et al., 2009; Senese & Wilson, 2013). Although this lead to a tremendous increase in the population of Status Indians, many First Nations women and their children could not return to their reserve-based communities for the reasons that were noted above (Anderson & Denis, 2003; Bourassa, 2004). Bill C-31 also introduced new challenges for First Nations women that relate to the second-generation cut-off rule (see *McIvor v. Canada,* critiques from Cannon, 2011; Hamill, 2011; NALS, 2010). With these factors in mind, it is not surprising that population of urban-dwelling First Nations women continue to outnumber the population of urban-dwelling First Nations men (Gerber, 2014). First Nations women are also more likely experience violence, trauma, and single parenthood than First Nations men due to the convergence of racism, sexism, and internalizations of the two – all of which may "push" them towards the city (Andersson & Nahwegahbow, 2010; Browne et al., 2009; Cooke & Belanger, 2006; Jamieson as cited in Halseth, 2013; LaRocque, 1994). To reiterate, urban settings do not always create space or support respect for First Nations women and their health needs.

Urbanization and Inuit women. Even though many Inuit women have maintained their languages and practices and established new identities in the contemporary Arctic (PIWC, 2006), they too appear to be "more urban" than Inuit men (Gerber, 2014). Although Inuit urbanization patterns have not been thoroughly investigated through a gendered lens, it is likely that key issues such as underemployment and the ongoing housing crisis in Nunavut have a particular impact on women (PIWC, 2006). For example, with long wait lists for public housing and general shortages in affordable housing

(Savoie & Cornez, 2014; Quilliit Nunavut Status of Women Council as cited in Seltzer, 2012), Inuit women who are living in complex socioeconomic and/or emotional situations may be forced to choose between abuse and homelessness (Seltzer, 2012), prompting migration. The women living in more stable and healthy environments, on the other hand, are still faced with the burdens of food insecurity, precarious or limited employment opportunities, and climate change in the Arctic (Savoie & Cornez, 2014; Seltzer, 2012) – all of which may trigger migration. As discussed, moving to urban centres does not necessarily bring more opportunities; accounts from recently migrated Inuit women indicate that there are several barriers to accessing the childcare, healthcare, and housing that they require in the city (PIWC, 2007; Seltzer, 2012). Even for the Inuit women who have been living in cities for years or generations, many still encounter racism, experience cultural unsafety in the health care system, and feel disconnected from the Arctic (PIWC, 2007).

Urbanization and Métis women. I have not come across any studies that specifically explore the relationships between gender and migration for Métis populations. This may be attributed to the underrepresentation of Métis peoples and Métis women in the literature, or to the fact that a large number of Métis have been living in urban areas (but not necessarily self-identifying, or being identified) for generations (Kumar et al., 2011).

Indigenous Midwifery

Early Indigenous midwifery. Indigenous midwives have a long history of helping women, families, and communities bring new life into the world. They were more than just women or men (Carroll & Benoit, 2004) who delivered babies; they were highly skilled, knowledgeable, and respected practitioners who offered continuous and holistic care to mothers, infants, and families across the lifespan and until death in some cases (FNC, 2009; Olson, 2013). They were also “keepers of culture” (Carroll & Benoit, 2004, p. 266) who carried on and shared traditional knowledge, teachings, and values with women to prepare them for their transitions into adulthood and motherhood (NAHO, 2008a; NWAC, 2007a; Ross Leitenberger, 1998; Vallianatos, Brennand, Raine, Stephen, & Petawabano, 2006). Pregnancy and birth were seen as sacred events, so women were cherished for their gifts as “life givers” and midwives for doing the Creator’s work (Benoit, Carroll, & Eni, 2006; Morgan & Wabie, 2012; NWAC, 2007a). Each birth served as a reminder to the community of the “delicate balance” (Carroll & Benoit, 2004, p. 265) that existed between the spiritual world and physical world. Elders, midwives, and other key community members prepared men and women for this profound life event through teachings, storytelling, and ceremonies (Benoit et al., 2006; Inuit Women’s Association of Canada [IWAC], 1995; Ross Leitenberger, 1998).

The roles, responsibilities, practices, and knowledge held by Indigenous midwives varied within and between First Nations, Inuit, and Métis communities. Linguistically, the definition of “midwife” ranged from *iewirokwas* or “she is pulling the baby out of the earth” in Mohawk (Benoit et al., 2006, p. 12), to “she can do everything” among the Nuu-chah-nulth peoples, to “to watch/to care” in Coast Salish communities (Jeffries as cited in Carroll & Benoit, 2004, p. 266). In one area of Nunavik, the term *sanaji* was used to describe a midwife who delivers a baby girl, and *agnaqutiq* for a baby boy (IWAC, 1995). Birth styles were equally diverse, with some First Nations communities adopting a woman-centered approach to birth (e.g. men and boys sent away for birth, as per stories in Ross Leitenberger, 1998), while others had established roles for partners and children (NAHO, 2008). Some Inuit women gave birth alone (e.g. Pond Inlet), whereas others relied on the support of their mothers, husbands, in-laws, daughters, and/or neighbors (NAHO, 2008). Place of birth also varied, with Mi’kmaq women in Newfoundland using special birthing tents, Anishnawbe women delivering babies into moss bags (NAHO, 2008), and Inuit women giving birth in shelters, outdoors, on boats, and on moving sleds (IWAC, 1995). The limited accounts of traditional Métis midwifery that are available indicate that their midwives were often childless women who were taught how to safely care for women, babies, and families by their Indigenous ancestors (Heritage Community Foundation, n.d.).

Although unique in their knowledge and practices, traditional Indigenous midwives have been depicted in stories as the ultimate multi-taskers. According to the Elders from First Nations communities in northern British Columbia, midwives were “herbalists, gynecologists, obstetricians, and nutritionists all rolled into one" (as cited in Ross Leitenberger, 1998, p. 30). Nishnawbe-Aski peoples (Aboriginal people of the Treaty nine area; Terry & Calm Wind, 1994) from northwestern Ontario described midwives as gifted herbalists, having extensive knowledge of how and when to use traditional medicines; dieticians, teaching mothers about prenatal nutrition; caregivers, supporting families when needed; deliverers; nurturers; and, *do-dis-seem,* having lifelong kin-based relationships with the children who they brought into the world (Terry & Calm Wind, 1994). Inuit midwives were equally versatile, in that they educated mothers and children while tending to the pregnancy, birth, and reproductive birth needs of women in their communities (IWAC, 1995). Altogether, Indigenous midwives were specialists, but not in the biomedical sense of the word. Rather, these specialties were interdependent and interconnected aspects of a midwife's being that were expected given the relational and holistic nature of Indigenous worldviews (Martin Hill, 2003).

Traditional Indigenous midwives have also been described as teachers, as they educated younger midwives through apprenticeships (Carroll & Benoit, 2004). Through this process, the midwives passed on technical knowledge to future generations about how to massage a fetus into its preferred position, turn breech babies, safely deliver the afterbirth, collect and use medicines to alleviate post-partum hemorrhaging, and prevent post-partum depression (Carroll & Benoit, 2004; IWAC, 1995; NAHO, 2008a; Skye, 2010). Midwives were also keepers of knowledge about ceremonies for pregnant parents (NAHO, 2008), naming (Terry & Calm Wind, 1994), keeping the umbilical cord (Olson, 2013), and handling the placenta (Olson, 2013; Ross Leitenberger, 1998). As a result, in addition to promoting the health and well being of their communities, traditional Indigenous midwives ensured the survival of local knowledge and the integrity of the connection to the land (NWAC, 2007; Carroll & Benoit, 2004).

The demise of midwifery in Canada. The historical demise of Indigenous and non-Indigenous midwifery in Canada was not a rapid or even process (Bourgeault, 2006; Burnett, 2010). In some communities, Indigenous midwives had virtually disappeared by 1900; in others, they remained active through the 1940s (Burnett, 2010). These differences were closely linked to settlement patterns, with less settled regions (e.g. present-day southern Alberta) relying on midwives for longer periods than more settled regions (e.g. present-day Toronto; Bourgeault, 2006). In any case, the demise of midwifery began with the arrival of European settlers. Even though Indigenous midwives were invaluable to the survival and health and well being of early settlers, they were seldom mentioned in written accounts or acknowledged by the white women they cared for (Burnett, 2010; Jasen, 1997). In the nineteenth and early twentieth centuries, writers and scholars (oftentimes men) focused on the more visible, masculine, and "fantastic" aspects of Indigenous health and healing (e.g. the Medicine Men of northwestern Plains communities) in order to satisfy their idealized understandings of Indigenous peoples and appeal to European audiences (Burnett, 2010). The work of Indigenous midwives was also overlooked; writers and scholars were more interested in Indigenous women and their apparent "parturition without pain" (Jasen, 1997). Indigenous approaches to childbirth were very different from those observed in Europe, where pain in childbirth was both the norm and a sign of civility. Through the colonial lens, these approaches were misinterpreted as "savage" and "uncivilized," and the ostensible ease of childbirth was misattributed to smaller infant head sizes and thus lower intelligence among Indigenous peoples (Jasen, 1997). These stereotypes about Indigenous women were problematic for Indigenous midwives because it framed their practice as unnecessary (Lux, 2001).

In reality, Indigenous midwives were necessary, and remained so for many generations. Historical evidence indicates that many communities depended on the collaboration of Indigenous midwives and non-Indigenous health care providers, such as nuns, missionaries, physicians, Department of Indian Affairs (DIA) nurses, field matrons, public health nurses, etc. (Burnett, 2010). The continued success of Indigenous midwives has been cited as one of the main reasons behind the DIA's reluctance to intervene in Indigenous obstetrics until the 1920s (Burnett, 2010). Evidently, biomedicine did not immediately "replace" Indigenous medicine; medical pluralism was practiced in several areas. Unfortunately, the age of pluralism and collaboration did not last. The practice of cultural rituals and ceremonies was banned under the *Indian Act* until 1951 (RCAP, 1996b). Indigenous women – and the knowledge they carried – were systematically removed from their lands following the creation of and amendments to Indian Status (for full discussion, see p.22). Church-run (and later, church- and government-run) residential schools also had an impact on traditional midwifery. Attendance interrupted the transmission of knowledge by preventing children from participating in midwifery apprenticeship programs (Lux, 2001). Children were also separated from their families and abused for speaking their languages and/or practicing their traditions – the implications of which continue to affect Indigenous parenting skills, reproductive knowledge and expertise, and health and well being (Anderson, 2000a; Carroll & Benoit, 2004; Ing, 2006; Roy, 2014).

Non-Indigenous health care providers were also involved in the gradual displacement of Indigenous midwives. For example, in the 1920s, the government hired field matrons and public health nurses to teach Indigenous women about "proper" sanitation, nutrition, child care, and home making (Government of Canada, 1928). It was hoped that by "educating" (i.e. assimilating) Indigenous women – who oftentimes did not seek out Western health care because of its poor quality – they would become "better mothers" and thereby improve Indigenous health outcomes (Burnett, 2010). It is likely that these "domestication" efforts interrupted the transmission of knowledge and practice in reserve-based communities. Meanwhile, non-Indigenous peoples were growing less dependent on Indigenous medicine, and pregnancy/birth outcomes were improving in hospitals due to advances in infection control and surgery (Burnett, 2010; Lux, 2001). Even though Indigenous midwives were still practicing when Indigenous women began giving birth in hospital (Burnett, 2010), they had to overcome new barriers, such as the continued attempts to separate the "biomedical," scientific," and "rational" from the "Indigenous," "unscientific," and "irrational."

For instance, in 1949, British Columbia officially banned the practice of midwifery, for midwives were viewed as "charlatans" who practiced outdated and dangerous forms of medicine (Carroll & Benoit, 2004). The ban applied to Indigenous and non-Indigenous midwives alike; the latter having emerged in the 19th century as groups of "neighbor midwives" who provided prenatal, perinatal, and postnatal care to women in their communities as needed (Biggs, 2004; MacDonald, 2004). Existing accounts suggest that early non-Indigenous midwives were often paid in gifts and tended to meals, housework, and other household tasks to assist new mothers. Over time, these "neighbor midwives" were joined by British-trained nurse-midwives, who were hired to help ameliorate the disparities in maternity care that existed between rural, remote, and urban communities (Bourgeault, Benoit, & David-Floyd, 2004). The influx of nurse-midwives did little to address the growing disparities (Biggs, 2004), especially for the Inuit. In the mid 20th century, the Government of Canada noticed that the infant mortality rates among the Inuit had been rising (Jasen, 1997). Misattributing these rates to a lack of oversight, biomedical services, and adequate childrearing among the Inuit, the Government chose to establish "nursing stations" in Northern Canada (Jasen, 1997). Initially, British nurse-midwives were hired to work at these stations to provide maternity care, even though their training was not formally recognized (O'Neil, 1989). It is likely that the care provided by the nurse-midwives was not culturally safe, as accounts from the 1950s and 60s indicate that health care providers viewed the Inuit as "highly efficient birthing machines" (O'Neil & Kaufert, 1995, p. 63). Eventually, the nurse-midwives were replaced with Canadian-educated nurses who were not trained to deliver babies. Thereafter, northern, rural, and remote communities and Indigenous communities in particular were no longer seen as "safe" places to give birth (O'Neil, 1989).

Thus began the process of maternal evacuation, wherein pregnant women living in rural, remote, and northern areas were "evacuated" or transported at approximately 36 weeks to larger, centralized health care facilities to give birth "safely" (FNC, 2009; IWAC, 1995; O'Neil & Kaufert, 1995). This practice is still the norm in many rural, remote, and northern communities (Tedford Gold et al., 2007), although an official written policy has yet to be seen (Olson & Couchie, 2013). In 2013, approximately 22.8% of all Ontarian women and 57.2% of Northern Ontario women had to travel more than two hours to give birth (Canadian Institute of Health Information [CIHI], 2013). These numbers are significantly higher in the territories; 40.3% of women living in the Northwest Territories, 23.0% living in the Yukon, and 37.9% living in Nunavut reported travelling over 100 km to give birth (PHAC, 2009). For Inuit women, the rates vary; in the 1980s, evacuation rates were as high as 91.0% (Crosbie & Stonier, 2003). Today, 25.0% of women in Nunavik travel to give birth, but they are able to receive care in their region and language due to the availability of Inuit midwives (Van Wagner et al., 2007). Another study involving participants from Iqaluit revealed evacuation rates of 60.0% (Ajunngniq Centre, 2006). It is estimated that the costs of travel associated with childbirth account for approximately one-quarter of Nunavut's health spending (Tedford Gold, O'Neil, & Van Wagner, 2005).

Although the origins of maternal evacuation policies can be explained in part by provider shortages (see above) and the benevolent efforts of public health to promote sanitation, Lawford and Giles (2012) argue that the evacuation policy was not only about good health, but also about advancing the colonial agenda. In their view, the government's marginalization of Indigenous birthing practices and traditions (e.g. by mandating hospital births, outlawing traditional healing) was "leveraged to coerce First Nations to adopt Euro-Canadian biomedical standards of care" (Lawford & Giles, 2012, p. 331). Shaw (2013) proposes that these evacuations were and continue to be justified through "the language of risk" (p. 526) wherein biomedical or "medicalized" discourse dominates (Jasen, 1997). While biomedicine and more medicalized approaches have undoubtedly improved health outcomes for Indigenous peoples in Canada (e.g. lower infant mortality rates; Smylie et al., 2010), they can be problematic when they dismiss or undermine other ways of knowing and/or when they promote cultural *un*safety. Accordingly, many women have been actively resisting the increasing "medicalization" of childbirth (Parry, 2008; Shaw, 2013) and advocating for the return of birth to Indigenous communities (Olson & Couchie, 2013). "Medicalization" is defined as "the biomedical tendency to pathologize otherwise normal bodily processes and states" (Inhorn, 2006, p. 354). It is also a social process whereby "expert-based biomedical paradigm dominates the discussion of health and frames it in negative ways, usually as illness" (Walters as cited in Parry, 2008, p. 798). In mainstream Canadian health care settings, risk discourses and biomedical dominance have recast childbirth as a condition (rather than a normal process) that requires constant monitoring and medical interventions to be safe (Shaw, 2013). Seeing as the Canadian health care system is an institution with colonial origins and a long history of stereotyping, mistreating, and marginalizing Indigenous peoples, it is not surprising that Indigenous scholars are highly critical of policies such as maternal evacuation.

Maternal evacuation has a particular impact on Indigenous women because they are consistently categorized as "high risk" clients (Birch et al., 2006; Chamberlain & Barclay, 1999; Yee et al., 2011).

Scholars argue that this label does not necessarily capture their "risk" with accuracy, as assessments are often based on narrow-defined biomedical criteria and Indigenous women continue to be depicted in the medical world as "high risk" or, paradoxically, as having easy births (Birch et al., 2006; Chamberlain & Barclay, 1999). These impacts can be emotional, physical, economic, and health-related. For example, the Inuit women interviewed by Chamberlain and Barclay (1999) described a number of stressors that accompanied maternal evacuation. These included being surrounded by strangers in an unfamiliar and uncomfortable environment, being forced to leave children at home alone or with a partner who had to forego employment to care for them, and being unable to get the breastfeeding assistance they needed post-partum (Chamberlain & Barclay, 1999). Interviews with Indigenous and non-Indigenous mothers who were receiving care in Marathon, ON painted a similar picture: travel for birth left the women feeling anxious, discriminated against, and uprooted and disconnected from their families, cultures, and sense of place (Orkin & Newbery, 2014). All of these negative experiences can compound the burdens imposed by unforeseen financial and psychological costs related to travel, accommodations, unemployment, and isolation from one's support networks (Olson & Couchi, 2013; Orkin & Newbury, 2014). There is even a growing body of evidence that links increased travel distances to negative health outcomes, such as higher rates of stress and anxiety (Kornelsen et al., 2011), a higher likelihood of adverse health outcomes for mom and baby (e.g. perinatal mortality; Grzybowski et al., 2011; Lisonkova et al., 2011), and an increased number of days in the neonatal intensive care unit (Grzybowski et al., 2011). For some Indigenous women, the fear of or need to avoid evacuation has led to the denial of pregnancies, lying about due dates, or including community members in the deception of medical authorities (Jasen, 1997). For others, the inability to give birth in home communities has taken a toll on social relationships (e.g. delayed bonding between fathers and infants, siblings and infants, grandparents and infants; IWAC, 1995) and the maintenance and/or revitalization of Indigenous knowledge (Tedford Gold et al., 2007).

Apart from maternal evacuation policies, other factors that contributed to the demise of midwifery in Canada include physician competition and the introduction of anesthetics as well as the rise in misogyny and sexism in the health care field, lulls in midwifery recruitment, the failure of midwives to organize and lobby for professional status, and more women wanting to have “their babies in the new way” (Lux, 2001, p. 97; see also Biggs, 2004; Connor, 1994; Mitchinson, 1991). In addition, any efforts that were made by interest groups were rapidly stifled by physicians, who refused to approve the introduction of worthy competitors for childbirth patients, and by nurses, who filled the roles that midwives were looking to take on (Biggs, 2004).

Midwifery reborn: Regulation in Canada. During these decades of displacement, midwives went “underground” (FNC, 2009, p. 2). It was not until the 1970s and 1980s that midwifery resurfaced as part of a social movement devoted to exploring and promoting low-tech, woman-centered approaches to maternity care (MacDonald, 2004). It was at this time that Americans and soon thereafter Canadians were beginning to question professional authority and the institution of medicine, and adopt more holistic understandings of health (Bourgeault et al., 2004). Social, cultural, and political landscapes were also being shaped by ideas from the home birth and women’s health movements that were challenging simultaneous advances in obstetrical technologies (Bourgeault et al., 2004; Houston & Witherspoon as cited in Shaw, 2013). While garnering some attention in provinces such as Ontario and British Columbia, midwifery was slow to develop during these movements because of national health insurance, a low birth rate, a surplus of nurses and physicians, and a lack of opportunity for educational development (Rushing as cited in Parry, 2008). Many of the midwives were who practicing “on the margins” (Burton & Ariss, 2014, p. 263) had been trained in the United States or had learned from apprenticeships (Relyea as cited in Parry, 2008). Even though these early models of education were fragmented, Canada-based midwives were increasing in numbers, organization, and lobbying capacity (Relyea as cited in Parry, 2008), and midwifery was being framed as a feasible and cost-effective solution to addressing the maternity care crisis that began in the 1980s (Van Wagner, 2004). Given the relatively low cost of home births, the steady decline in the number of family physicians who were practicing obstetrics, and the uptake and success of midwifery in other industrialized countries, the legislation of midwifery was tabled in a number of jurisdictions across the country (Van Wagner, 2004).

With the launch of the Health Professions Legislation Review in 1983, Ontario was the first province to see action in the legislation of midwifery. While many Ontario midwives opposed legislation on the grounds that it imposed restrictive standards on practice, institutionalized midwifery, and detracted from its social justice and woman-centered roots, others supported legislation because it would establish standards of care, ensure the survival of the profession, meet the need for education, and increase access to maternity care (De Vries as cited in Van Wagner, 2004; Van Wagner, 2004; Hawkins & Knox as cited in Parry, 2008). After years of deliberations, the midwives decided to support legislation, if only to promote their own agenda of improving access and expanding their practices (Van Wagner, 2004). They also proclaimed that it was only desirable if it preserved and strengthened the basic principles of the midwifery model of care, and if it recognized midwifery as a self-regulated profession (i.e. independent of nurses and physicians) to allow for direct-entry education (Van Wagner, 2004). In 1994, Ontario became the first province to regulate and integrate midwives into the health care system (CAM, 2010b). This marked a “significant moment for birth care in Canada and… a critical juncture for midwifery as profession” (MacDonald, 2004, p. 49), as Canada was one of the only industrialized countries without a long-standing and formally accepted midwifery profession.

In Ontario, midwifery is regulated under the *Regulated Health Professions Act, 1991* and the *Midwifery Act, 1991* (Canadian Midwifery Regulators Consortium [CMRC], 2013). According to these guidelines, midwives must complete a four-year university degree through the Ontario Midwifery Education Program (offered at Laurentien University, McMaster University, or Ryerson University) and subsequently receive licensure from the College of Midwives of Ontario in order to practice (AOM, 2014). Registered Midwives (RMs) are primary care providers and are therefore fully funded by the Ministry of Health and Long Term Care (AOM, 2014). They follow the Canadian model of midwifery care – the scope of which includes the full course of prenatal, perinatal, and postnatal care up to six weeks postpartum (AOM, 2014). This model is guided by three principles: (1) informed choice (i.e. the birthing women are the primary decision-makers), (2) choice of birthplace (i.e. the birthing women chooses to give birth at home, in hospital, or in a birthing centre), and (3) continuity of care (i.e. the same midwife or group of midwives attends her throughout her course of care; CAM, 2010a; FNC, 2009). Ontario is currently home to the vast majority (53%) of RMs in Canada (CAM, 2013), seeing as it was the first province to regulate the profession. Even though the number of RMs has been rising since legislation (e.g. increased from 720 in 2007 to 1324 in 2013; CAM, 2013), the supply continues to fall short of the increasing demand. It is estimated that 4 in 10 women in Ontario who would like to have a midwife cannot access one (AOM, 2007; AOM, 2014; Douglas, 2011). Ensuring the sustainability of the midwifery profession will require a larger Midwifery Education Program, an increase in the number of provincially funded midwifery positions (Kornelsen, 2003), widespread promotion of the benefits and legitimacy of midwifery (Møller et al., in press; WHO, 2013), the establishment of pay equity between midwives and physicians (AOM, 2013), and the implementation of professional development, continuing education, incentives, and support programs to improve retention and interprofessional collaboration (Graves, 2012; Kornelsen, 2003; Munro, Kornelsen, & Grzybowski, 2013; Versaevel, 2011; WHO, 2013). Midwives in Ontario have already made remarkable strides in terms of promoting and advocating for their profession, opening two new midwife-led birth centres, one of which houses SGMT (see the Toronto Birth Centre; Teotonio, 2014). The survival of midwifery in Canada will also depend on uptake in other provinces and territories. Even though Prince Edward Island and the Yukon Territory are the only provinces/territories that have yet to formally recognize and legislate midwifery, midwifery across the rest of Canada is far from consistent (Carroll & Benoit, 2004; CMA, 2013). For example, Quebec is home to approximately 14% of RMs in Canada having implemented legislation in 1999, whereas Nova Scotia and Newfoundland/Labrador are still in the early stages of education and access since midwifery was only regulation in 2010 (CAM, 2013).

The revitalization of Indigenous midwifery. While community midwives and lobbyists were pushing for regulation at the provincial level, Indigenous midwives and their allies were rallying support for their own agenda. The 1980s were pivotal for Indigenous midwives; with revisions to the *Indian Act*, the devolution of government health services, and the mobilization of Indigenous activists, the time was ripe for Indigenous women to assert their right to regain control over their childbirth practices, health care services, and local midwives (Carroll & Benoit, 2004; MacDonald, 2007). Contrary to their non-Indigenous counterparts, the struggle for Indigenous midwifery was less about occupational autonomy and professional status, and more about creating space for and distinguishing Indigenous ways of knowing (Abbott as cited in Carroll & Benoit, 2004). The combined efforts of midwives and allies led to the exemption of "Aboriginal midwives" from Ontario legislation as outlined in Section 35 of the *Regulated Health Professions Act* and Section 8 of the *Midwifery Act* (Carroll & Benoit, 2004; CMRC, 2013; FNC, 2009). These efforts culminated in the creation of the Tsi Non:we Ionnakeratstha Ona:grahsta' Maternal and Child Centre (for translation, see p. 54) at Six Nations – a reserve-based Aboriginal midwifery practice has been in operation for twenty years (Benoit et la., 2006). The exemption clauses "allow Aboriginal midwives to provide traditional midwifery services to Aboriginal persons or members of an Aboriginal community and to use the title Aboriginal midwife" (CMAC, 2013). These clauses have not only provided opportunities for Indigenous women and their communities to revitalize their traditional knowledge and healing practices through midwifery, but it has also facilitated the repatriation and returning of Indigenous birthing to communities such as Six Nations of the Grand River (Carroll & Benoit, 2004).

Being able to give birth in one's own community is profoundly significant. It can ensure the sustainability of local maternity services and the health and well being of Indigenous peoples, as it lessens the need for maternal evacuation, builds community capacity, and strengthens community ties, traditional knowledge, and the relationships with the land (IWAC, 1995; Lalonde et al., 2009; Tedford et al., 2007). It can also enhance the recruitment and retention of health care providers, improve health outcomes, promote self-determination, and contribute to the creation of new forms of knowledge and models of care (NAHO, 2004). However, like the Ontario exemption clause, the idea of "returning birth" cannot function in isolation (Couchie & Nabigon, 1997; Lalonde et al., 2009). The exemption clause can only hold meaning if Indigenous peoples are provided with the education programs, services, and supports that they need to define and/or revive their own birth culture (Couchie & Nabigon, 1997). The reclamation of birth and birthing can only be successful if the processes are supported by adequate funding; relevant education programs; culturally safe implementation, monitoring, and evaluation systems; continuous support from the health care system, interprofessional collaboration; the active participation of community members; and the understanding that midwives are much more than "deliverers" of babies (Lalonde et al., 2009; Olson & Couchie, 2013). Today, Indigenous midwifery is as much about service delivery and meeting practical health care needs as it is about healing and community development (Benoit et al., 2006).

The resurgence in the numbers, organization, and education of Indigenous midwives across Canada has been remarkable. Although this trend can be partially attributed to the formal legitimization of midwifery in Canada, it has been primarily driven by Indigenous women – and in particular – those who were willing to gain Canadian credentials in the early years to support systemic change and bring new opportunities to their communities (Carroll & Benoit, 2004). These efforts have certainly paid off, as Indigenous midwives are currently working alongside physicians, nurses, and obstetricians and gynecologists in places such as Nunavik and Nunavut (Olson & Couchie, 2013; Van Wagner et al., 2007). Key physician groups, such as the Society of Obstetricians and Gynecologists of Canada (SOGC), have even called for further midwifery care in Indigenous communities (NWAC, 2007a). Evidently, the work of contemporary Indigenous midwives is deeply intertwined with social change, social justice, and cultural survival. All midwives strive to empower women and empower the communities to which they belong (Burton & Ariss, 2009). In the words of an Indigenous midwife that was interviewed by Burton and Ariss (2009, p. 13): "it is not just about catching babies… it is about making change out there in your community, and making a strong community, one person at a time."

One organization that has come to serve as the collective voice of Indigenous or Aboriginal midwives in Canada is the National Aboriginal Council of Midwives (NACM). Founded in 2002, the NACM operates under the umbrella of the Canadian Association of Midwives and is currently composed of 60 members – a collection of Aboriginal midwives, midwife Elders, and student midwives (NACM, 2012d). Included in their mission statement is the intent to "promote excellence in reproductive health care for Inuit, First Nations, and Métis women… [And] advocate for the restoration of midwifery education, the provision of midwifery services, and the choice of birthplace for all Aboriginal communities consistent with the U.N. Declaration on the Rights of Indigenous Peoples" (NACM, 2012f, para. 1). Through representing the professional development and practice needs of Aboriginal midwives across Canada, the NACM hopes to see "Aboriginal midwives working in every Aboriginal community" (NACM, 2012f, para. 2). At present, there are twelve Indigenous midwifery practices in Canada. They are located in Rankin Inlet and Cambridge Bay (Nunavut), Nunavik (two practices in Quebec), Fort Smith (Northwest Territories), Manitoba (Norway House), and Ontario (Tyendinaga, Attawapiskat, Poawassan, Akwesasne, Six Nations, and Toronto; NACM, 2012b). There are also three community-based Indigenous midwifery education programs, and seven university-based midwifery education programs across Canada (NACM, 2012e). According to the NACM, an "Aboriginal midwife" is a:

> … Committed primary health care provider who has the skills to care for pregnant women, babies, and their families throughout pregnancy and for the first weeks in the postpartum. She is also a person who is knowledgeable in all aspects of women's medicine and she provides education that helps keep the family and the community healthy. Midwives promote breastfeeding, nutrition, and parenting skills. A midwife is the keeper of ceremonies for young people like puberty rites. She is a leader and mentor, someone who passes on important values about health to the next generation. (2012a)

This definition offers much insight towards the roles and responsibilities of contemporary Indigenous midwives, and what distinguishes them from other midwives. First and foremost, Indigenous midwives are working at an important interface between different types of knowledge and different types of relationships. They balance their roles as primary health care providers who offer exemplary clinical care with their "identities as knowledgeable Aboriginal women" (Olson, 2013b, p. 42). They are also responsible for working within the health care system while upholding their values through "reciprocal and equal relationships with women, families, and their communities" (NACM, 2012c, pt. 10). The multiplicity of these roles is reflected in the NACM's core values, which include healing, respect, autonomy, compassion, bonding, breastfeeding, clinical excellence, education, responsibility, and cultural safety (NACM, 2012c; Olson et al., 2012). Taken together, this means that Indigenous midwifery is not only about the provision of collaborative, continuous, family-centered, evidence-based, and covered (i.e. provincial or territorial funding) care, it is also about an individualized approach to perinatal care that respects physical, emotional, and cultural diversity and creates opportunities to build strong and trusting midwife-client and community-wide relationships (NACM, n.d.).

The definition put forth by the NACM also draws attention to the parallels between contemporary and traditional Indigenous midwives as keepers of culture. As discussed, many of the early Indigenous midwives were responsible for performing ceremonies and sharing teachings with women and families that deepened their connections with each other and the land (Ross Leitenberger, 1998). For example, in some First Nations communities, the placenta was buried after birth with tobacco as a “respect for where life comes from” and to ensure that “the baby is grounded in that place” (Participant Kathy as cited in Olson, 2013a, p. 348). Today, many Indigenous midwives are sharing teachings and knowledge in ways that create opportunities for Indigenous women, their children, and their families reestablish the physical and spiritual connections to land and place that are so fundamental to health and healing (SGMT, 2014; Olson, 2013a). Similarly, by empowering Indigenous women and returning their right to choose their own birth type and place, Indigenous midwives are (re)creating what Ingold (2000) refers to “spheres of nurture” wherein Indigenous women can create positive memories, control their own destinies, and thrive wherever their community may be (Olson, 2013b; Olson, 2015). This is of significant political and philosophical importance for Indigenous peoples given the long history of removal, relocation, and evacuation; the cosmological interdependence of identity, place, and health that guides Indigenous worldviews; and, the efforts towards decolonization and self-determination (Olson, 2013b).

Central to the practice of Indigenous midwifery is the concept of relationality. Relationships with clients, colleagues, practice groups, hospitals, non-midwifery colleagues, and professional organizations can be a significant source of stress or support for all midwives (Versaevel, 2011). Within an Indigenous context, however, relationality is not just about the relationships that one has with their peers (Wilson, 2001). Relationality involves “the spirit, the uniqueness of each individual, and relationship-based communal connection and cohesiveness” as well as the responsibility to nurture and honour the constantly evolving, interconnected, and continuous relationships that exist between “all one’s relations” (Graham as cited in Hopkins, 2012, p. 179; Hart, 2010). Here, “relations” refers to family, friends, communities, and others bound by kinship, as well as to the web of organisms that makes up all creation (Wilson & Wilson as cited in Kajner, 2012). Being responsible or what Wilson would describe as “accountable” to this network of relations is a fundamental concept within Indigenous epistemologies, ontologies, axiologies, and methodologies (Wilson as cited in De Leeuw, Cameron, & Greenwood, 2012, p. 188). The practice of “relational accountability” can look like an individual participating in their relational networks while balancing personal responsibility with the responsibility for others (Kajner et al., 2012). Traditional Indigenous midwives were often responsible for caring for women, their children, and their families across the life span (NWAC, 2007; Olson, 2013a). Although the Indigenous midwives of today may be limited in their ability to provide continuous care due to resource shortages, overwhelming caseloads, or a lack of systemic support, they still strive to exercise relational accountability on a daily basis by spending time with women and babies (e.g. visiting clients, attending births, teaching students), the community (e.g. attending community events, offering health promotion and outreach programs, co-leading research projects), the health care system (e.g. tending to administrative tasks, building interprofessional relationships, advocating for change), and with themselves (e.g. self care, pursuing continuing education) to the extent possible (NACM, n.d.).

Relationality is also embedded within traditional and contemporary models of Indigenous midwifery education. For example, prior to colonization, young Inuit girls would learn about childbirth by listening to stories, receiving verbal instructions, and witnessing births firsthand while preparing for womanhood (IWAC, 1995). Many of these oral and relational approaches to education have endured, with mentorships, storytelling, and “doing rather than telling” being incorporated into the midwifery program curriculum at the Inuulitisivik Health Centre (Epoo et al., 2012). With locations in three communities, the Inuulitsivik Health Centre is unique in that midwives work in collaboration with nurses and physicians, but take the lead when it comes to maternity, newborn, and well-woman care (Van Wagner et al., 2007). Since its introduction, transfers from the community to the south for care dropped from 91% in 1983 to less than 9% in 1998 (NACM, 2012b). Central to the success of the Centre is its training program, wherein midwives teach local and technical reproductive health knowledge to their students in Inuktitut (Epoo et al., 2012). Even though Quebec regulations prohibit “traditional midwives” such as the Inuit midwives at the Centre from practicing outside of Nunavik or expanding without consent from the Ministry of Health (Carroll & Benoit, 2004), the Inuulitsivik Health Centre is considered to be the “most successful in integrating the new Canadian model of midwifery” (Carroll & Benoit, 2004, p. 272).

In keeping with the Indigenous understanding of knowledge as something that is shared with all (Wilson, 2001), Indigenous midwifery training programs are beneficial to both students and women and to the community at large. One of the most noteworthy of the Indigenous midwifery education programs doubles as an Indigenous midwifery practice. The Tsi Non:we Ionnakeratstha Ona:grahsta’ Maternal and Child Centre (translation follows) located on Six Nations of the Grand River has being providing a wide range of maternity care and sexual health services to Indigenous women living in and around the Territory since 1996 (Benoit et al., 2006). Reflective of its diversity of residents, the centre’s name represents the union of the Mohawk word for “the place they will be born” (Tsi Non:we Ionnakeratstha) and the Cayuga word that means “a birthing place” (Ona:grahsta’; Six Nations Council, 2006). Being partially funded by the Ministry of Health and Long Term Health, the centre has also developed an Indigenous midwifery education program that trains interested community members in an environment that is familiar and respectful (Couchie & Nabigon, 1997; NAHO, 2004). By offering a wide range of traditional and contemporary health services alongside their midwifery training program, the Six Nations Maternal Child and Health Centre is as much about improving maternal and child health as it is about educating and empowering the community through workshops, ceremonies, and the fact that it is community-owned and operated (Carroll & Benoit, 2004; Tedford Gold et al., 2007). The Inuit midwives working in Nunavik are also involved in educating women, families, youth, and the community at large about pregnancy (Macdonald et al., 2014). Cognizant of the challenges that their communities face, Inuit midwives are finding creative ways to share traditional knowledge and practical reproductive health information to promote healthy pregnancies (Van Wagner et al., 2007).

Even though some of the Indigenous midwifery practices have been in operation for decades, very few have been thoroughly evaluated or explored from a research standpoint. Most studies examine the Inuulitsivik Health Centre. In a retrospective review of prospectively collected perinatal outcome data from 2000-2007, the Centre was shown to have had low rates of intervention and perinatal mortality, expected rates of congenital abnormalities, high rates of participation in neonatal care, and lower rates of C-sections relative to other Inuit communities (Van Wagner, Osepchook, Harney, Crosbie, & Tulugak, 2012). These findings were consistent with those observed during an earlier evaluation of the centre (Houd et al., 2004), as well as with England's (1998) evaluation of the birthing centre in Rankin Inlet. They also provide support for Couchie and Sanderson's (2007) report on best practices for returning birth to rural and remote Aboriginal communities. The safety and effectiveness of midwifery care in general has also been supported by the literature. In an investigation by Janssen and colleagues (2009), midwife-led home births in British Columbia were associated with very low and comparable rates of perinatal death as well as reduced rates of obstetric interventions (e.g. C-sections) and particular adverse outcomes (e.g. postpartum hemorrhage) when compared to physician- or midwife-led hospital births. Additional support for home births can be found in Hutton, Reitsma, and Kaufma's (2009) comparison of maternal and perinatal mortality and intrapartum intervention rates in Ontario, wherein favorable outcomes were reported for both at-home and in-hospital births led by midwives. Midwifery care is also comparable to and, in some cases, more beneficial than physician-led care. Sutcliffe and colleagues' (2012) "systematic review of reviews" (p. 2383) found that midwife-led care led to increased maternal satisfaction, better health outcomes for low-risk women in certain situations (e.g. need for prenatal hospitalization), and cost savings via fewer interventions (e.g. episiotomies, anesthesia, forceps). Similar rates of C-sections, postpartum hemorrhages, and inductions were also observed between the two models of care. Another systematic review that compared midwife-led continuity models with other types of maternity care reached similar conclusions (Sandall, Soltani, Gates, Shennan, & Devane, 2013). Even though this

Cochrane review did not include studies involving home births or traditional/lay midwives, the authors found higher rates of spontaneous vaginal births and lower rates of interventions (except C-sections) and pre-term births among women who had midwives in hospital or midwife-led care units. Further evidence of midwifery's ability to improve or maintain perinatal outcomes, increase cost-effectiveness, and enhance client satisfaction in a Canadian context have been summarized elsewhere (for concise review, see CAM, 2010a).

Researchers interested in Aboriginal midwifery can look to Australian studies for guidance. In a holistic economic evaluation of the midwifery program within the Daruk Aboriginal Medical Service – a community-controlled health service – Jan and colleagues (2004) compared the costs and experiences of Indigenous women who had attended the program with those who had attended a comparable non-Daruk midwifery program. While the net cost of the program was estimated to be a "modest" $1200 (Australian dollars; approximately $1211 in Canadian dollars), Indigenous women who attended the Daruk program – apart from reporting a positive experience overall – were more likely to visit their midwives at an earlier date, attend routine antenatal appointments, and visit their midwives more often than Indigenous women in the other program (Jan et al., 2004). In 2011, an evaluation of the Winnunga Nimmityjah Aboriginal Health Service Aboriginal Midwifery Access Program was conducted (Wong et al., 2011). As a follow-up to an earlier study conducted in 2002, Wong and colleagues (2011) collected and analyzed data on a number of maternal and infant health outcomes and characteristics from 2004-2008 to determine whether the urban-based centre was having a positive impact on public health. When compared to the general population, the centre's Indigenous clients were less likely to have pre-term births, low-birthweight babies, and C-sections, but more likely to smoke during pregnancy. The authors concluded that the centre provides high quality-care antenatal care but still needs to address the high rates of smoking (Wong et al., 2011). Another notable example of evaluation within the context of Indigenous midwifery involved the Malabar Community Midwifery Link Service (Homer et al., 2012). Located in a suburban pocket of a major city, Malabar is similar to SGMT in that it caters to but does not exclusively serve Indigenous clients, but different in that it is primarily staffed by non-Indigenous midwives (Homer et al., 2012;

SGMT, 2014). To promote cultural safety, Malabar has Indigenous community health workers and Aboriginal Health Education Officers working alongside nurses and midwives. The findings from the evaluation were very positive; clients praised the service for its ease of access, continuity of care, quality and trustworthiness of its providers, and its ability to make the client feel “special” (Homer et al., 2012, E453). Altogether, what these studies from Australia reiterate is that Indigenous midwifery is as celebrated as it is desperately needed, whether in rural or remote communities or urban centres (AOM, 2012). Even though the realization of the NACM’s vision of an Aboriginal midwife in every Aboriginal community will not be easy, being able to understand, celebrate, evaluate, and improve upon Indigenous midwifery practices such as SGMT would be an excellent place to start (Cook, 2011). In addition, given the increasing urbanization of Indigenous peoples and the existence of only one inner city Indigenous midwifery practice, now is the time to learn how and why SGMT works. Should Indigenous midwives wish to expand their services, improve access to high-quality maternity care, and promote health and well being among their communities, the research gaps – in urban areas in particular – need to be filled (NAHO, 2004; NWAC, 2007a).

Cultural Safety

The history of cultural safety. The term “cultural safety” was developed in the late 1980s in response to the growing concern that the nursing profession in New Zealand/*Aotearoa* was failing to meet the health needs of the Indigenous Māori peoples (Ramsden, 2002). Like their Indigenous counterparts in Canada, the Māori face a disproportionate burden of poor health, owing to the ongoing impacts of colonization and continued colonialism, and a combination of historical, political, social, and economic forces. Even though Māori rights are outlined in the Treaty of Waitangi, these rights have been undermined by colonial legacies, marginalized by neoliberalism, and until the 1980s overlooked by the nursing profession (Ramsden & Spoonley, 1994).

During the 1980s, the nurses and midwives in New Zealand/*Aotearoa* made a conscious effort to identify a clear path by which health services could more effectively meet the needs of their Māori clients

(Ramsden, 2002). In 1988, Irihapeti Ramsden – a Māori nurse who belonged to the people of Ngai Tahupotiki and Rangitane – made a groundbreaking statement proposing that nurses needed to provide care *respective,* instead of *irrespective,* of the aspects of an individual that maintain his or her integrity as a member of the human race (as cited in Ramsden, 2002). Rather than ascribing to the then-dominant model of transcultural nursing, nurses and midwives were being encouraged to be mindful and respectful of age, gender, race, ethnicity, political beliefs and more (Ramsden, 2002). The same year Dr. Ramsden and other Māori nurses, nurse educators, and student nurses attended a *hui* – the Māori word for assembly or gathering – at *Otautahi* or Christchurch, New Zealand (Māori Language Institute [MLI], 2014). This *hui* was called after a number of concerns were raised about the low numbers of Māori nursing students, the difficulties of professional recruitment and retention, and the negative experiences that the Māori were having with the health care system. One of the most significant outcomes of the *hui* was the formalization of the concept of "cultural safety" (Papps & Ramsden, 1996). Indeed, the term "cultural safety" was developed by and for the Māori peoples; it was developed from within Māori cultural reality (Ramsden, 2002). In this regard, cultural safety is as much a concept or a tool as it is a form of Māori resistance to the dominance of Western ways of knowing in health care (Kearns & Dyck, 1996).

In 1989, another *hui* was held to nominate a group of Māori nurses to prepare the *Kawa Whakaruruhau* – a set of cultural safety standards that would be used to guide the nursing and midwifery education programs in the country (Ramsden, 2002). A few years later, the Nursing Council of New Zealand adopted these standards and formally integrated cultural safety into their curriculum. The standards required nursing school to incorporate the obligations of the Treaty of Waitangi into their mission statements and philosophies of care, but also, twenty percent of the national examinations were to be dedicated to cultural safety (Ramsden & Spoonley, 1994). As an approach that brought about significant structural change and challenged conventional nursing paradigms, cultural safety was met with both support and censure (Ramsden, 2002). In 1992, for example, *Metro Magazine* criticized cultural safety for only being sensitive to Māori and not to others (as cited in Ramsden & Spoonley, 1994). Other sources misrepresented cultural safety as a concept that was about placing "political correctness" above effective medical care (Ramsden & Spoonley, 1994; Ramsden, 2002). While the negative reaction of the public can be partially attributed to colonialism and the legacy of opposition to anything that enfranchises Indigenous rights, it can also be explained by the discomfort associated with discussing race relations (Papps & Ramsden, 1996), as well as the right-wing conservatism that was present in New Zealand throughout the 1990s (Ramsden & Spoonley, 1994). Other early concerns with cultural safety included its definition, its perceived ambiguity, and its relevance to particularly Indigenous peoples, rather than all marginalized populations (Polaschek, 1998). In spite of the contentions surrounding the concept, dedicated supporters such as Irihapeti Ramsden continued to refine, realize, and advocate for culturally safe health care. Ramsden has since become one of the most prominent figures in cultural safety. Koptie (2009) characterizes her as "pathfinder" for empowerment and considers her 2002 doctoral thesis a "reference point" (p. 31) for all Indigenous peoples who are struggling to locate and experience their identity within mainstream academia or institutions such as health care.

Defining cultural "unsafety." Cultural safety is an "evolving term" (NAHO, 2006). Even though it has been discussed, disputed, and redefined on a number of occasions, cultural safety still lacks a finalized, universal definition (Gerlach, 2012). As touched upon above, however, "cultural *un*safety" can be much easier to describe. Ramsden (as cited in Polaschek, 1998) proposed that a health service was culturally unsafe if the Māori peoples perceived it as foreign and incapable of meeting their service, health, and interpersonal needs. Wood and Schwass (1993) broadened the definition of "cultural *un*safety" to include "any actions which diminish, demean, or disempower the cultural identity and well being of an individual" (p. 5). These "3 Ds" were developed to complement the "3 Rs" of cultural safety, which encompass recognizing and respecting cultural identities, and safely meeting rights, needs, and expectations (Wood & Schwass, 1993, p.6). This model was quickly adopted and refined by Ramsden in consultation with other New Zealand/*Aotearoa* academics such as Coup and Spoonley. Ramsden and Spoonley (1994) in particular used the "3 Ds" to shape their understanding of "cultural risk" – an analogue to culturally unsafe care wherein people from one culture believe that they are being diminished, demeaned, or disempowered by the actions or delivery systems of people from another culture. The

Nursing Council of New Zealand (as cited in Papps & Ramsden, 1996) followed suit, describing unsafe practice as either "an action *or an omission* which endangers the wellbeing, demeans the person, or disempowers the cultural identity of the patient/client" (p. 493; emphasis added). Similar variations of the original "3 Ds" are still in use today, being cited in the updated *Kawa Whakaruruhau* and in more recent reviews on cultural safety in Canada and abroad (Brascoupé & Waters, 2009; Browne et al., 2009; Gerlach, 2012; NCNZ, 2011; Richardson, 2010).

It may be argued that the ease with which "cultural *un*safety" is defined can be partially attributed to the number of negative experiences that Indigenous peoples – and Indigenous women in particular – have had with the mainstream health care system (Halseth, 2013; Smith et al., 2006). For example, in 2000, a study exploring Carrier First Nation women's encounters with mainstream health services shed light on a number of unsafe or "invalidating" practices (Browne et al., 2000). Even though the women reported positive and affirming experiences, they emphasized the negative encounters during which they were dismissed, disregarded, stereotyped, and made to feel like they had to "transform themselves" because they were "intruding" on the health care system (Browne et al., 2000). These invalidating encounters induced feelings of shame, embarrassment, humiliation, and mistrust (Browne et al., 2000). In a similar study conducted in 2008, urban Indigenous women living in British Columbia were asked to discuss their experiences with mainstream health services and with Indigenous-run health services (Kurtz et al., 2008). The women expressed a preference for the Indigenous-run services, as their encounters with mainstream services had been associated with varying degrees of racism, discrimination, "silencing", and communication barriers (Kurtz et al., 2008). Evidently, culturally unsafe practices are as much about provider behaviour and organizational policy as they are about the larger social, political, economic, and historical structures that perpetuate colonial stereotypes and everyday racism. One of the most concerning consequences of "cultural *un*safety" is that it can dissuade individuals from seeking health care. Negative experiences with the health care system can directly or indirectly deter Indigenous peoples from seeking and/or accessing the care they require (NAHO, 2006; Smith et al., 2006). For example, Indigenous peoples have reported avoiding primary care until it is critically necessary (Denison et al., 2014; Dodgson

& Struthers, 2005; Kurtz et al., 2008; Papps & Ramsden, 1996; Smith, Edwards, Varcoe, Martens, & Davies, 2006), limiting their communication with maternity care providers (Whitty-Rogers, Evans, & Etowa, 2009), and postponing maternal evacuation or pre- or post-natal visits for as long as needed (Browne et al., 2000; Haertsch as cited in Kruske, Kidlea, & Barclay, 2006; Jasen, 1997; Kildea as cited in Kruske et al., 2006; Petten, 2002; Smith et al., 2006). Avoiding care can trap Indigenous peoples in a cycle that begins with culturally unsafe care and ends with the perpetuation of poor health and, in some cases, trauma (Elliot et al., 2005; Roy, 2014). Other consequences of "cultural *un*safety" include low service utilization, denial of suggestions that there is a problem, non-compliance with referrals or prescriptions, a reluctance to engage with or open up to health care providers, anger, and low self-worth (Raphael as cited in Brascoupé & Waters, 2009).

Defining cultural safety. Cultural safety was created to replace cultural sensitivity (Ramsden as cited in Polashek, 1998). According to Ramsden (2002), cultural safety is an outcome of education that operates a continuum that begins with cultural awareness, continues with cultural sensitivity, and ends with cultural safety. Cultural awareness is described as the first step towards understanding "difference" (Ramsden, 2002). In this phase, providers are sensitized to a client's formal "cultural" rituals through workshops or training sessions (Ramsden as cited in Ramsden, 2002). NAHO's example of cultural awareness includes a provider that acknowledges that an Indigenous client may be using a traditional healer (2006). Similarly, a culturally aware midwife would acknowledge that a client's cultural practices may have implications for their pregnancy, birthing expectations, and needs (Schneider, 2002). While cultural awareness is a key first step, its failure to acknowledge the social, political, economic, or historical context of a client and the diversity that exists *within* certain groups can promote stereotyping (Nguyen, 2008; Ramsden, 2002). The next step within the continuum is cultural sensitivity. Culturally sensitive providers understand that differences are legitimate, recognize that said differences need to be respected, and reflect upon how they are bearers of their own culture (as cited in Ramsden, 2002). Cultural sensitivity also requires that providers understand that no two people experience reality in the same way (National Collaborating Centre for Aboriginal Health [NCCAH], 2013a). A culturally sensitive provider would thus be able to engage in behaviours that are perceived as respectful and polite by their clients without assuming that, for example, all Métis clients wish to take part in traditional ceremonies or practices (Baba, 2013; as cited in Ramsden, 2002). Yet, like cultural awareness, cultural sensitivity remains firmly embedded within the process of "Othering" (Baba, 2013; Browne & Varcoe, 2006). These broad conceptualizations of a "cultural group" may also contribute to the misrepresentation and mistreatment of Indigenous peoples living in urban areas (Ramsden, 2002).

An additional step that is often added to the continuum in a Canadian context is "cultural competency" (NCCAH, 2013a). New Zealand scholars such as Ramsden, Pomare, and Papps dislike the term, arguing that it implies that cultural safety can be reduced to a pre-determined set of skills or abilities (Ramsden, 2002). Nevertheless, according to the NCCAH, a culturally safe environment involves the integration of cultural awareness, cultural sensitivity, and cultural competency (2013a). Cultural competency encompasses all of the knowledge, skills, and attitudes of practitioners that can be used to empower clients (NCCAH, 2013a). It is about "creating a health care environment that is free from racism and stereotypes, where Indigenous people are treated with empathy, dignity, and respect" (HCC, 2012, p. 5) by adapting the delivery of services to meet the needs social, cultural, and linguistic needs of clients (NCCAH, 2013a). While culturally competent care may provide clients with a greater sense of control over their care and, by extension, a greater inclination to seek care or follow regimens, cultural competency still requires that the provider understand the "Other" (DeSouza as cited in Gerlach, 2012). In addition, cultural awareness, cultural sensitivity, and cultural competency all fail to address the effects that power dynamics and broader forces have on Indigenous health and the Canadian health care system (NCCAH, 2013a). It is for these reasons that cultural safety, the final step of the continuum, was developed (as cited in Ramsden, 2002).

Ramsden's understanding of cultural safety is based on two key assumptions – the first being that all patient-provider relationships are bicultural or "unique, power-laden, and culturally dyadic" (Dyck & Kearns, 1996, p. 373), and the second being that culture is "located within a constantly shifting network of meanings enmeshed within historical, social, economic and political relationships and processes" and thus cannot be reduced to an "easily identifiable [or politically neutral] set of characteristics" (Anderson & Reimer-Kirkham as cited in Browne & Varcoe, 2006, p. 162). The notion of "biculturalism" radically diverges from and challenges monocultural and multicultural discourses (Polaschek, 1998). Monoculturalism supports Western superiority, while multiculturalism supports transcultural nursing (Ramsden, 2002). Multiculturalism suggests that each cultural group possesses a unique and appreciable set of beliefs, values, and practices and that each group is of equal value. Although praised for supporting diversity, multiculturalism has been criticized for its reduction of culture to the customs, foods, and ceremonies that distinguish a cultural group from the dominant "norm" (Browne & Varcoe, 2006; Taylor, 1992). Equating culture with ethnicity promotes stereotyping and cultural reductionism, and downplays the social, economic, historical, political, and power-laden differences that exist within and between groups (Brascoupé & Waters, 2009; Browne & Varcoe, 2006; Browne et al., 2009; Gerlach, 2012; Rasmden, 2002). This "culturalist" perspective has become entrenched in dominant health care discourses in New Zealand and Canada (Browne et al., 2009). It is this perspective that makes transcultural nursing and multicultural theory so problematic for Indigenous peoples. According to Leininger (as cited in Ramsden, 2002), transcultural or ethno-nursing posits that, if providers learn about and understand as much as they can about their client's "culture", then they will be able to provide appropriate care and predict the health outcomes and needs of certain cultural groups. Ramsden (2002) criticizes this approach for assuming that the nursing profession is "normal" to the client, whereas in reality, it is foreign. Woods (2010) reiterates this criticism, calling upon nurses to abandon the transcultural nursing idea that one day they will be able to fully comprehend their client's culture and ways of life. Instead, providers should learn from biculturalism and provide care regard*ful* of differences (Rasmden, 2002); clients should be treated as individuals whose health is influenced by the "intersectionality and simultaneity of race, gender, class relations, the practice of racialization, the connectedness to historical context, and… the curtailment of life opportunities by structural inequities" (Anderson & Reimer-Kirkham, 1999, p. 63).

In practice, culturally safe care begins with the provider critically reflecting on how their positionalities and privileges influence their client's realities inside and outside of the care setting

(Ramsden, 2002). Guided by this knowledge, providers must then transfer some of the power that they possess as health care workers to their clients, insofar that the clients become empowered to determine and evaluate the "safety" and quality of their own care. By learning how to act and provide care in a culturally safe manner, providers can create environments wherein their clients are made to feel – by their own definition – culturally safe (Ramsden as cited in Ramsden, 2002). Encounters that have been defined as culturally safe tend to be those that are built on trust, communication, respect for multiple worldviews, and a deep understanding of the historical and ongoing impacts of colonization (NCNZ, 2011). The Nursing Council of New Zealand defines cultural safety as:

> The effective nursing practice of a person or family from another culture, and is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability. The nurse delivering the nursing service will have undertaken a process of reflection on his or her own cultural identity and will recognise the impact that his or her personal culture has on his or her professional practice. (NCNZ, 2011, p.7)

In Canada, cultural safety has been adapted for use by organizations such as the NAHO (2008b), which refers to cultural safety as:

> … what is felt or experienced by a patient when a health care provider communicates with the patient in a respectful, inclusive way, empowers the patient in decision-making and builds a health care relationship where the patient and provider work together as a team to ensure maximum effectiveness of care. Culturally safe encounters require that health care providers treat patients with the understanding that not all individuals in a group act the same way or have the same beliefs. (2008b, p. 19)

The NAHO also reiterates that cultural safety is a direct departure from cultural sensitivity, in that it considers how power imbalances, institutional discrimination, and colonial relationships continue to impact the health of Indigenous peoples both within and beyond the health care system (2008b). Examples of culturally safe care include the setting aside of Indigenous space and offering the choice of traditional ceremonies and rituals (NAHO, 2008b). The Health Council of Canada (2012) has published a similar definition. They describe cultural safety as an "outcome, defined and experienced by those who receive the service" that is founded on "respectful engagement" and the recognition that "we are all bearers of culture" (2012, p. 5). They also acknowledge the influence of power dynamics and institutional discrimination and the need for systemic change (HCC, 2012).

Another prominent definition of cultural safety comes from Jessica Ball at the University of Victoria. Ball's (2008) five "Ps" of cultural safety include *protocols*, whereby providers show respect and demonstrate reciprocity; *personal knowledge*, wherein providers develop a critical consciousness of their social location, power, and cultural identity; *partnerships*, where provider engage in relational practice and collaborative problem solving; *process,* where providers "talk less, and listen more" to ensure equity and dignity for all partners; and, *positive purpose,* wherein approaches are strengths-based, confidential, and beneficial. Unlike Ramsden, Ball conceptualizes cultural safety as a paradigm shift in care rather than a step on a continuum (Brascoupé & Waters, 2009). Other definitions of cultural safety come from the Health Council of Canada (HCC, 2012) and the Assembly of First Nations (AFN, 2012), although the latter is oriented more towards education and governmental contexts. Although scholars like Brascoupé & Waters (2009) have called for further work uniting cultural safety, education, self-determination, and other determinants, this application is beyond the scope of the larger study as well as this project.

The works of Ramsden (2002), Browne and Varcoe (2006) and Ball (2007, 2008) were united with the findings from the literature, the survey tools (e.g. questions in the Interview Guide, see Appendix C), and the project's research questions to create the following definition of cultural safety:

> Cultural safety is an *outcome* experienced by the recipient of a particular service. It is a state of being that can only be defined and measured by those who have experienced a culturally safe encounter. In a culturally safe encounter, service recipients are made to feel comfortable, respected, able to be themselves, and assisted in terms of having their cultural location, values, and preferences taken into consideration. As such, cultural safety is as much about supportive relationships as it is about supportive spaces.

In this definition, the term “spaces” was meant to encompass all micro- and macro-level settings, including interpersonal experiences, physical environments, and sociopolitical contexts. I used this definition as a starting point when conducting interviews, in particular when describing what was meant by “cultural safety.”

Theoretical underpinnings of cultural safety. Inherent in every definition of cultural safety is its desire to achieve social justice by empowering Indigenous peoples and encouraging providers and communities to advocate for Indigenous rights (Ramsden, 2002). These emancipatory goals draw attention to the parallels between cultural safety and schools of thought such as post-colonialism. Even though post-colonialism is not Indigenous in origin, its critique of dominant Western structures and its focus on the interplay of social, historical, and political processes are of significant value to the Indigenous research agenda and to cultural safety (Anderson et al., 2003). That being said, it is not surprising that Ramsden and Spoonley (1994) describe cultural safety as the “modest option” (p. 171) within a post-colonial framework. Post-colonialism and post-colonial scholarship generally involves the “critical analysis of the experience of colonialism, past and present, and how conceptions of race, racialization, and culture have been constructed within particular historical and colonial contexts” (Anderson et al., 2003, p.199). Post-colonial theory is thus concerned with “unmasking” colonizing practices in order to examine how race and culture have been constructed as “rational” categories to “Otherize” those who are not of European descent (Anderson et al., 2003; Smye, Josewski, & Kendall, 2010).

Although post-colonialism has been criticized by some scholars for its place in the Western academy and implying that colonialism is “over”, others find merit in its attention to power and its broad and critical interpretations of culture (Anderson et al., 2003; Smye & Browne, 2002; Browne et al., 2009; Kelly, 2006; Smith, 2012). For example, the Aboriginal Nurses Association of Canada (2009) lists a “postcolonial understanding” as one of its core competencies for culturally safe and culturally competent nursing education. In the literature, Browne and Smye (2002) used cultural safety as an interpretative lens as a means to analyze the impacts that British Columbia’s mental health policies were having on

Indigenous voices and health needs from a post-colonial perspective (2002). Anderson and colleagues (2003) took the notion of cultural safety as an interpretative lens one step further, using post-feminist theory to inform and enrich their postcolonial analyses. Through a series of interviews with health care providers and patients from a number of backgrounds and socioeconomic groups, the authors found that culturally safe care was important to all people – that is, all genders, all countries of origin, all languages. For instance, while some providers of Colour shared experiences of "unsafety" when serving White clients, some White middle-class clients expressed feeling unsafe when being treated by providers who made assumptions about their privileges owing to their membership with the "dominant culture." Here, Anderson and colleagues (2003) are not saying that cultural safety affects all people equally, but rather, that structural constraints, limitations on life opportunities, and assumptions about culture/ethnicity are damaging to everyone's health.

Applying cultural safety in Canada. Some scholars (e.g. Browne & Varcoe, 2006) advocate for the introduction of more critical perspectives into Canadian health care curriculum, while others remind decision-makers and providers that "much can be taken for granted when a perceived panacea like cultural safety emerges" (Dion Stout & Downey, 2006, p. 327). If cultural safety is introduced in a Canadian context without the incorporation of traditional knowledge, the use of an Indigenous-specific focus, or considerations around the logistics of the health care system, cultural safety may create new challenges and deepen older ones (Dion Stout & Downey, 2006). For example, if applied uncritically, "culture" could remain tied to ethnicity, perpetuating approaches that are based on generalizations and stereotyping (Johnstone & Kanitsaki, 2007). Dion Stout and Downey (2006) warn that nurses may feel the need to "dumb down" – that is, speak to and treat clients as if they are incapable of understanding basic knowledge insofar that the client is made to feel patronized and discriminated against – when caring for Indigenous clients. However, should the concept of cultural safety be introduced within a health care environment that rejects colonial stereotypes, focuses on strengths, continually revises and refines its practices, and understands culture as more than "just dress, dinner, decorations" (Ball, 2007, slide 7), there is a very good chance that this concept can become a reality for all clients (Johnstone & Kanitsaki, 2007).

Within a Canadian context, there have been attempts to create new programs or reorient existing programs towards cultural safety. Although it may not be explicitly referenced in every guiding document, education program, or health initiative, the findings of a recent environmental scan reveal that significant efforts have been made towards improving the cultural relevancy of Indigenous health services (Baba, 2013). For example, contributions from the Aboriginal Transition Fund have been used to develop culturally safe tools for Cancer Care Ontario's colorectal screening program as well as a set of training material for a cultural safety curriculum at the Anishnawbe Health Centre in Ontario (as cited in Baba, 2013). Baba (2013) also shows that many MPH, Nursing, and MD programs across Canada have integrated components of cultural safety into their curricula. Still, there are no standardized assessment criteria for cultural safety, and many of these initiatives could also qualify as cultural awareness, sensitivity, or competency endeavours (Baba, 2013). Additionally, in my experience, university education programs have a long way to go in terms of integrating cultural safety into their curricula. At present, it remains difficult to evaluate and implement cultural safety on a larger scale in Canada (Baba, 2013; Josewski, 2011). However, this should not exclude cultural safety initiatives from the public health agenda. Those who feel culturally safe are not only more likely to access care earlier, feel more at ease, and feel empowered through their care, but also – and as a result – they are more inclined to share personal information with their providers, develop trusting relationships, and adhere to care regimens (NCCAH, 2013a).

For Indigenous peoples, the evidence base for cultural safety is ancient and embedded within traditional teachings such as the medicine wheel (Brant Castellano as cited in Brascoupé & Waters, 2009). In mainstream health care settings and systems, there is a need for evidence that links cultural safety to positive health outcomes and complements traditional knowledge, in order for professionals such as Indigenous midwives can receive the financial and human health resource support they require (Brascoupé & Waters, 2009; Johnstone & Kanitsaki, 2007). Even though the connections between cultural safety and midwifery have been established internationally (see Payne, 2010; Stamp et al., 2008), the literature remains largely comparative, uniting midwifery scholarship with cultural safety scholarship (see Phiri et al., 2010), or prescriptive, identifying the need for more cultural safety in maternity health care for Indigenous peoples (see NCCAH, 2013b; Morgan & Wabie, 2012; Skye, 2010; Smith et al., 2006; Yee et al., 2011). Given the rising demand for midwifery and Indigenous midwifery services and the inclusion of "cultural safety" among the National Aboriginal Council of Midwives' core values, exploring and evaluating cultural safety in the context of Indigenous midwifery is both valuable and timely (NACM, 2012c).

Background Information and Study Relevance

Seventh Generation Midwives Toronto

Seventh Generation Midwives Toronto (SGMT) is a midwifery practice that is located in Toronto, Ontario and was founded by a group of Registered Aboriginal Midwives and Aboriginal Midwifery Students in 2005 (NACM, 2012b). Currently located at the Toronto Birth Centre and affiliated with Sunnybrook Health Sciences Centre, SGMT provides high quality maternity care to women and their families throughout pregnancy, labor, birth, and the first six weeks postpartum. Even though SGMT welcomes all women into their care, what is unique about this practice is that they aim to provide culturally safe care to Indigenous families living in the Greater Toronto Area. According to their vision statement, SGMT (2015) "believes in the sacredness of all life… [and] that birth is a profound and awesome event in a woman's life" (para. 1). By giving women and their families the choice to, for example, incorporate traditional teachings and/or ceremonies into their care experience, SGMT enables Indigenous women to reclaim control of their culture, knowledge, and bodies while integrating Indigenous and Western ways of knowing about pregnancy, birth, post-partum, and parenting (SGMT, 2014). SGMT is also involved in educating other health care professionals, supporting and mentoring other Indigenous peoples entering health care professions, and connecting clients with other Indigenous and/or social services in the GTA (AOM, 2012). Evidently, the care provided by SGMT "involves much more than taking blood pressure, having a discussion about informed choice, and making sure mom and baby are physically healthy" (Wolfe as cited in AOM, 2012, p. 9).

Well Living House

The Well Living House (WLH) is an action research centre that focuses on Indigenous infant, child, and family health and wellbeing (Well Living House [WLH], n.d.). Situated at the Centre for Research on Inner City Health at St. Michael's Hospital in Toronto, the WLH is currently engaged in a number of collaborative, solutions-based "knowledge work" projects that advance Indigenous knowledge translation, build community capacity, and strengthen the community's ability to assess, respond to, and ameliorate the health inequities and barriers to care that affect Indigenous peoples. The larger SMGT evaluation study and this thesis project are both examples of WLH action research endeavors. The WLH is accountable to St. Michael's Hospital and to the Counsel of Grandparents – a committee of highly respected and influential Elders who represent the voices of Indigenous communities across Canada. At present, the Counsel of Grandparents consists of Jan Kahehti:io Longboat, Carol Terry, and Madeleine Kētēskwew Dion Stout (WLH, n.d.). Among other things, the Grandparents hope that the WLH will become a place of refuge and renewal, as – according to Jan Longboat - "each time a child is born it represents not only the birth of an individual but an opportunity to rebirth our families, communities, and nations" (WLH, n.d., p.2). It is therefore the long-term vision of the WLH that every Indigenous infant will be born into an environment that promotes health and wellbeing at the individual, family, and community level. Director Dr. Janet Smylie, a family physician who also provides reproductive and mental health care to clients at SGMT, believes that the strength of the WLH depends on the ability of the Indigenous community to "come together – across generations, knowledge systems, Indigenous nation identities, and community-institutional divides" (WLH, n.d., p.3). As such, the WLH values both Indigenous and mainstream academic ways of knowing, and seeks to build upon the synergies that exist between the two in order to achieve their broader goals (WLH, n.d.).

Relevance to Public Health

In Canada, the scope of midwifery practice encompasses the complete course of prenatal, perinatal, and postnatal care for healthy pregnant women and normal newborn infants (Canadian Association of Midwives [CAM], 2010). Midwives are responsible for physical examinations, prescription writing, diagnostic tests, deliveries, and well-woman and baby care, as well as a number of public health-related activities (CAM, 2010b; Edwards & Byron, 2007). For example, during pregnancy, midwives inform their clients about which foods to eat, which foods to avoid, and which exercises or daily practices may be of benefit to the health of the mother and/or baby (Biro, 2011). Proper nutrition and sufficient physical activity are only a few of the important behavioural determinants of health that midwives can help promote (Reading & Wein, 2009; Butler-Jones, 2013). Midwives are also required to offer routine screenings for genetic abnormalities, infectious diseases, and any other conditions that may affect infant or maternal health outcomes (Biro, 2011). In this regard, midwives are directly involved in disease surveillance and infectious disease control measures. Clinical duties notwithstanding, midwives are involved in social activism, advocating for women's rights and their profession's rights, as well as in health education, in that they teach clients and community members about topics such as sexual health, parenting, and breastfeeding (AOM, 2012; Lavender et al. as cited in O'Luanaigh & Carlson, 2005; MacDonald, 2007). Indigenous midwives take these responsibilities one-step further by keeping, sharing, and carrying on their traditional cultures, teachings, and knowledge (Olson et al., 2012). Midwives, and Indigenous midwives in particular, are not just clinicians, they are also community leaders, teachers, mentors, dieticians, caregivers, and public health practitioners (Burton & Ariss, 2009; Carroll & Benoit, 2004; Olson et al., 2012; O'Luanaigh & Carlson, 2005; Terry & Calm Wind, 1994; Van Wagner et al., 2007).

Pregnancy, childbirth, and early life are significant events for mothers, infants, and families worldwide (Lalonde, Butt, & Bucio, 2009). Worldwide, birth is recognized as a sacred event; for public health practitioners, birth is an important stage within the Life Course (Reading & Wein, 2009; Skye, 2010). The "Life Course" perspective in public health functions on the premise that health follows a lifelong trajectory that begins with gestation and ends with death. This means that events that occur during pregnancy, childbirth, and/or childhood influence the health and wellbeing of an individual later in life (Cohen et al., 2006; Felitti et al., 1998; Gluckman, Hanson, Cooper, & Thornburg, 2008). Several sources have found that early experiences or outcomes can, in the case of birth weight (Curhan et al., 1996a; Curhan et al., 1996b), predispose individuals to good or poor health regardless of later conditions (these are referred to as “latency effects”), affect an individual later in life but not immediately (“pathway effects”), or accumulate over time to contribute to good or poor health (“cumulative effects”; Hertzman, 2000). These effects have been examined and verified by a number of scholars (Gluckman et al., 2008; Langley-Evans, 2015; Shonkoff, Boyce, & McEwan, 2009; Victora et al., 2008). For example, in one study, infants who were fed formula were found to have a higher energy intake, greater gain in body weight, and, by extension, a greater risk of obesity later in life when compared to breast-fed infants (Harder, Bergmann, Kallischingg, & Plagemann, 2005). As such, the benefits of high-quality midwifery care can last a lifetime (Shaw, 2013). These benefits can also extend to the mothers, as pregnancy, childbirth, and the early life of their infant can influence their long-term spiritual, physical, mental, and emotional health and wellbeing. While a negative birthing experience, the loss of a child, or post-partum depression can be detrimental to health, a positive pregnancy, birth, and post-partum experience can build maternal confidence, self-esteem, and parenting skills in ways that protect mothers and infants from adverse health outcomes in the future (Michels, Kruske, & Thompson, 2013; Pridham, Lytton, Chang, & Rutledge, 1991; Quine, Rutter, & Gowen, 1993). As reproductive health care providers, midwives and midwifery care play a significant role in shaping these experiences and ensuring that the conditions for early childhood development – a SDOH – are as favorable as possible (Chapple, 2010).

In addition to “healthy child development”, the Public Health Agency of Canada (2013) lists “health services”, “gender”, and “culture” among the key determinants of health. "Aboriginal background" falls under the "culture" category. According to the NAHO and the NCCAH, there are also a number of determinants that are unique to Indigenous peoples in Canada (2007; Reading & Wein, 2009). Reading and Wein (2009) divide the Indigenous SDOH into three categories: proximal, intermediate, and distal. Proximal determinants include health behaviours (e.g. alcohol, smoking during pregnancy), physical environments (e.g. lack of affordable and safe housing; geography), employment and income, education, and food insecurity. Intermediate determinants can be thought of as the origins of these proximal determinants. They include the health care system and accessing health services, the education system and early learning, community infrastructure and resources (e.g. economic development in a First Nations community), environmental stewardship (e.g. relationship to the land), and cultural continuity (e.g. cultural cohesion within a community). Colonialism, racism, social exclusion, and self-determination are included among the distal determinants, which have the most profound impact on Indigenous health (Reading & Wein, 2009). When woven together, these determinants have the capacity to benefit or detract from the health and well being of Indigenous peoples across their life span (NAHO, 2006). It is because of these determinants of health – and the long-standing failure of mainstream public health and the medical field to address them – that Indigenous peoples continue to experience disproportionate burden of poor health (Lalonde et al., 2009; Reading & Lein, 2009).

Public health practitioners can help address a number of these determinants by ensuring that all Indigenous women and their families have access to safe and effective reproductive health care services. There are significant inconsistencies in the tracking and recording of Indigenous infant mortality data across Canada. Still, the data that is available reveals significant disparities between Indigenous and non-Indigenous birth outcomes (Smylie, 2011), and although these adverse outcomes have decreased in absolute terms in recent years, the inequities remain. For example, it is estimated that the infant mortality rate (IMR) in Inuit communities is 4 times the Canadian average (Wilkins as cited in Stout & Harp, 2009). Similarly, in a 2004 BC study (Luo et al., 2004), Status First Nations IMRs were found to be twice as high as Non-First Nations IMR – 2.3 times as high in rural areas and 2.1 times as high in urban areas. Upon further examination, however, it appeared that the reductions in IMR had been remarkably less consistent and less marked for those living in urban areas, suggesting a need for better maternal health services in urban BC. The authors also found that post-neonatal mortality rates were 3.6 times higher among First Nations versus non-First Nations infants – a trend that can be partially attributed to higher risks of SIDS, infection, and external causes of death among First Nations compared to Non-First Nations peoples (Luo et al., 2004). These trends were paralleled in a 2010 study (Heaman et al., 2010) comparing birth outcomes between First Nations peoples living on reserve and those living off reserve in Manitoba. Among other things, this investigation found that the risks of preterm, small-for-gestational-age, and low birth weight infants were lower on reserve than off reserve, but the risks of large-for-gestational-age and high birth weight infants were higher on reserve than off reserve. The off reserve trends may reflect poor utilization of prenatal care services due to the prioritization of issues such as income and food security, or due to a lack of knowledge about or availability of culturally appropriate services (Heaman et al., 2010). While these data fail to capture the outcomes in all provinces and among all Indigenous groups, they do draw attention to the need for public health practitioners to assist in the design, delivery, and evaluation of high quality maternity care services in all types of Indigenous communities (Smylie et al., 2010).

One of the prerequisites for enhancing maternity care is enhancing *access* to maternity care. In Canada, low income adults are more likely than high income adults to report waiting five days or more for a doctor’s appointment, even though the health care system is publicly funded (Schoen & Doty, 2004). These inequities in access to health services in Canada are hardly new; Indigenous peoples have been expressing their dissatisfaction with the mainstream health care system and dissuading impact it has had on their access patterns for decades (Benoit et al., 2003; Browne et al., 2000; Denison, Varcoe, & Browne, 2014; Kurtz et al., 2008; Møller, 2010; NAHO, 2008a; Olson, 2013a; Peters, 2006; Senese & Wilson, 2013; Shaw, 2013). For urban Indigenous peoples, issues related to jurisdiction, eligibility, service availability, cultural safety, and the SDOH can compound these barriers to access (Kurtz et al., 2008; Shah, Zeo, Al-Wassai, & Shah, 2011). Public health practitioners working at the systems-level should be aware of these barriers and work collaboratively with communities and key stakeholders to eliminate them. Public health nurses and other frontline staff can also make a difference by learning about Indigenous peoples, reflecting on and responding to their assumptions and beliefs, ensuring their clients are actively involved in their care, and striving for cultural safety to avoid dissuading encounters. All public health workers can learn from Indigenous midwives. By creating an opportunity for communities to exercise control over the design, provision, and evaluation of their own reproductive health care services, Indigenous midwives are working towards a broader Indigenous public health agenda. This agenda includes achieving health equity, increasing access to maternity care, supporting families, challenging stereotypes, and forging new relationships between biomedicine, Indigenous knowledge, and gender (Carroll & Benoit, 2004; Cook, 2011; Homer et al., 2012; Morgan & Wabie, 2012).

Of the twelve Indigenous midwifery practices located across Canada, SGMT is the only practice that is located off reserve within a major urban centre (NACM, 2012b). Seeing as SGMT is truly the first of its kind, this project and the larger evaluation study will be relevant to public health because it will share with health care professionals, decision-makers, community members, and others what makes SGMT unique. The results from this realist and utilization-focused evaluation (Patton, 2008; Pawson & Tilley, 2004) will communicate why it works, how it works, what needs to be improved and why, and what is next. They will also provide insight towards what Indigenous women in the GTA want, need, and have received in terms of culturally safe reproductive health care. Furthermore, by privileging the voices of Indigenous women, this project challenges racist, sexist, and colonial attempts to silence and oppress Indigenous women (Bourassa et al., 2004). As a result, it is anticipated that the women's perspectives on cultural safety will also shed light on the SDOH that intersect with racism, sexism, and colonialism and operate on an individual level. Thus, this project will inform readers about the SDOH at play in the GTA, as well as the ways in which SGMT has been addressing these SDOH. This is incredibly important from a public health standpoint, as taking action on the SDOH is considered to be a prerequisite for achieving one of public health's key objectives – health equity (Mendell, Dyck, Ndumbe-Eyoh, & Morrison, 2012). This type of information is of value to those who are interested in addressing the SDOH via maternity care services, and to those who wish to enhance access to or evaluate Indigenous midwifery services in other urban areas in Canada and abroad. The findings from this project can also be used in a health promotion context, as it intends to create more supportive maternity care environments, build community capacity within the GTA, and reorient health services towards cultural needs (WHO, 1986).

Chapter Three

Methodology

Situating the Researcher

One of the defining characteristics of qualitative research is the reflexive and introspective practice of "situating oneself" as a researcher (Creswell, 2013). This practice operates on the premise that individuals influence and are influenced by the set of social, cultural, economic, and historical structures within which they exist. As a result, individuals cannot be uncoupled or "distanced" from their physical environments. In other words, all researchers are speaking "from" somewhere (Pettman, 1992). Creswell (2013) describes "situating oneself" as the process whereby researchers consciously unearth, reflect upon, and declare in writing how their personal beliefs, assumptions, and biases may influence the ways in which the research is conducted, interpreted, and disseminated. Browne, Smye, and Varcoe (2005) suggest that researchers should also reflect upon their privileges, research motivations, and locations within broader social, economic, historical, and professional contexts. However, "situating oneself" is not simply an activity in self-awareness. Rather, critical self-reflection can provide researchers with insight towards how their biographies affect their research, how their privileges affect their personal relationships, and how to approach research projects with humility and respect (Cargo & Mercer, 2008; Sword, 1999). In summarizing these key insights, the written component of "situating oneself" is not only valuable in community-based participatory action research, but also, it serves to clarify – to the audience in particular – the context within which the project is conducted and interpreted (Sword, 1999).

One question that I have been asked on a number of occasions in relation to my graduate work is "why Indigenous peoples?" It is a valid question – I am a young woman of mixed European descent who grew up in a suburban area north of Toronto where Indigenous peoples are not as visible or as populous as other groups (according to 2011 National Household Survey, <1% of City of Markham residents self-identified as "North American Aboriginal"; StatsCan, 2013e). Even though I have had a number of opportunities to reflect upon and refine my response, I have yet to provide an answer that sufficiently captures all of the stories that I have heard, all of the people that I have met, and all of the experiences that have lead me down this path. As a seasoned academic, I was convinced that my lack of clarity on the matter could be resolved by “sitting down and writing it out”. Yet again, I found myself writing myself into autobiographical circles that were as illogical as they were unclear. It was at this moment, however, that I realized that it was this struggle – these “circles” – that needed to be at the heart of my critical self-reflection. It is not “why Indigenous peoples”, but “why it is so challenging to answer such a question” that is worth exploring.

I am a White, heterosexual, able-bodied cysgender woman who grew up in a middle-class Catholic family of four. I have spent most of my life in the GTA surrounded by grandparents, extended family members, and a church community that is both loving and supportive. While not much of an athlete, I found comfort and confidence in the education system, excelling in academia. I attended three Catholic schools, all of which were in low-crime, suburban neighborhoods. In high school, I completed an International Baccalaureate Diploma, and in university, I completed an Honours Bachelor of Science without any student debt. At present, I am working towards a graduate degree at Lakehead University. Even though I have since taken out loans, I have no personal experience with prolonged income insecurity. I also do not have any personal experience with the realities of food insecurity, poverty, violence, abuse, addiction, or racism. Going into this project, I realized that the Indigenous women I would be interviewing may not have been given the same opportunities and comforts that have extended from my White, heterosexual, able-bodied, cysgender, and educated privilege. While conducting interviews, it became clear that many of the Indigenous women had lived experiences (e.g. with racism, abuse, trauma, addiction, etc.) that were different from my own. In many ways, I was and continue to be an “outsider” to the women I interviewed. Even though I am working to dismantle and mitigate my “unearned privilege”, I am cognizant of the fact that it is always operating to some degree, and must be explored, discussed, and accounted for in a research context (Chevez, Duran, Baker, Avila, & Wallerstein, 2008; Wallerstein & Duran, 2006; p.316).

I am also aware that my thinking has not always been as critically inclined. It was not until university that my understanding of Indigenous peoples really progressed beyond what I saw in Disney's *Peter Pan* and *Pocahontas.* As a child, my understanding of "diversity" and "culture" stemmed from friendships with my peers who were newcomers from China and Korea. While I do recall taking Canadian history classes in elementary and secondary school, I can say with confidence that I never learned about the residential school system, the Sixties Scoop, the *Indian Act,* or that Indigenous peoples thrived prior to colonization. It was not until I was well into my undergraduate degree that my journey towards "unlearning" or what Peters (2010) describes as "self transformation" really began. After taking a number of social sciences electives, volunteering at a clinic in Central America, living with a rural physician, and working with an environmental consulting firm that had close relations with the Saugeen First Nation, I realized that I was living in a Eurocentric bubble. It was for that reason that I began enrolling in Indigenous Studies courses at McMaster University. At the time, I was very interested in pursuing a career in medicine. It did not take me long to realize that I knew next to nothing about health, science, knowledge, history, or people – and that the majority of people in Canada that I encountered, physicians included, did not either. At first I was enraged, and then I was humbled, and then I was inspired to continue learning. Since then, I have crossed paths with a number of Indigenous peoples and communities through my studies at McMaster University and Lakehead University, my work with individuals involved in the federal corrections system and youth in Hamilton, and through my current opportunities with WLH and SGMT. While these experiences have certainly deepened my understanding of what it means to be Indigenous in Canada, I realize that I will never be able to fully grasp the nature of an Indigenous reality. However, it is not my responsibility – and it was not the intention of this project – to discover this reality. Rather, it was and is about walking alongside Indigenous peoples, and allowing communities and individuals to define their own realities, destinies, and identities. Herein, I relinquished my role as a graduate student and oblivious outsider and repositioned myself as a learner and a partner (Sword, 1999). I can only hope that this thesis project contributes to the growing body of Indigenous health research that is done in a “good way”, and benefits Indigenous midwives, mothers, children, and families across all nations.

Research and Indigenous Peoples: An Overview

As an approach that has been praised for its congruency with Indigenous values, its distinction from Western conventions, and for its ability to reduce the colonizing effects of research, community-based participatory research (CBPR) has been widely employed and highly recommended for use in Indigenous research contexts (CIHR et al., 2010; Smith, 2012). In the sections to follow, I will provide a comprehensive overview of CBPR, describing its features and parameters, as well as the ways in which it will be used to guide this project. In order to fully appreciate the value of this approach it is worth exploring why research has become “one of the dirtiest words in the [I]ndigenous world’s vocabulary” (Smith, 2012, p.1).

What began as a supposedly benign collection of traveller logs documenting European experiences on Turtle Island soon gave way to the legacy of colonial practices and publications that exploited, misrepresented, disempowered, harmed, and “Otherized” Indigenous peoples under the guise of “research” (Smith, 2012). Following the “unilateral assumption of a universal model of research with a central authority in knowledge production” (Ermine, Sinclair, & Jeffrey, 2004, p. 17), the Western academy was and continues to be implicated in the advancement of the colonial agenda (LaRocque, 2010). Historically, research endeavours were often imposed on communities without permission, relevancy, or benefits to those involved – save for the benefits to the West (Blaut, 1993). Western research also had and continues to have a tendency to pathologize Indigenous peoples, perpetuate stereotypes, and deepen inequalities by focusing on negative social issues or “deficiencies” instead of the burdens of colonialism (Ermine et al., 2004). Thus, it is not surprising that Brant Castellano (2004) feels that Indigenous peoples have been “researched to death” (p. 99).

Even though a number of ethical guidelines have since been developed in Canada and abroad to protect Indigenous peoples from harmful research practices, the vast majority of research concerning

Indigenous peoples remains “firmly embedded in a rigid Western scientific paradigm” (Cameron, Andersson, McDowell, & Ledogar, 2010, p. 91). While it would be inaccurate to state that contemporary Indigenous and Western worldviews are completely incompatible, it is important to note, that the “epistemologies, ontologies, axiologies, and methodologies”, upon which their worldviews are based, are quite different (Wilson as cited in De Leeuw et al., 2012, p. 188). While there are indeed significant variations within and between Western and Indigenous peoples in Canada as well as abroad, Indigenous worldviews are generally based on the understanding of knowledge and reality as relational and local (Wilson, 2001), whereas Western post-positivist worldviews are based on the notion that there is one reality, that knowledge is an individual entity, and that objectivity is required to obtain that knowledge and thus understand reality (Popper, 1959). In addition to leaving little room for other ways of knowing, the latter is problematic because Western post-positivists “self-delude themselves into thinking that their research is value-free” (Scotland, 2012, p. 11). For Indigenous peoples, this has translated into the delegitimization of Indigenous knowledge, the persistence of insensitive and deceptive research practices, and an abundance of “disease-oriented” and/or biomedical research projects that have been conducted “on” Indigenous peoples “by” non-Indigenous researchers (Cochran et al., 2008; Smith, 2012). These types of projects have been harshly criticized for overstating the negative aspects of Indigenous communities, perpetuating colonial stereotypes, ignoring underlying social inequities, and failing to confer any benefits to the communities wherein “researchers… suck [their] blood and leave” (Cochran et al., 2008, p. 22; Smith, 2012).

For many Indigenous peoples, the term “research” conjures up bad memories and negative emotions (Cochran et al., 2008; Maar et al., 2011; Smith, 2012). However, Brant Castellano (2004) wisely points out that research – or, in its broadest sense, the purposeful gathering and interpretation of information to enrich and inform knowledge – has always been practiced by Indigenous peoples, even though it may not have been defined as such. In other words, Indigenous peoples and research are not incompatible. In fact, several Indigenous scholars and community groups have been working towards the reclamation of Indigenous research practices by developing if not reviving, recreating, and employing Indigenous methods and methodologies (for examples, see Johnston-Goodstar, 2012; Kovach, 2010; LaFrance, Nichols, & Kirkhart, 2012; Martin, 2012; Smith, 2012; Smylie et al., 2009; Wilson, 2008). Even though Indigenous methods and methodologies are heterogeneous, it is important to note that in general, what truly distinguishes Indigenous research practices from conventional approaches is that they build cultural protocols, values, and behaviours directly into the research itself (Smith, 2012). These approaches create space for participation, reflexivity, knowledge sharing, "reporting back" to communities, and establishing mutually beneficial relationships. Furthermore, by privileging Indigenous voices and valuing multiple ways of knowing, Indigenous research – when conducted by or alongside Indigenous peoples in a "good way" – can promote self-determination and de-colonization (Smith, 2012).

Indigenous research should be conducted in ways that fit within an Indigenous research paradigm (Wilson, 2001). An Indigenous research paradigm is a reflection of the worldviews and principles held by a certain Indigenous community or nation. That is why it should be used to guide the nature of a research project, from its methodological assumptions, to its selection of methods, to its dissemination strategies (AFN, 2009; FNC, 2007b; Kovach, 2010). Indigenous research is less about "Indigenous methods" and more about where its underlying paradigm, methods, and methodologies intersect. For example, while Indigenous Talking Circles may appear "identical" to non-Indigenous focus group interviews, projects that use one or the other will likely approach, conduct, interpret, present, and disseminate these interactions differently (Wilson, 2001). As a collaborative, reflective, and flexible approach that not only depends on the incorporation of multiple worldviews, but also "seeks to understand and improve the world by changing it" (Baum, MacDougall, & Smith, 2006, p.864), CBPR would fit well within such an Indigenous research paradigm (Wilson, 2001). The characteristics of CBPR also make it ideal for fostering mutually beneficial research partnerships between Indigenous and non-Indigenous peoples (Smith, 2012). It is for these reasons that participatory and transformative approaches such as CBPR hold such promise in the field of Indigenous health research. The methods employed in CBPR will be discussed further below.

Study Setting: Toronto

Located on the northwestern shores of Lake Ontario, the City of Toronto is home to over 2.79 million people. This prominent Canadian metropolis is not only known as the capital of Ontario, but also, with over 140 languages spoken, it is considered to be one of the most multicultural cities in the world (City of Toronto, 2014). Within this “cultural mosaic” is a young, vibrant, and rapidly growing community of First Nations, Inuit, and Métis peoples (Environics Institute, 2010b, p. 74). Due to the limitations of existing enumeration measures and the physical and ethnic mobility of many urban-based Indigenous peoples (Anderson et al., 2006; Browne et al., 2009; Peters, 2004), it has been difficult to determine the exact number of Aboriginal peoples who live in Toronto. At the time of the 2006 Census, 26 575 Aboriginal peoples were reported to be living in Toronto (StatsCan, 2006a). In 2011, that population appeared to fall to 19 265 (67.4% self-identified as First Nations, 25.3% as Métis, and 1.6% as Inuit) within the NHS (StatsCan, 2011c). Interestingly, the NHS also identified Toronto as the census metropolitan area with the largest population of First Nations peoples without registered Indian Status (14 505 individuals; see StatsCan, 2011c). Given the sheer size of this estimate and the associations between Indian Status, access to health services, and health outcomes, it is likely that Status is an important issue for many First Nations peoples living in the GTA (Anderson et al., 2006; Bourassa & Peach, 2009). Yet, as previously discussed, these statistics should not be taken at face value; Census data is known to significantly underreport the Indigenous population (Belanger et al., 2013; Smylie et al., 2011; StatsCan, 2007) and the non-response rate for the voluntary NHS in Toronto was 26.5% (StatsCan, 2014). More accurate counts have been put forth by community agencies, which estimate that the Aboriginal population in Toronto exceeds 70 000 people (City of Toronto, 2014).

Indigenous peoples are not “new” to the lands that are now the “GTA”. In fact, being a part of the Traditional Territory of the Mississauga of the New Credit First Nation, these lands have been a place of meeting, gathering, and trading for generations (McCaskill et al., 2011). The experiences and demographics of Indigenous peoples in present-day Toronto have been documented in several – albeit imperfect – reports (see above for TARP, McCaskill et al., 2011; UAPS, Environics Institute, 2010b). The

Indigenous population captured in these reports appear to have access to a wide range of Aboriginal-run services and organizations (e.g. Dodem Kanonhsa', Aboriginal Legal Services of Toronto, Native Child and Family Services of Toronto, Métis Nation of Ontario, Anishnawbe Health Toronto, etc.) and a deep pride in and connection to their cultural identity, but continue to struggle with alarming yet poorly understood levels of poverty, homelessness, racism, and their accompanying social issues (Belanger et al., 2013; McCaskill et al., 2011). These reports also offer some insight towards the diversity of nations and communities that are represented among the Indigenous population, with 60% of TARP respondents self-identifying as Anishnawbe, 14% as Haudenosaunee, 11% as Métis, 8% as Cree, 3% as Mi'kmaq, and 1% as Inuit (McCaskill et al., 2011). Given Toronto's southern location and its proximity to the Six Nations of the Grand River First Nation and the Mississauga of the New Credit First Nation, the predominantly First Nations-identified population is expected from a geographical standpoint (also demonstrated in Anishnawbe Health Toronto, 2013; StatsCan, 2014). That said, this trend should not be misinterpreted as justification for First Nations-centric services and programming, as homogenized approaches may not be able to meet the diverse needs of each First Nations, Inuit, and Métis person (StatsCan, 2014). Similarly, although the Indigenous population in Toronto may be slightly more female (O'Donnell & Wallace, 2011; McCaskill et al., 2011), Senese and Wilson's (2013) work draws attention to a perceived shortage of Aboriginal-specific services for men in the city.

Even though these reports are limited in their applicability to the Indigenous population in Toronto in its entirety, they certainly offer a glimpse into the diversity of Indigenous peoples and identities across the city. For organizations that serve Indigenous clients in Toronto, recognizing and respecting this diversity is central to the promotion of cultural safety. For example, in their Statement on Aboriginal Identity, SGMT (n.d.) recognizes that "the majority of Aboriginal families we serve will be from Turtle Island, [but] we also aim to support Indigenous peoples from other territories" (p. 1). In this statement they discuss their mandate to accept and respond to the differences that exist in the ways that people identify in terms of their connection to the Aboriginal community (SGMT, n.d.). This perspective aligns with the understanding of culture that was discussed above, wherein "culture" is seen as a complex and fluid concept that evolves with social, historical, political, and colonial forces. Knowing this, SGMT "encourages all people claiming Aboriginal identity to explore what it means for themselves, particularly in relationship to all parts of their being" and aims "to support the vulnerability and courage it can take to explore these complex issues" (SGMT, n.d., p. 2-3). This approach creates space for and accommodates the diversity of Indigenous identities that has been described but insufficiently captured in the literature.

Research Design

This project is nested within a larger community-based, participatory, utilization-focused, and realist evaluation study that is ongoing at SGMT. Realist evaluation is a type of theory-driven evaluation that seeks to discover what it is about a certain programme that works, why it works, and for whom (Pawson & Tilley, 2004). Grounded in realism, realist evaluation finds the middle ground between the "big policy ideas and the day-to-day realities of implementation" (Pawson & Tilley, 2004, p. 18). It also views "programmes" as open, complex, and self-transformational social systems that are introduced within open and complex social systems and capable of changing the conditions that made them work in the first place. Accordingly, the SGMT evaluation strives to "make sense of" of SGMT and urban-based Indigenous midwifery practice. Simultaneously, the evaluation is utilization-focused, in that it is conducted with the intended users for its intended uses (Patton, 2008). Entitled *Developing and implementing a practice-based performance measurement system with Seventh Generation Midwives Toronto (SGMT)*, this evaluation is co-led by the midwives at SGMT in partnership with the WLH. The results will be used to guide the construction and implementation of a culturally relevant and evidence-based evaluation system for SGMT. It includes key informant interviews (with midwives, staff, and former clients), pre- and post- questionnaires (with current clients), and legacy data analysis (of quantitative maternal and infant health outcomes). The results from this thesis project (i.e. interviews with former Aboriginal-identified clients) were used to inform the thesis and will be used to enrich the "cultural safety" aspect of the evaluation system.

Following the design of the larger study, this project was developed in accordance with the principles of community-based participatory action research (CBPR). CBPR is one of the many approaches that are categorized as "participatory research" (Holkup, Tripp-Reimer, Salois, & Weiner, 2004). Central to the undertaking of participatory research is the dismantling of the power imbalance between the researcher and "researched" through collaboration (de Leeuw et al., 2012). As a flexible partnership approach to research that involves the equitable and active inclusion of researchers, community members, and organizational representatives *throughout* the research process, CBPR is not a "research method", per se (Israel et al., 2008). Rather, it is a systematic effort to incorporate the community and their local knowledge into the research process in order to bring about social change (Castleden, Morgan, & Lamb, 2012; Wallerstein & Duran, 2006). As such, an "ideal" CBPR project would begin with a community approaching a researcher, or a researcher working alongside a community to address their specified needs (Castleden et al., 2012).

As per the ideal CBPR scenario, I contacted SGMT in December 2013 to determine whether or not they would be interested in a research partnership, and if they were, what their research needs were. Fortunately, they were very interested, and already engaged in a number of CBPR studies. As an outsider to the organization and to the Indigenous community in the GTA, I was careful not to impose any of my preconceived notions about what needed to be done (Israel et al., 2008). I did, however, have to prepare a "pseudo-proposal" for MPH purposes based on the literature and my research interests. I fully expected that the set of research questions, methods, and the like would change as a result of collaboration. In the months to follow, they did. Through a series of emails, videoconferences, and meetings with SGMT and the WLH research team, we were able to discuss, revise, and establish a project that was mutually beneficial from an academic standpoint, and of significant value and use to SGMT and the Indigenous community in the GTA.

According to Israel and colleagues (2008), there are nine principles of CBPR. They include (1) recognizing "community" as a unit of identity; (2) building on the strengths of a community; (3) involving the community in all phases of the research process; (4) promoting co-learning and capacity building; (5) balancing research and action; (6) emphasizing the SDOH; (7) systems development through cyclical processes; (8) disseminating findings to all partners; and, (9) requiring a long-term commitment to sustainability and social justice. Other scholars may add “reflexivity” and “cultural humility” to the list, as the importance of engaging in critical self-reflection on how their locations of power and privilege impact how, why, and for whom research is conducted has been emphasized by many (Chevez et al., 2008; Cornwall & Jewkes, 1995; Tervalon & Murray-Garcia, 1998). Here, it becomes clear that CBPR is rooted in critical social theory and draws on the epistemologies and methodologies of poststructuralism, postcolonialism, and feminism (Wallerstein & Duran, 2008). In addition, as an approach that critically engages a wide range of partners, incorporates multiple perspectives, and addresses community-identified concerns, CBPR can also accommodate Indigenous worldviews in a respectful and decolonizing manner (Israel et al., 2008; Smith, 2012). This benefit has rendered community-based approaches the “standard” for designing research projects that involve Indigenous peoples (de Leeuw et al., 2012).

CBPR has been used in several Indigenous health research settings, including Varcoe, Brown, Calam, Harvey, and Tallio’s (2013) study exploring the maternity care experiences and outcomes of women from the Nuxalk, Haid, and ‘Namgis First Nations. Following the principles of CBPR, groups of community researchers were hired and trained by the academic researchers to conduct interviews with 100 women and smaller groups of key community members. Many participants expressed their displeasure with their maternity care experiences – recalling encounters with providers and a health care system that that were wrought with discrimination, racism, and a lack of understanding about Indigenous realities – and a need for culturally safe maternity care in rural areas (Varcoe, Brown, Calam, Harvey, & Tallio, 2013). CBPR has also been applied to a handful of studies examining maternity care (Cheyne, McCourt, & Semple, K., 2013; Doctor et al., 2012; Foster et al., 2010; Josif, Barclay, Bar-Zeev, Kildea, & Brittin, 2012) and Indigenous women’s health (Browne et al., 2000; Dickson & Green, 2001; Kelly, 2008; Kornelsen, Kotaska, Waterfall, Willie, & Wilson, 2011; McHugh & Kowalski, 2010). They have been widely used in research exploring Type II Diabetes in First Nations communities (Macaulay et al., 2007; Mendenhall et al., 2010; Mohatt et al., 2007; Salsberg et al., 2008; Wilson & Young, 2008) and the impacts of climate change on Indigenous health (Drolet, 2012; Peace & Myers, 2012; Pearce et al., 2009). These initiatives are a testament to the value and power of community involvement in CBPR as a means to improve Indigenous research processes and outcomes (Macaulay et al., 2007).

While it should not be assumed that CBPR "works" for every Indigenous community, it was the most appropriate and effective means of responding to the research questions within the context of this project. In addition to improving the accuracy, relevancy, reliability, validity, and cultural sensitivity of a research endeavour without imposing external presumptions about knowledge or reality on the community (Minkler, 2005), CBPR aligns with the values and goals of the WLH. It was also successfully applied by the WLH to the *Our Health Counts* study in Hamilton (Smylie et al., 2011). CBPR was selected by the WLH for its emphasis on shared decision-making and its congruency with the principles of Aboriginal data governance and management, and subsequently adapted to actively promote balance throughout the research process between Aboriginal organizational partners, academic research team members, community members, and collaborating Aboriginal and non-Aboriginal stakeholders (Smylie et al., 2011, p. 23). In effect, the team established a "Governing Council" and research and data sharing agreements to honour existing guidelines, teachings, community wishes, and Indigenous experiences throughout the *Our Health Counts* research process (Smylie et al., 2011). Being nested within a larger study co-led by the WLH, this project was undertaken in accordance with the research and data sharing agreement (see Appendix B) that articulates the roles and responsibilities of the SGMT midwives, WLH research team, student researchers, and Grandparents Counsel (i.e. 'Governing Council'). Furthermore, as per the design in *Our Health Counts* Hamilton*,* capacity building, respect, cultural relevance, representation, and sustainability were all embedded within the study and project as "core features" (Smylie et al., 2011). These features are congruent with what Stoecker (2008) describes as the goal of CBPR; it is not to "do research", but rather, to achieve broader goals such as solidarity, self-sufficiency, learning, and social justice. If there was one thing I learned from attending research team meetings, it was that these core features operated and intersected on multiple levels. For these features to shine through at the outcomes-level, they were needed at the team level. For example, I learned that checking in and out (i.e. giving opportunity for everyone to share how they are feeling or where they are at before and after meetings), smudging, and resolving conflicts with respect during meetings were just as important to the relevancy, sustainability, and meaning of a project as the survey tools were.

CBPR does not come without its challenges. Even though I received tremendous support and guidance from SGMT and WLH throughout the research process, I had to adapt to scheduling and timeline changes, navigate team dynamics, and be open to shifts in the focus of the project. Being a young graduate student with few competing obligations, these changes – whether anticipated or unanticipated – were not difficult to manage. If I was a researcher who was balancing multiple projects, a family life, and/or stricter deadlines, I may have struggled to offer the level of commitment required by CBPR (Castleden et al., 2012). That said, given the flexibility and adaptability inherent in CBPR, I could understand how this approach could also accommodate busier schedules while ensuring that broader goals are met.

From a community standpoint, CBPR may be burdensome for those who are not prepared to offer the level of commitment that is required, or who may have been asked to forgo certain responsibilities to participate in the project (de Leeuw et al., 2012). Because SGMT and the WLH had collaborated on other projects, and because the midwives had experience balancing research with clinical practice, the groups that were involved were well equipped with the skills, knowledge, and resources that were needed to participate. Other criticisms have questioned whether the involvement of community members in data analysis is valid given the brevity of their training, and, if using an interpreter, whether the quality of the interpreter is limiting the quality of the data (Smylie et al., 2009). Interpreters were not needed for this project, and the peer reviewer (i.e. community member) was carefully selected by the midwives and trained by Dr. Smylie to ensure the quality of the analysis process.

In order to overcome the challenges of CBPR, researchers must establish the types of relationships that are prioritized by Indigenous communities and support successful CBPR (Smith, 2012). These relationships are those that are based on trust, communication, honesty, and mutual respect, and continue long after the research project is complete (Flicker & Worthington, 2012; Smith, 2012).

Although power dynamics in conventional research settings can make it difficult to nurture these types of relationships, researchers can and should put in the time, resources, compassion, and critical self-reflection that is required to build and sustain them (de Leeuw et al., 2012). Relationships are integral to the success of Indigenous research because “relationships do not merely shape reality, they are reality” (Wilson, 2008, p. 6). While working alongside SGMT and the WLH, I was constantly reminded of the importance of relationships and trained with regards to honouring these relationships.

After being vetted by the midwives, I was formally introduced to the staff and researchers working at the WLH and the midwives at SGMT during an Orientation Week that took place from June 10 to 14, 2014. During this week, members of the WLH research team reviewed the SGMT evaluation materials with me (e.g. survey tools) and taught me how to conduct interviews and obtain informed consent in a “good way.” This early training period and the mentorship that accompanied it was extremely valuable; I learned about the Indigenous community in Toronto, how to approach and conduct Indigenous health research at the WLH, how to position myself as a researcher, how to honour reciprocity (e.g. volunteering time to WLH community events and other parts of the evaluation study), and what resources and supports were available to me. That being said, all was not learned in a week. The midwives and members of the WLH research team offered guidance and support every step of the way, teaching me how to respectfully enter client’s homes, communicate effectively and safely, and make meaningful contributions while being an “outsider.” I also had the pleasure of attending several research team meetings, social events, and conferences (November 2014, Indigenous Health Conference; upcoming: November 2015, Canadian Association of Midwives Conference) where I was able to get to know the people I worked with beyond the confines of this research project. I sincerely hope that the relationships that I built will last, and that I will stay connected to the WLH and SGMT community(s) after this this project. I also remain keen on honouring a “lifelong commitment to [critical] self-evaluation and self-critique” (cultural humility, as defined by Trevalon & Murray-Garcia, 1998, p. 118), where I continuously reflect upon my positionalities and respond in ways that dismantle inequities and improve health.

Participant Selection and Recruitment

The individuals who were eligible to participate in this project were those who (1) were at least 18 years of age, (2) self-identified as Indigenous or Aboriginal at SGMT, and (3) delivered their baby with SGMT between March and June of 2014. This time frame was selected in an attempt to capture women who had recently completed their course of care. It was anticipated that these clients would recall their experiences more accurately, be more willing to share their stories, and be easier to reach from a recruitment standpoint.

Purposive sampling was used to select former clients who were eligible to participate. Purposive sampling, although non-random, is an effective sampling method for projects that rely on information that is only held by certain members of community (Tongco, 2007). Seeing as this project focused on the experiences of Indigenous women (i.e. a subset of the SGMT clientele), the midwives and WLH research team agreed that a purposive sample would render the most reliable and robust data. Because the midwives know their clients best, they were responsible for creating a purposive sample (i.e. list of approximately twenty eligible clients) that best represented the diversity in age, Indigenous background, education level, birthing location, parity, socioeconomic status, and other factors that exist among their clientele. Once the client list was finalized, Bobbie Maxwell – one of the receptionists at SGMT – contacted eligible clients via telephone to introduce the project and inquire about their interest in participating. If the clients were interested, Bobbie asked whether they would consent to being contacted by myself. If the clients consented, Bobbie shared their contact information with me. I contacted the clients; briefly discussed the purpose, parameters, and procedures of the project; answered their questions; and set up interview times. During each phone call, I reminded the clients that they were under no obligation to participate, that their care at SGMT would not be affected in any way by their participation, and that they could change their minds at any time. Promotional posters were originally going to be used for recruitment but were foregone since the eligible clients were at the point in their care where their visits to SGMT were infrequent.

Even though the participant selection and recruitment process was expected to take one to two months, it began in October 2014 and ended in March 2015. The midwives had to make several additions to the original client list and time frame of recruitment, as many of the eligible clients could not be contacted. In several cases, the phone numbers and addresses on file were out of service and/or not current, so there were significant delays in reaching and recruiting eligible clients.

Data Collection

The data for this project was collected from in-depth, semi-structured interviews that were conducted as per the Interview Guide (see Appendix C). The Interview Guide was developed and refined by the midwives, the members of the WLH research team, and myself. As was the case with all of the survey tools (for Information Letter, see Appendix D; for Client Consent Form, see Appendix E; for Verbal Consent Checklist, see Appendix F; for Verbal Consent Form, see Appendix G), the Interview Guide underwent plain language translation to ensure its comprehension by all. The questions were carefully designed to reflect the underlying research questions and the values of SGMT and the WLH. For example, in keeping with the SGMT Statement on Aboriginal Identity (SGMT, n.d.), participants were not only asked whether they identified as Aboriginal, but also, *how* they identified. The open-endedness of this question sought to create space for the diversity of Indigenous identities in the GTA by challenging the conventions that generalize the three groups of "Aboriginal people" identified in the *Constitution Act.* It is also important to note that the Interview Guide was not used as a script, but rather, as a starting point for conversation. In attempt to be what Creswell (2013) defines as a good interviewer, the wording and ordering of questions varied with each participant to reflect the environment and their personality. Interview times ranged from twenty minutes to one hour, based on how much the women were willing to share. I did not make any notes during the interviews, as I felt it would be best to give my full attention to the woman. Rather, I made notes after the interview, jotting down key themes and new ideas that each participant brought to the table, and writing a reflection on the interview experience. After conducting nine interviews, I felt that we had reached saturation. No new ideas were emerging, and the stories and experiences – albeit as unique and insightful as the women themselves – had similarities that suggested convergence on a thematic level. I discussed these trends with the WLH research team, and they agreed that we had reached saturation with nine women.

In order to accommodate individual schedules and comfort levels, participants were allowed to choose the date, time, and location of their interviews. As a result, I met with women in their homes, at coffee shops, or in a private room at SGMT. Even though the WLH research team had originally planned to send a team member to accompany me on home visits to promote cultural safety, availabilities were limited and the midwives were confident that I could do well with the proper training. As such, the midwives mentored me, teaching me how to create space for women to speak, how to be polite and respectful in someone's home, and how to ask interview questions in a "good way" in October 2014. They also supervised and critiqued mock interviews to prepare me for the formal interviews. The midwives, members of the WLH research team, and the thesis supervisor also recommended that I, in keeping with the literature (e.g. "audit trails" in Carlson, 2010; Creswell, 2013), keep a journal documenting my experiences as an interviewer. These entries were very helpful in refining my skills as the interviews progressed, and identifying preliminary themes during the analysis phase.

Before the interviews could take place, I had to obtain informed and non-coercive consent from the eligible clients. I met with eligible clients in person to provide them with a copy of the Information Letter (see Appendix D). The Information Letter provided a comprehensive overview of the project (i.e. purpose, parameters, funding source, ethics board information, risks, benefits, alternatives to participation, ability to withdraw, confidentiality and privacy measures, dissemination strategies, etc.), and the contact information for the research team. I took the time to read through the Information Letter with each eligible client and answered any and all questions they had. I stressed that participation was in no way mandatory, that they could drop out at any time, and that their participation (or lack thereof) would have no impact on their care at SGMT. The processes around security, confidentiality, and de-identification of transcripts were also emphasized. After reviewing the Information Letter, I gave each client as much time as they needed to decide whether or not they would like to consent to participating.

Once the clients verbalized that they were sufficiently informed and ready to participate, they were asked to sign the Client Consent Form (see Appendix E). A Verbal Consent Checklist (see Appendix F) and Verbal Consent Form (see Appendix G) were also prepared in advance for those who might have been uncomfortable with or incapable of signing a textual agreement. Even though I presented this option to each client, none expressed a preference or need for verbal consent. Participants were also given permission to end the interview at any time or skip certain questions if they felt uncomfortable. None of the participants stopped the interview or expressed feelings of distress. After the Client Consent Form was signed, the participants were asked whether they: (1) preferred to be digitally recorded or manually transcribed (i.e. via laptop), (2) wished to receive a copy of their transcripts for revision before analysis to promote naturalistic inquiry (i.e. member checking), and (3) wanted to be sent the results once the project was complete. Eight women consented to being digitally recorded on an audio device provided by the WLH, and one woman consented to manual transcription on my laptop. Two out of eight women wanted their transcripts sent to them for review and revision prior to analysis. Each woman was asked whether they would like to receive a copy after they provided their written consent. It was hoped that most of the women would agree to engage in "participative member checking" in order to verify the accuracy of the transcripts and increase the overall trustworthiness of the project (Carlson, 2010). Eight out of nine women expressed an interest in being sent the results. I will ensure that these women receive copies of this thesis as well as any future publications that come from this work.

Digitally recorded information was securely and confidentially stored at CRICH in a locked cabinet until it was transcribed. I transcribed all of the interviews verbatim, as it is an excellent way for researchers to familiarize themselves and establish a connection with the data despite the time commitment (Riessman, 1993). Additionally, seeing as the transcription process has an influence on member checking (Carlson, 2010), I removed multiple "um" s and "ah"s and replaced them with "…" to improve the readability of the transcripts. Because the transcripts were to be read by the analysis team (for description, see below), I felt that these improvements to the readability of the text were warranted. All identifying information (e.g. baby names, midwife names, hospitals, specific community names, etc.) was removed from the transcripts and replaced with a de-identified phrase in square parentheses. For example, if the woman had said, “when Mackenzie was born…” it was replaced with “when [baby’s name] was born…” We chose to forego a pseudonym key to improve the readability of transcripts between reviewers. The soft copies of the de-identified transcripts were stored on and transferred over the secure SMH server. After each interview, participants were provided with honoraria of $25 and an SGMT bib. Participants were required to sign the Honorarium Receipt (see Appendix H) to verify that they received these gifts for audit and accountability purposes. Original copies of the signed Honorarium Receipt and Client Consent Forms were stored in file folders in a locked cabinet at SGMT. The transcripts, digital recordings, and forms will be securely destroyed after 10 years.

Cognizant of my place in the project and community, I approached the data collection process in a way that was informed by cultural safety (Cameron et al., 2010), to the extent possible. By giving participants the freedom to choose when, where, and how (i.e. digital recording or manual transcription) they were interviewed, this project challenged conventional “researcher/researched” paradigms (Smith, 2012) shifting the power and control away from the researcher and onto to the participants. Central to this shift was my flexibility in meeting women wherever, whenever, and however. The interviews were not meant to be an inconvenience to participants; they were not meant to make the women feel uncomfortable, disrespected, or unable to be themselves (i.e. “culturally safe”). As per the WLH and SGMT training, I took care to be as flexible, accommodating, approachable, responsive, and non-judgmental as possible during interviews. This meant dressing appropriately, being friendly and open to conversation, thanking women for their time, adapting to changing situations (e.g. breaks to change diapers or breastfeed; being distracted by external events), adjusting tones and expressions accordingly, respecting and not judging their living situations or choices, being genuine, and taking the time to reflect on each interview. Culturally safe data collection was not about pressuring participants to divulge information to answer research questions. Rather, it was about meeting women where they were at, focusing on their strengths (Cameron et al., 2010), and finding ways to create space for them to feel comfortable and safe in sharing their stories.

Data Analysis

Analytical framework. The transcripts were analyzed using multi-phase, iterative, naturalistic, and team-based methods that guided another “community-based participatory action research study embedded in a critical Indigenous theoretical framework” (Smylie et al., 2009, p. 444). Informed by the works of Bell Brown (1999) and Crabtree and Miller (1999), Smylie and colleagues’ (2009) approach to thematic analysis relies on reaching consensus; adopting a critical, decolonizing, and naturalistic lens; and, working from within a “decolonizing framework”. This framework is guided by seven key assumptions about Indigenous reality. These include (a) that Indigenous peoples had their own health services and care systems prior to colonization; (b) that these systems, being grounded in local knowledge, were diverse; (c) that these systems were epistemologically distinct from biomedical ways of knowing; (d) that these systems were oppressed and outlawed through colonization; (e) that colonization has and continues to negatively impact the health of Indigenous peoples; (f) that contemporary Indigenous health knowledge and behaviours are influenced by an interplay of social, historical, political, economic, and cultural factors and vary within and between individuals and communities; and (g) that decolonization is required to improve the health of Indigenous peoples (Smylie et al., 2009, p. 437-438). It is from these assumptions and the key ideas presented in the Literature Review (see Chapter 2) that the critical and decolonizing nature of the interpretive lens emerges.

Central to Smylie and colleagues’ (2009) approach is the use of collaboration to ensure that the themes are as true to lived experiences of participants as possible. Accordingly, the interpretive lens drew heavily on naturalistic inquiry, which is “up close and personal […], tends toward intimacy… [and] demands empathy” (Norris & Walker, 2005, p. 133). Naturalistic inquiry is also about theorizing *with* people, rather than about people (Norris & Walker, 2005). It is for this reason that the analysis team consisted of Dr. Janet Smylie – a research team member, Shannon Simpson – a community representative, and myself – a novice non-Indigenous researcher. Even though the participants were not directly included as collaborators in the analysis process, their voices were represented through Shannon – an Indigenous woman working in Indigenous education who gave birth with SGMT years prior. Her insights helped us “make sense of” the data in keeping with “good thematic analysis” (Braun & Clarke, 2006, p. 25-26). In addition, by being an active member of a research *team* – despite being a non-Indigenous researcher – I felt that the themes did not simply emerge (Braun & Clarke, 2006), but rather, they came after extensive, relevant, critical, and consensus-based thematic analysis that increases the trustworthiness of the findings. Naturalistic inquiry has also been described as a paradigm that recognizes the existence of multiple realities, perceives investigator-respondent relationships as interrelated and constantly evolving, and promotes the use of emergent and flexible research designs to accommodate the complexity of these intersecting dimensions (Guba, 1981). Thus, naturalistic approaches demand “a certain amount of self knowledge, a capacity to observe one’s self and critically analyze [one’s] own experience” (2005, p. 15). Here, the parallels between the naturalistic aspect of the interpretive lens and the use of the following decolonizing, iterative, collaborative, and consensus-based Indigenous CBPR methods become clear.

Analysis process. Consistent with the methods used in Smylie and colleagues (2009), the analysis stage began with the selection of a team that would support the creation of the consensus codebook. Initially, it was hoped that this team would consist of an external reviewer, two or more members of the WLH research team, and myself. However, after discussing the logistics (e.g. availabilities) and necessity of building a team of that size, the WLH research team and SGMT midwives agreed that a team consisting of one senior academic research team member (i.e. Dr. Smylie), one community representative (i.e. peer reviewer), and myself would be sufficient. The peer reviewer had to be an individual who had some perspective on being a client at SGMT, but was also “distanced” enough from the practice and women interviewed that their insights would enrich the interpretations put forth by myself and Dr. Smylie who were “closer” to the project. With knowledge of the women in their community, the midwives suggested Shannon Simpson, an Indigenous woman who lives in Toronto, works in Indigenous education, and gave birth with SGMT years prior. Shannon kindly accepted the midwives’ offer. Thereafter, Dr. Smylie taught her how to conduct this type of thematic analysis.

Once the team was mobilized, the transcripts were distributed to each member for review. During this phase, the team members were given one to two weeks to read the transcripts and identify 10-12 key themes that reflected the underlying research questions. These steps were similar to those outlined by Braun and Clarke (2006) and Creswell (2013). However, unlike mainstream approaches to thematic analysis, the team worked collaboratively and iteratively to identify the key themes. This process is referred to as “consensus coding” (Smylie et al., 2009). Giving Indigenous voices the opportunity to “correct misinformation or to challenge ethnocentric or racist interpretations” (Royal Commission on Aboriginal Peoples [RCAP], 1996a, para. 4) via methods such as consensus coding can promote ethical research practice, especially in cases where non-Indigenous researchers (i.e. myself) are involved.

On May 4, 2015, the analysis team met in person to discuss and compare their interpretations of the transcripts. In a little over one hour, the team reached consensus on ten preliminary themes and a set of subthemes that captured the Indigenous women’s perspectives on and experiences with cultural safety at SGMT. These themes were also grouped into five larger “containers” (i.e. overarching themes). After the first meeting, I began preparing the consensus codebook. This required returning to the transcripts and linking quotes that supported the ideas in the themes and sub-themes with the help of NVivo 10.2.0 (QSR International, 2014). From there, I revised, reworded, and removed a few of the themes and sub-themes so they aligned more accurately with the quotes and interview contents. All of my revisions were returned to the analysis team for feedback; they felt that the changes were appropriate and the quotes were vivid, capturing the “essence of the point [we were] demonstrating without unnecessary complexity” (Braun & Clarke, 2006, p. 23). As a result, they gave me permission to move forward with the analysis. The finalized consensus codebook included twelve themes and several sub-themes that were grouped into four containers. To respect the principles of community involvement and open dissemination in CBPR (Israel et al., 2008), we shared each version of the codebook with the midwives at SGMT, and gave them the opportunity to give feedback. The midwives had nothing but positive feedback, so no changes were made.

The analysis team was also involved in the reading, revision, and approval of the in-depth analysis section (see Chapter 4). Here, the iterative process was needed to ensure that the interpretation of the transcripts was as true to the lived experiences of the Indigenous women as possible. This was perhaps the most important goal of the entire project, as Indigenous voices have often been misrepresented, misinterpreted, and marginalized by culturally unsafe research practices (Smith, 2012). After two to three weeks, the analysis team met again to discuss the analysis section; the team felt that no changes were necessary. Collaborative methods were also used to refine the thesis in its entirety. The first draft of the thesis was sent to the supervisor and to the midwives at SGMT. The midwives offered their feedback within one month of receiving the thesis, making recommendations and revisions that I honoured when finalizing this piece. The involvement of the midwives at this stage in the research process was important because it honoured community by promoting transparency (LaFrance et al., 2012). It also ensured that there was a “good fit” between the methods and analysis and that the language and concepts were consistent with and relevant to Indigenous midwifery – two criteria for good thematic analysis (Braun & Clarke, 2006). In addition, by giving the midwives the opportunity to shape the written thesis, we ensured that process and results of the evaluation met the needs and desires of their community and organization, and that research partnership was mutually beneficial (e.g. SGMT gaining research skills); these are key goals of participatory, decolonized evaluation (Johnston-Goodstar, 2012). Altogether, what these collaborative, iterative, and decolonizing analysis methods sought to bring forth were results that were meaningful and beneficial to the many communities (i.e. Indigenous women; Indigenous families; Indigenous midwives) that are touched by Indigenous midwifery in Toronto.

Ethical Considerations

Ethics approval for this project was received from the Research Ethics Board at Lakehead University (September 2014) and the Toronto Academic Health Sciences Network (TAHSN; June 2014). To fulfill my institutional requirements, I completed several courses, including the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans Course on Research Ethics* (completed March 2014), the *Canada Good Clinical Practice Course for Basic or Social Scientists Involved with Human Research* (completed May 2014), and the *Toronto Central LHIN Cultural Competency Training*

Program – Working with Aboriginal Clients (completed May 2014). I also completed the *Ontario Core Cultural Competency Training Program* offered by the BC Provincial Health Services Authority while conducting interviews to deepen my understanding of Indigenous cultural competency in health care (completed January-April 2015).

This project was designed to honour the three principles outlined in the TCPS 2: Respect for Persons, Concern for Welfare, and Justice (CIHR et al., 2010). For example, before obtaining consent, eligible clients were provided with a plain language Information Letter (see Appendix D) that outlined their rights and responsibilities as well as the purpose, parameters, risks, benefits, alternatives to participation, and other aspects of the project. I reviewed this Letter with each eligible client in the style that the eligible client preferred (e.g. some women preferred reading it aloud themselves; others wanted me to read it to them). The purpose of this process was to give each individual the opportunity to learn enough about the project to make an informed decision, which aligns with the "Respect for Persons" principle. Here, each eligible client informed that they were permitted to "skip" any questions that they did not feel comfortable answering. I also emphasized the voluntary nature of participation (e.g. assured eligible clients that their participation or lack thereof would not impact their care at SGMT) and explained the policies and procedures around security and confidentiality (e.g. de-identification of transcripts; for full details, see Data Collection). To ensure that the eligible clients felt that all of their questions/concerns were addressed, I gave each client a pen to mark areas of interest, and asked them on several occasions whether they understood and/or had questions. Eligible clients were also given as much time as they needed to decide whether or not they consented to participating in order to prevent coercion. As previously mentioned, a Verbal Consent Checklist (see Appendix F) and Verbal Consent Form (see Appendix G) were created in advance to accommodate any eligible clients who preferred and/or required a verbal approach. Even though none of the participants ended up using these Forms, simply having these resources available respected diversity in a way that is consistent with the principles in TCPS 2.

As a CBPR project, the research design upheld the tenets in the TCPS 2 "Concern for Welfare" and "Justice". By challenging the conventional "researcher/researched" power dynamic and by actively including Indigenous peoples in the initiation through the dissemination of the project, the CBPR approach required that the needs of the community – rather than the needs of the research - came first. For example, even though I originally planned to interview the midwives at SGMT, the research team felt that my skills and availabilities would better suit the client interview piece of the study based on their research needs. Seeing as the WLH research team and SGMT midwives knew their communities best, I was happy to shift my focus. This project also upheld the tenets of "Concern for Welfare" and "Justice" within an Indigenous context by valuing the procedural aspects of research. Within an Indigenous research paradigm, methods and methodologies – and not just outcomes – are recognized for their capacity to promote respect, healing, and education (Smith, 2012). It is for this reason that each stage of the research process (including data collection and analysis) was designed and implemented with cultural safety in mind. CBPR can also be conducted in ways that honour the four principles of OCAP: Ownership, Control, Access, and Possession (FNC, 2007b). Being nested within a larger Indigenous evaluation study, this project and its findings are owned, controlled, access, and possessed by SGMT, the WLH, and myself. For example, before presenting the findings from this project at a conference or in an academic article, I will have to discuss the opportunity and receive approval from SGMT and the WLH. The details of this arrangement are outlined in the Research Agreement below (see Appendix B).

One of the core values that guide Indigenous ways of knowing and, by extension, Indigenous research is reciprocity (CIHR et al., 2012). As a collaborative project that depended entirely on the sharing of personal stories, reciprocity was practiced in a number of ways. Firstly, in return for offering their "gift of story" (Kovach, 2010, p. 46), each participant was given $25 (to cover any interview-related costs and to acknowledge their appreciation for participation) and an SGMT bib. These honoraria were provided by SGMT. Some of the women shared that they were planning on donating the money to the practice as a thank-you for their experiences – a gesture of reciprocity. The peer reviewer was also honoured for her contributions with funds from SGMT. Reciprocity was also exercised on the individual level throughout the initiation and beyond the dissemination of the project (Kovach, 2010). Keen on "giving back" to the WLH and SGMT who so kindly shared their privileged information and welcomed me to the team (Smith, 2012), I assisted with the larger evaluation study by conducting and transcribing interviews with eleven non-Aboriginal clients. If all goes as planned, I will be involved in the analysis process once this project and my MPH are complete. I also attended multiple WLH/SGMT research team meetings and social events, supported my colleagues at the first annual Indigenous Health Conference in Toronto (November 2014), and volunteered at fundraiser events such as *Spirit Moon* (2014) to get to know the communities I was working with, as "relationships matter" (Smith, 2012, p. 125). Even though I am still figuring out where I belong within the context of the Indigenous health research community, I am certain that I will continue to learn from and grow in the relationships that I have established long after I graduate from the MPH program.

Chapter Four

Demographics

Nine women were interviewed for this project. The average age of participants was 33.8 years old (youngest: 30, oldest: 37). The educational attainment of the participants varied; one woman had completed some high school, one had her high school diploma, two had college diplomas, three had university degrees, and two had done work at the graduate level. This distribution differs from figures presented in the literature. For example, in the 2006 Census, 36% of Aboriginal women in Ontario had no certificate/degree/diploma, 25% had a high school diploma, 21% had a college degree/diploma, 11% had a university/Bachelors degree, and 1% had a Masters/PhD (StatsCan, 2006b). Data collected from the NHS revealed similar trends; approximately 23% of Registered and Treaty Indian women over the age of 15 living in Toronto reported no certificate/degree/diploma, 26% had a high school diploma, 22% had a college diploma, and 7% had complete university or higher (StatsCan, 2011b). Unfortunately, data on educational attainment in the other Aboriginal groups (e.g. Inuit, Métis, multiple Aboriginal identities) are not available.

Four of the participants were first-time mothers, and five of the participants had at least one other child. Eight participants gave birth in hospital, and one gave birth at the Toronto Birth Centre/SGMT. Seven participants were living with their partners, one was living alone, and one was living with a family member. With respect to Aboriginal identity, each woman self-identified differently. Participants self-identified as (in no particular order): Métis, “Métis plus” (this participant attributed the “plus” to her mixed European ancestry), half-Aboriginal, First Nations/Aboriginal, Ojibwe/Aboriginal woman, Native, Status First Nations/Status Indian/Ojibwe, Anishnaabe/Aboriginal woman, and Native. Zero participants self-identified as Inuit. This distribution is fairly consistent with existing – albeit flawed – data sources enumerating the population of Aboriginal women in Toronto. In the NHS, 63%, 29%, and 1% of Aboriginal females aged 20-64 living in Toronto self-identified as First Nations, Métis, and Inuit single identity, respectively [StatsCan, 2011a; note: because NHS data is delineated by “age group” where age groups include 15-19, 20-24, etc., I could not isolate the population-level statistics for the women who met the inclusion criteria (18+). As such these figures reflect data from 18-64 year old Aboriginal women who participated in the NHS]. While it is impossible to predict which NHS category each Aboriginal woman would self-identify with, the NHS criteria can be applied to produce a rough estimate of Aboriginal identities represented in this project – 67% women self-identified as First Nations, 33% as Métis, and 0% as Inuit.

All of the participants had an Aboriginal-identified midwife on their care team. Seven women had an Aboriginal-identified midwife as their primary midwife, one had an Aboriginal-identified backup midwife, and one had an Aboriginal-identified student midwife. The latter two participants had a non-Aboriginal midwife as their primary midwife.

Analysis and Results

The following is an overview of the twelve key themes and their respective sub-themes that emerged from the collaborative, iterative, and consensus-based analysis process. The themes were grouped into four “containers” (i.e. overarching themes), which included (I) Relationships and Communication, (II) Sharing Knowledge and Practice, (III) Building Community, and (IV) Practice as Home. These containers, in addition to the themes and sub-themes, were developed to answer the following research questions: 1) *How do Indigenous women living in the GTA conceptualize “culturally safe maternity care”* and 2) *To what extent did their experiences at SGMT align with these conceptualizations?*

The analysis team arrived at these containers, themes, and sub-themes by using the women’s responses to the cultural safety-specific questions (questions 1-5 under “Imagine a relationship with a caregiver in which you feel comfortable, respected, and able to be yourself; see Appendix C) as starting points, and then connecting these responses to their lived experiences and ideas that were shared during other parts of the interview. As such, the analysis team read and analyzed each transcript in its entirety.

The containers were created because many of the ideas connected on a deeper level. Therefore, the containers can be understood as "determinants" and the themes as "components" of cultural safety. The analysis below can be interpreted as follows: for Indigenous women living in the GTA, culturally safe maternity care is determined by relationships and communication, the sharing of knowledge and practice, the building of community, and the sense of "home" created within a practice. Additionally, the containers and themes capture ideals or "desires", whereas the sub-themes capture the realities of the practice. Interwoven throughout the analysis is the evaluative piece – that is, the extent to which the women's experiences with cultural safety SGMT aligned with their ideals and expectations. These containers, themes, and sub-themes are presented below in no particular order, using quotes for support. "A1" denotes Aboriginal client #1; "A2" denotes Aboriginal client #2, and so on. These numbers reflect the chronological order of the interviews (i.e. A1 was the first woman to be interviewed).

Relationships and Communication

This container includes all of the themes (i.e. components of cultural safety) that relate to relationships and communication. All of the women drew attention to the importance of the midwife-client relationship, and the many ways in which this relationship can promote cultural safety. The women felt culturally safe when: their Indigenous midwives created room for and supported respect for their choices, experiences, and identities (theme 1), their care was continuous (theme 2), the midwife-client relationship was personalized (theme 3), they received emotional support (theme 4), and they had an experience that was unlike their past encounters with cultural *un*safety (theme 5).

1. Indigenous midwives create room for and support respect for women and their choices and experiences.

a) Supporting women in all of their choices, withholding judgment, and not making assumptions. Many of the women had or wanted to have a midwife was who was non-judgmental. They did not want to be judged or made to feel guilty for their choices around pregnancy, birth, and the post-partum, or around life. When the midwives supported the women in their choices and did not make assumptions, the women felt comfortable and respected.

> (A4): She was so easy to relate to, so easy to talk to, and she didn't make me feel bad about any of my past and I've done some… I'm an ex-drug addict, prostitute slash, you know? *[Laughs]*… But she… that never phased her.
>
> (A5): culturally appropriate care would be something that… is respectful of any practices that I would have that I would want to do, not judgmental about choices that I'm making, giving me informed or information about a choice I made that they may not necessarily… follow their model of care or they may not back up – giving me the information but respecting my choices regardless.

The women also felt respected when the midwives did not make any assumptions about their desire to access teachings and ceremony. They wanted to know that their midwives respected the diversity of the Indigenous community.

> (A7): …not all Native people want teachings, right, so you can't just assume that everybody wants what I want, right? *[Laughs]*
>
> (A8): *[Cultural safety means]* … just feeling respected… assumptions aren't made… offering… offering smudges but not expecting that necessarily that you do smudges.

It was equally important for the women to feel respected and supported in a wide range of settings, including at home, at the birthing centre, and/or in hospital.

b) Acting as bridges or mitigators in mainstream health care settings. Some of the women told stories about how their midwives advocated for them in mainstream health care contexts (e.g. in hospitals; with doctors) when their autonomy was threatened or taken away. Midwives should continue to bridge the gaps and mitigate disconnects in these scenarios, as it appears to enhance the support they provide to women.

> (A3): ... *[the midwives]* worked with me, like weeks before even… my birth rights, figuring out what we we're gonna do, how we were gonna talk to my doctor about it, because I knew he

> wasn't… he didn't understand what I wanted, right? […] So that was a big thing that I was concerned about with my OB is that he just wanted to induce me and that was it. But with my midwives, they made it clear that they were gonna work with me to make it as natural as possible.
>
> (A7): … she was able to be my advocate when I was unable to like… I guess I wasn't expressing myself like… in a way that the doctor was understanding. So she was able to like be in my corner and be like "no, she doesn't actually have to do this. Like she's not… there's nothing indicating that she needs to be in this position." So because of that, she kind of gave me… the strength to continue to be my own advocate even when she wasn't in the room.

The approaches and attitudes of the midwives were not only crucial when navigating mainstream health care settings, however.

c) Being positive and affirming. For some women, having a midwife that approached the entire care experience with a positive attitude and outlook was highly important.

> (A3): …with my midwife, she was always positive, and that's one thing that I always look for when talking to her because I know she'd always have a positive feedback or just – she was really positive and sincere, right? She didn't always have a negative attitude.

It was also important for these attitudes to be grounded in and/or supplemented by a deep respect for diversity.

d) Respecting and honouring diversity of identity, of experience, and of choice. All of the women wanted their midwives to respect them as individuals and honour their diversity. Diversity was broadly defined to encompass culture, knowledge, family situations, life choices, and decisions related to pregnancy, birth, and the post-partum period. The consensus seemed to be that when the midwives respected and honoured diversity, they were better able to meet their client's individual needs.

> (A4): I told her I didn't want to breastfeed, and she respected that instead of constantly, "you gotta breast feed, you gotta breast feed."

> (A5): … I needed somebody who could respect the fact that whoever ended up in the *[birth]* room was gonna be in the room and that they could do their work and… be respectful of that space that was there.
>
> (A5): … cultural sensitivity extends beyond just looking at somebody's colour of their skin, but also just how they walk in the world. So being really sensitive to… just because you learned something, or just because you believe something doesn't mean that the other person necessarily needs to hear that.
>
> (A7): …as part of respecting and I guess would be like an awareness – yes. They *[the ideal culturally safe caregiver]* would need to have an awareness of the culture. And it's different cultures, right? Like it's not… Aboriginal people aren't just all like one culture *[laughs]*, which makes it even more complicated!

Respecting and honouring diversity also meant giving women the time they needed to receive information, ask questions, and make decisions.

e) Giving women the time that they need. When the women felt that they had enough time to establish trusting relationships with their midwives and obtain knowledge without being made to feel guilty or rushed, they felt more comfortable and safe in their care.

> (A7): Like they actually took the time to… get to know you and your family situation and your concerns and the appointments are… there's lots of time for questions that I had. So with my son, I had a lot more questions than I did with my daughter *[laughs]*, but it was nice. I didn't feel like I was taking up too much time.
>
> (A8): … Once I was in the room with the midwives, it was… all the attention was on me. Just taking the time to ask any questions or, you know, not make me feel like I was… being asked to get in and out as quickly as possible… Just, just taking the time to make sure I felt comfortable and… despite all the distractions *[of renovation at SGMT]*, I felt like… I would be able to build a good relationship with… the midwives there.

Altogether, when Indigenous midwives create room for and support respect for women and their choices and experiences, they are fostering an environment that is conducive to cultural safety. In this environment, midwives support women in all of their choices without judgment, act as bridges/mitigators in mainstream health care settings, are positive and affirming, respect and honour diversity, and give women the time that they need.

2. Continuity of care.

a) Being available to women. There was widespread support for the 24/7 model of midwifery care. Knowing that their midwife was there to answer their questions and provide support at any time made the women feel safe.

> (A3): Like once you call them they get back to you as soon as possible and they meet your needs, right? If you have any questions or concerns they try to answer them the best they can.

Availability was not sufficient, however; many women felt it would be ideal to be cared for by the same midwife(s) during their pregnancy, birth, and throughout the post-partum period.

b) Having the same midwife/midwives throughout the care experience. Many women believed that this continuity was needed to develop safe and trusting relationships with their midwives. Some women did not have this experience due to midwife absences (e.g. vacation, leave, etc.).

> (A5): [*My primary midwife*] went on leave… it sort of spun everybody into “okay, what do we do with her [*the client*] now?”
>
> (A6): I was originally assigned to one midwife, and… I was shuffled around because they were going on vacation… […] I had three different midwives, and I never got to know them as long – as well - as I could’ve with one midwife throughout.
>
> (A9): I wanted someone to be permanent. Not permanent, but just a certain person where I didn’t keep sharing everything to someone else and to somebody else on the road, right?

The women also drew attention to the importance of receiving support during the post-partum period.

c) Offering support throughout the post-partum period. Some felt that the post-partum support was what made midwifery special. Unsurprisingly, there was a desire to extend the post-partum period beyond 6 weeks within the midwifery model of care.

> (A1): … my favourite part about being with a midwife is, like, the after care after the baby is born, post-partum care. […] …it's always sad when it ends *[laughs]*.
>
> (A4): I actually do wish that we could've kept them longer, but I understand that it's – for the time of the baby and then a little bit after the baby – they don't have that kind of… you know what I mean? They're not pediatricians, right, but I would've loved if they were! *[Laughs]*
>
> (A6): And maybe a little longer than 6 weeks follow-up would be nicer. Something like 6 months would be great, yeah *[laughs]*… cuz I know I still have questions that I would like to call them about for answers.

One aspect of post-partum care that was of particular importance was the home visits.

d) Visiting women in their homes. Some women appreciated the comfort, convenience, and safety of being in their own home, while others felt that the visits deepened their connections with their midwives. A few recommended that the practice increase their home visits, both before and after birth.

> (A6): I like the home visits. They were… if we could have more of those, cuz it's really hard to get around when you're very, very pregnant. And even after, when you're recovering, it would be nice to have them come to your house. It'd be good if the visits were longer.
>
> (A8): So there were times when just being able to be here… and have someone come to me where I'm working here *[at home]*… and just, just understanding what my home environment was. I think that was important as well. And for some reason, it just helps with the bonding – the relationship – when they get to see you in your element, you know?

That being said, it is important to note that the home visits were not always helpful.

e) Student midwives can function as threat or bridge to continuity of care. One woman felt that she saw her student-midwife too often, and her primary midwife not enough. In this case, the student's perceived lack of knowledge and expertise – when coupled with the relative frequency of their visits –

limited the extent to which the woman could realize her ideal birth experience. Indeed, the woman did offer some suggestions to improve the student-midwife supervision and education process.

> (A2): … because she *[baby]* is our last, I really wanted to be supported by a knowledgeable, experienced midwife. So I didn't feel like I got the knowledge that I… wished I had and that's what you go for a midwife for, right? It's to have that one-on-one care with someone you know and trust. And so not having that whenever I did have to see her in a setting where it was important I didn't feel like I trusted or believed her, right?
>
> (A2): … like any other apprentice program, you do need someone to shadow and you're not going to gain that knowledge by doing things completely on your own. You really do need that person in the back, even if the person was in the room while the person was doing things...

For another woman, the relationship that she had with her student-midwife was a defining feature of her care experience. The student-midwife was able to connect with this woman in ways that her primary midwife could not. In this situation, the student-midwife was Indigenous, and the primary midwife non-Indigenous.

> (A9): Throughout the pregnancy, the student was awesome because she was, for one, she was Aboriginal so she gets it. Secondly, she just had a calming effect on me. And so, I liked that. And she, she didn't make anybody feel lesser or higher than her. She was at the same level and that's what I loved about that. […] I felt like I didn't have with the… the head lead of the midwives that… watches over us, I guess. I didn't feel that connection. But with the student, I did.

Evidently, continuity of care – a key component of cultural safety – can be enhanced or undermined by several factors, including the availability and consistency/continuity/constancy of midwives, the quality and frequency of post-partum support and home visits, and the relationships with student-midwives. Continuity of care – and by extension, cultural safety - also rely heavily on the depth and quality of the midwife-client relationship.

3. Personalized relationships.

a) Kin-based. Many of the women voiced their desire to have a deep, personal, kin-based, and/or reciprocal relationship with their midwife(s). Most – but not all – of the women developed this type of bond with at least one of the midwives on their care team.

> (A1): … I would like to imagine my childbirth experience to be, to feel like I'm amongst sisters and not with a medical professional. And with my sisters I know… their story, and so I feel like I would like to know my midwives' story a little bit more.
>
> (A4): … after [*baby*] was born, he got E. Coli in his blood, and I was at [*Toronto hospital*], and my midwife actually gave me money to buy food because they don't feed… the grown ups at [*Toronto hospital*]. So that was great.
>
> (A6): I wanted a more personal approach, I guess. And someone who knew me, my situation, my story… Someone I felt comfortable with… encouraging.
>
> (A7): So when you met with them [*the midwives*], it's just, they're more… I guess they're looking at you as more than as a number, or like a health card number, or whatever. […] …with the midwives, I found the biggest difference was they were talking to me as a person.

These relationships were stronger and deeper when they were built on shared understandings and experiences.

b) Built on shared understandings and experiences. For the majority of the women, cultural safety began with having an Indigenous midwife with whom – by virtue of her background - understandings and experiences could be shared.

> (A6): For me, the ideal is the Aboriginal midwife, just being Aboriginal herself. She understands what it means to be an Aboriginal woman because she's lived that life. All the hardships… poverty, growing up on reserve… all these experiences. She would know and understand and we'd have that connection. We'd understand each other. You know about residential schools, traumas? That's what we go through, that's what we live through. So… it's… an ease for her to understand.

> (A7): So as an Aboriginal person I wanted to use somebody that maybe had some… would understand some of my own beliefs and also would be able to help me with some cultural aspects of being pregnant and giving birth and caring for a baby.
>
> (A9): … [*the student midwife*] understands because she's been through certain things in her life that… I don't know, but I feel like she's, she will understand and relates more because of her [*Aboriginal*] background.

However, one woman felt that she was able to connect with her non-Indigenous midwife in similar ways because she [the midwife] was cognizant of her roles, responsibilities, and positionalities within the context of cultural safety.

> (A8): I like the fact that my non-Aboriginal midwife practiced culture care just as much as my Aboriginal one, maybe even more. She might have been even more sensitive because she wasn't.

These accounts suggest that both Indigenous and non-Indigenous midwives are capable of establishing deep and meaningful relationships with Indigenous clients. Still, there were differences between midwives.

c) Varied with each midwife. The women noted that each midwife had their own approach and style. Because of these differences, the women's relationships with their midwives varied. Some attributed this variance to differences in "fit" or compatibility. Although not framed as a criticism, this may represent a call for more consistency among midwifery care teams. There was also variation in the sharing of knowledge and practice and the offering of emotional support between midwives.

> (A6): They all have their own style, I found. And… I actually… I like *[second primary midwife]* a lot, more than my original midwife. *[Laughs]*… I just… *[original primary midwife]* was… she was nice and understanding and everything, but she… I just… she wasn't as maybe informative as *[second primary midwife]*. I liked her, she was nice, just different… different personalities.
>
> (A7): … collecting traditional knowledge is not an easy task just on it's own. So it really depended on the midwife. Like *[primary midwife]* was really good with having that information. But… maybe some of the other midwives aren't as… good or as comfortable.

> (A9): Yeah, she *[student midwife]* was more to my level and I felt more comfortable with her than with the, with the main one *[laughs*]. […] They're all good people, they just, they're just suitable for other people, you know what I mean? Different personalities.

Taken together, the women's stories position the development of deep, kin-based relationships that are built on shared understandings and experiences as crucial to the continuity and cultural safety of their care. These types of relationships also emerged as a key prerequisite for comprehensive emotional support.

4. Emotional support.

a) Being available and being "there" to offer personalized emotional support. In emotionally or mentally stressful situations, the women looked to their midwives for guidance. There were many stories that emphasized the importance of the midwives being present in stressful situations to calm the women down and make them feel comfortable.

> (A2): I was at a place where I didn't want to be giving birth, cuz she was coming early. I was, you know, emotional about it. I was in the hospital and really didn't want to be in the hospital, and… she was just there emotionally for me, that she just provided such great emotional support.
>
> (A6): I had to have an emergency C-section, and that wasn't something I was really expecting or prepared for. But I knew in the back of my mind that it could happen, and I knew she was there for me. I was experiencing a lot of pain and I didn't think I could get through it. But she was there, encouraging me to keep going, to keep thinking about the end result, which was the baby coming. She was… she's really good at calming me down.

One of the approaches that the women found helpful in terms of managing anxieties was the use of "predictable expectations."

b) Being clear about what is happening and what to expect. When the women were told what was happening and what they should expect in ways that were easy to understand, they regained their sense of control, their confidence, and their ability to manage uncertainties. Here, the midwives made the women feel comfortable.

> (A4): They were awesome, they, you know, discussed everything, they explained everything, they… made it easier for me, which was nice. […] It made me comfortable, it put me at ease, which was easier for the baby too cuz, you know, if mommy's stressed, baby's stressed.
>
> (A6): When we got the news from the doctor that I had to have a C-section, things just went really fast. She *[primary midwife]* explained to me what was going to happen. […] It was good to have her in *[the operating room]*, explaining in normal terms what was happening to my body, cuz I couldn't see it. She told me what they were doing to my body, where they were touching me, what they were using… instead of just having some doctor on call, doing some surgery.
>
> (A8): I felt like I wasn't ever gonna have a big surprise, 'cuz I… I would voice all my concerns. […] I wasn't missing any information. Where sometimes you walk out and you wonder if someone's gonna tell you what you need to know or not… I just felt, I felt safe, I felt like my child was safe, that… nothing was gonna get forgotten.

In addition to being clear about what to expect, it was also important for the midwives act as counsellors and/or therapists when needed.

c) Offering help in regards to managing emotional and mental stress. Many women had to contend with anxiety, fear(s), and/or difficult situations during their pregnancy, birth, and/or post-partum period. Relying on their midwives for mental and emotional support, the women felt respected and safe when their midwives validated their fears and offered guidance that reflected their identities and life situations.

> (A2): *[Cultural safety means]*… being able to address my fears even if they are outside the box […] …just understanding the fears, understanding where they're coming from and addressing them, but not… diminishing them? Not, sort of, pushing them to the side that would be the way they are.
>
> (A3): I think a lot of what she told CS [*Child Services*] helped them decide to let me keep him.
>
> (A5): I think ideally a caregiver, for me, would be somebody who has the clinical knowledge, but the emotional… the skills to understand the emotional needs of the clients and to be able to

> balance - similar to what I was just talking about – understanding somebody's life as well as their pregnancy. So… looking at the whole picture.
>
> (A9): When I would mention it [her fears] to her [student midwife], she had this way of like agreeing, kind of? … And then she, you know, she'll let me speak and then she'll ask me if, you know, if she, if I want her input on it. […] It made me feel good because I thought she was listening and I thought I wasn't going crazy *[laughs]*. It's not only me, it's happening to somebody else, so yeah. So that helped a bit.

In a few cases, the women felt that the midwives could have offered more emotional support. Perhaps this is an area on which the practice can expand.

> (A5): I think emotionally, I was a little... I was a little over- and under-supported.

In the context of culturally safe Indigenous midwifery care, comprehensive emotional support meant having a provider who was available and "present," knowing what to expect, and receiving guidance in regards to managing anxiety, fears, and the like. For many women, this type of support was acknowledged as central to their comfort, confidence, and wellness. Unfortunately, there was a sense that the women did not receive this type of support in all of their health care encounters.

5. Experiences with culturally unsafe care: Women know what they *don't* want.

a) Sharing stories of cultural unsafety in the mainstream health care system. Every woman recalled having some sort of negative experience with the mainstream health care system – both past and present. Hospitals were criticized for their lack of privacy, and their restrictive, regulated, and invasive atmosphere (e.g. continuous monitoring), while health care providers were found to be condescending, discriminatory, apathetic, and/or disrespectful.

> (A2): …when you walk into a hospital, even when I was trying to get things going with her and it wasn't happening, walking down the halls, I could feel the energy of the staff going, "oh, you know, just get things going, you know, why don't you take the drugs or why don't you do this". And I don't know if it was just for my head but it's… a different energy.

> (A6): … well I was originally with a doctor, an OB/GYN. And I felt like she… she wasn't really supportive too much of my situation – what I was going through… *[She made her feel…]* Like just a number. Like she didn't care for me at all or my baby's welfare.
>
> (A7): … I had these moccasins made for me to… that an Elder wanted me to have made. They were made to the specifications that he had to try to help with my birth, with *[baby]*. So it was very important to me that I wore these moccasins. […] So a couple times, like the nurses wanted me to take the moccasins off, and so they don't understand – right? […] So like that's… I guess, an example of… the hospital not necessarily being a culturally safe place.
>
> (A8): I feel like I have a background of having doctors not listen to me. Or not respect my opinion. And so there was a fear that if I had to make some decisions, that I wasn't gonna be… my options weren't gonna be considered, I was gonna be told what I had to do.
>
> (A9): They were watching me, checking my blood pressure, I couldn't leave or go anywhere until my blood pressure went down. I couldn't go to the bathroom – it was a lot of stuff that just kind of triggered me being mad. I just wanted to leave, right? Plus, the nurse that came in, like not a very nice friendly nurse, she was kind of rude.

When making sense of cultural safety, many of the women used these negative experiences to clarify what they did *not* want from their care experience.

b) Drawing on negative or unsafe experiences to understand cultural safety. After comparing their negative experiences to their time at SGMT, the women were able to reach conclusions about their ideals (i.e. culturally safe care). It was evident that the care provided by SGMT aligned more closely with (or was completely on par with) their ideal than any of the care they had received in the past.

> (A2): With my second, I… was able to walk freely, but it was more of the disbelief that I got from all of the staff and stuff that I was actually doing that and achieving a natural birth that I didn't want to deal with again with these two, so that's why we decided on having it at home.
>
> (A3): [*Including teachings and ceremonies]* made me feel good because I was doing it more natural, right? Because with my daughter [*older child*], I had to get induced, so I didn't want to

> go through that again. And I wanted… it to be as natural as possible, because I wanted to get that experience because I've never had that experience ever!
>
> (A4): *[My ideal…]* It would be *[primary midwife]… [Laughs]…* It seriously would, she was just so awesome. I couldn't ask for someone better than her. Even if I tried to imagine I couldn't – she was just so… Like I've had 4 babies before this and not one of those doctors were anything in comparison to her.

Reflecting on the themes presented above, it is apparent that relationships and communication are key determinants of cultural safety for Indigenous women in the GTA. The women were looking for midwife-client relationships that were personalized, continuous, emotionally supportive, and grounded in a deep respect for identity, diversity, and culture. They were also looking for relationships that were as far removed from their past negative experiences in the mainstream health care system as possible.

Sharing Knowledge and Practice

The themes in this container capture the women's experiences with the various types of knowledge and practice offered by SGMT. The women felt culturally safe when they could access both Indigenous knowledge and practice (theme 6) and practical reproductive health knowledge and resources (theme 7) as needed, and without judgment. There was also recognition of the challenges that came with navigating the "interface" that exists between Indigenous knowledge and practice (IK &P) and practical reproductive health knowledge and resources in a Western biomedicine-dominated health care system (theme 8).

6. Accessing Indigenous knowledge and practice (IK & P).

a) Many women chose SGMT for its Aboriginal focus and/or to access IK & P. There was an expectation among most of the women that SGMT would use an Aboriginal approach to birth, and thereby provide clients with access to IK & P. Only two women said they originally sought out SGMT to access midwifery care instead of culture-based care.

> (A3): I knew about the midwives and stuff so I was like, they're more natural and they're, you know, more Aboriginal, so why not? Why not see what services they provide?
>
> (A5): I really appreciate the Aboriginal health care model. I really believe in the practice of holistic healthcare and, sort of, whole body care. […]… It's the idea that you're not just dealing with the medical aspect of things, but you're dealing with the spirit and… they respect, sort of, however you want to practice in the world.
>
> (A9): … they *[SGMT]* were more connected to the Native community. So I wanted to go that route, I wanted to learn if they had teachings, if there was anything I pick up through them.

Even though many were interested in an Aboriginal approach, some did not know exactly what this meant, what to ask for, and/or how to ask for it.

b) Many women were unsure what to ask for, and/or how to ask for it. This lack of knowledge and/or awareness around accessing IK & P was attributed to the loss of IK & P in their communities, and/or their lack of exposure during childhood. Many women wished they had this knowledge; one woman felt ashamed that she did not know what to ask for. These accounts emphasize the importance of not making assumptions about how much knowledge a woman does or does not have (see theme 1).

> (A1): I guess I didn't know how to… like how to ask them to share, or what to ask them to share, or what they knew or what they could share.
>
> (A1): …in our culture, well in the community that I was brought up in, we haven't really shared childbirth, traditional knowledge about childbirth. And so it's not something that my sisters and I carry with us today that we can share amongst others. So if they have anything that they could share related to traditional knowledge and childbirth, I would love to hear about it because I feel like it's something that's been lost.
>
> (A2): We had felt ashamed that we didn't know, like "we should know this" so why would we have to ask, you know what I mean? […] We could've used a little bit more [*IK & P*], just because, because we are half and my partner was adopted out to a [*European*] family we don't

> have a lot of that cultural background that we'd like to have and so it would've been nice for them to provide us some stuff that we wouldn't have known about.
>
> (A8): Culturally-speaking, I wasn't quite sure what I was looking for, but… any kind of cultural knowledge being passed on was gonna be a big benefit to me as well. […]… that's the one thing that I really felt… like things that I thought, "oh I wish I grew up with this," but I didn't have this.

These accounts also beg the question of responsibility, namely who should be responsible for creating opportunities to access IK & P.

c) Room for midwives to ease initiation of access to IK & P. For the women who did not know what to ask for, IK & P was only included in their care when the midwives offered it to them, or directed them towards the appropriate resources (e.g. community organizations). The women also noted that other members of their community might not be in a position to ask or to know about IK & P. As such, the midwives were seen as both capable of – and should be responsible for – creating opportunities for women to access IK & P if they so choose.

> (A2): It wouldn't have been something that we would have asked. Whereas my midwife just took it upon herself to say, "hey do you wanna smudge?" and we're like "yeah, that's great, like we didn't even know that was an option" because of, you know, you're in a hospital.
>
> (A5): So ask the question "would you be interested?" or "is there something you'd want to participate in or have as part of your care?" Give people the opportunity to say "yes" or "no". They are coming to an Aboriginal clinic, they're coming to a clinic for… everybody has their own reasons, but a lot of people are gonna know that that's something is part of the care, or hope that that's a part of the care, part of the package. You shouldn't have to ask for it, you should be offered as an option.
>
> (A7): … I think like at least having the knowledge and offering the knowledge that your clients can sort of like say "yeah, I'd love to hear about that" or not, it would be really important. 'Cuz I think that is the reason why people would want to go to an Aboriginal clinic versus like, you know, *[another]* midwifery clinic or whatever, right? Like what makes Seventh Gen different,

> and part of that isn't just that they have respect for the culture, but maybe they could also, in the future, help to… give people that information.
>
> (A8): I knew a lot of mothers… that go there and the kind of circumstances that they're in and a lot of them would be either too shy, too afraid, too proud to ask. So I do think that if they could incorporate that into the, each session… they know what they want to talk to you about. So if it's genetic counselling on your third visit, perhaps that's, you know, "I have a teaching of this, this, and this, would you care to get any of these teachings today?" Then it's easy to say yes, rather than asking what you don't know.

Emerging alongside the need to ease the initiation of access was the desire to have access to *more* IK & P via SGMT.

d) Big desire for increased access to Indigenous knowledge, teachings, and ceremonies around the perinatal period, women's health, parenting, role of partners/family, etc. After asking the women about whether their midwives shared any Indigenous teachings and/or ceremonies with them during their care experience, the question to follow was: Would you have wanted the midwives to share more (question 7, under "This final set of questions focus on identity and knowledge sharing"; see Appendix C). Their responses were nearly unanimous; almost all of the women expected to have and/or wanted to have had more IK & P incorporated into their care. Many women were looking to reconnect with their culture and learn more about IK & P. However, due to a perceived lack of communication and/or assumptions held by the midwives, a few of the women were not given this opportunity.

> (A1): There was a story *[on the website]* about a woman who didn't know her culture but then she had drumming introduced during the birth of her baby and that sounded really beautiful… and maybe it was specific to her… I don't know… to the relationships she had with her midwife or to their specific culture that they were able to have that experience. But… maybe they could offer that to everyone, cuz that sounds amazing.

> (A5): I think I was hoping that I would have an experience where I would learn a little bit more. My grandparents passed away when I was fairly young and so… and we moved to a very White community, which… sort of… segregated any teachings that I would've experienced from them.
>
> (A8): Definitely the answer's yes… I guess I was trying to think of why that *[more IK & P]* didn't happen, and I think it worked both ways where I just made an assumption it would and they made an assumption I would ask if I wanted a teaching to… come into play.
>
> (A9): Well now that you say ceremonies, I would have loved to have that. I would have loved to, like, go through that part and more of the teachings. Because there are woman teachings, right? There are… birthing teachings and those are the kind of things that I was looking for.

Even though "IK & P" encompassed a wide range of teachings, knowledge, rituals, and practices (e.g. smudging, teas, teachings about parenting, etc.), the outcomes associated with access were universally and overwhelming positive.

e) When the women accessed IK & P, the outcomes were positive. For some women, being able to access IK & P facilitated cultural transmission; for others, it strengthened their identities. Overall, accessing IK & P made women feel physically, emotionally, spiritually, and mentally "good."

> (A2): … she [*primary midwife*] smudged with some tobacco that she got and that was quite sacred to her. So that was really special that we really got to smudge before her birth. […] It calmed me down because I wasn't ready for her to be born – she was too early. We were 10 days shy of a home birth [*laughs*], so… but it did… it made me feel special because she brought in some tobacco that really meant a lot to her and it was the first time she was using it.
>
> (A3): That was one of the other big things that I really enjoyed with the midwives was, is because we could smudge when I was in labour, right? That was a big thing for me. Doing that… meant a lot and especially giving my daughter a cedar bath when she was born, that meant a lot to me too, right? So it's impacted me a lot, my culture, in the last few years. And I'm happy to be giving my children that now because I understand it more and I know a little more about my culture, and

> now they can pass it on, right? So… I'm hoping that they'll be able to do that when they have children, right*?*
>
> (A4): *[Including IK & P made her feel…]* Good, especially the one with the… *[Motions to breasts, laughing].* You know how long it takes for your chest to go down? It took me two days with that [*sage tea*] so it was very helpful.
>
> (A6): We smudged with the sage. The smoke detectors were on bypass at the hospital, which was really nice. What else… she had this… she gave me these herbal teas to bring on labour – she gave me a bag of that. Plus she gave me some cedar to make a bath for the baby, so that was really nice. Oh… *[original primary midwife]* did mention that you can keep the baby's belly button. If it's kept in a medicine pouch and then given your child later in life, it will help her find her path in life. So I kept her belly button.
>
> (A8): Being able to use… an Aboriginal approach to my birth, I think was, made me a stronger person, yeah.

The choice to access/incorporate IK & P enhanced cultural safety, whereas the absence of choice/opportunity to do so undermined cultural safety. One woman, with whom IK & P was not shared, felt diminished and devalidated in her Aboriginal identity as a result of this failed opportunity.

> (A5): *[How did them not sharing IK & P make you feel?]* Well that I'm not Aboriginal, right? That I'm not Métis. That I'm not… that that's not how I practice or present.

Collectively, these outcomes confirm that access to IK & P is a key component of cultural safety. When considered alongside the women's expectations and desires for the practice (i.e. Aboriginal approach; accessing more IK &P, respectively), these outcomes also draw attention to the capabilities and responsibilities of midwives with regards to promoting cultural safety (i.e. room to ease initiation of access). Cultural safety was not only about having access to IK & P, however.

7. Accessing practical reproductive health knowledge and resources. The women – especially those who were first-time mothers – were also hoping to access practical reproductive health knowledge and resources. They needed this type of information to feel comfortable, safe, informed, and in control. Most women were very satisfied with this aspect of their care experience.

> (A1): …what to expect, or if I were to have complications what to expect in the case of a complication… […] They were always really good at informing about things.
>
> (A2): … having them talk to me, and really provide me with information so I can make an informed consent, an informed decision, and that would be where I felt respected.
>
> (A5): I think practically my needs were met. I think they did everything they needed to do for my physical needs.
>
> (A8): My primary concern was… the logistics, I guess, *[smiling]* of the pregnancy.
>
> (A9): Well the main thing is guidance. For a new mother not knowing anything, like… that was one of my big things. I would love to have guidance and… where to go and what, like, where… what happens next, you know? Like the steps.

Evidently, accessing practical reproductive health knowledge and resources was equally important to accessing IK & P. Even though these various types of knowledge and practice could be shared in an effective and complementary manner, this was not always the case. Some of the women touched upon the influence that the tensions between Western and Indigenous knowledges/approaches in the biomedical-dominant mainstream health care system had on their care experience. The analysis team agreed that the women were speaking to the "interface" between Indigenous knowledge and Western Euro-Canadian knowledge.

8. Navigating the interface between IK & P and practical reproductive health knowledge/resources.

a) Defining what is "normal." The first of the challenges that presented at this interface was the definition of "normal." One of the women felt that her midwives relied too heavily on clinical definitions of "normal" that did not take her personal experiences and understanding of her body into account. This left her feeling unheard, as many of the ensuing interventions and restrictions were unnecessary. Another woman approached this issue from a similar angle, recommending that midwives pay more attention to situations where their definitions of normal are at odds with their clients' definitions of normal.

> (A5): … instead of hearing me say that "this *[blood pressure reading]* is normal for me" it was… it was all about, "well, your baby could do this, and your baby could do that, and you could end up with this or you could end up with that" instead of, you know, hearing what I was saying. I wasn't having any other symptoms of anything.
>
> (A7): … with different people, they have different pain tolerances – they have different situations, right? So I totally understand it's hard for a midwife or a nurse or a doctor – anyone – to assess like how serious something is. *[Thinking]*. But I guess if somebody thinks that – if someone is saying that they think something isn't normal to be maybe pay a little bit more attention, 'cuz I don't know how to define normal.

Others explored this issue from an epistemological perspective, sharing examples of how the power dynamics between Indigenous knowledge and Western knowledge shaped the perceptions of their providers and their partners.

> (A7): *[Cultural safety…]* … it's just taking something as, I guess, the word "normal" comes back into it, is treating cultural things as "normal". So it's not a novelty thing that like I was seeing a healer and he was giving me teas to drink.
>
> (A8): … my… career experience… prepared me for how midwives work. And I think he *[husband]* really saw it as if we didn't get a call back immediately, maybe we were being ignored or… He's just very used to the certain medical kind of model where… it's very standardized. […] I think his opinion changed over time, for sure, but I think there's definitely a learning curve when you know nothing about midwifery and having to go along with something you're unsure of.

These stories shed light on the challenges that practices that operate the interface between various types of knowledge and practice (e.g. SGMT) must face. They also suggest that more balanced approaches are needed when dealing with complex issues in order to promote cultural safety. In addition to reconciling definitions of "normal," some of the women also spoke to the importance of SGMT's reach.

b) Sharing holistic health knowledge, resources, and practices in ways that are accessible to all members of the Aboriginal community. Even though none of the women explicitly mentioned the term "health literacy," the analysis team agreed that the discussions around equity and equality in access converged around this topic. Here, the women stressed the importance of SGMT reaching the LGBTQ community, oral learners, people with different levels of understanding around ceremony, and all other Indigenous sub-groups and ensuring their equal access to IK & P and practical reproductive health knowledge and resources.

> (A5): … having a class that's accessible to partners and not just male partners. I think that the other piece that I brought up earlier was just watching the language on some of their intake forms and paying attention to pronouns, and making it a little more accessible to the LGBTQ population would be helpful as well.
>
> (A5): The Aboriginal women's drumming circle is a pretty impressive thing… but my background makes it complicated for me to do that. Not everyone identifies Métis as Aboriginal.
>
> (A7): … when you're in an urban environment and an Aboriginal population, you have a lot of people who aren't necessarily… aware of their… of their traditional birthing practices. […] An ideal world would be somewhere where they have teachings, maybe, available. Even… it's an oral tradition, but you can like, stories and things like that to sort of… that would be something, another aspect. Just to reconnect parents with their, with their culture.

Building on this idea of equal access for all, some of the women warned of the dangers of making assumptions. They acknowledged that when information is not communicated in a "good," safe, and accessible way, it can interrupt knowledge transmission and/or push clients away.

> (A8): I remember that experience being told about the cedar bath, and I really had a lot of questions, like I don't… so, do I pick the cedar? Do I let the cedar fall off? Do the cedar have to be dry? […] I really have no clue how to do the ceremony. […] I think some things have to be

> spelled out so people feel comfortable doing it, cuz if it's not… answered all the questions, you feel like you're misrepresenting the cultural practice and you're not passing it on properly.
>
> (A9): I felt like the, the way they responded is like, "you don't know that already?" or "you should know that", that feeling I got. […] … there's a certain way you talk to people: you talk to them and you can't talk at them, right? And that's kind of how we both… felt. […] After that conversation with them about daycare and, you know, this and that, and that feeling of, you know, me like, them looking down on me, I just, at that point, I just kind of shied away from them.

Like the definition of "normal," the promotion of health literacy (i.e. ensuring all members of the community have equal access to IK & P and practical reproductive health knowledge) is a complex issue that operates at and intersects with the interface between Indigenous and Western knowledges and knowledge systems. Once again, the midwives at SGMT – who are constantly navigating this interface – emerge as practitioners who are both capable of and responsible for promoting cultural safety. This theme is also implicated in cultural safety because barriers to access (e.g. assumptions) can prevent clients from feeling comfortable, respected, and able to be themselves. This connection between access and cultural safety also shifts the attention towards the broader dimensions of cultural safety.

Building Community

The themes in this container capture the community dimensions of cultural safety. The interviews suggest that cultural safety both fosters and is fostered by community. The women were very proud of SGMT, acknowledging its capacity to provide what they were looking for – cultural safety (theme 9). The women were also made to feel culturally safe when their midwives took steps to deepen their connections to the Indigenous community in Toronto (theme 10).

9. SGMT received widespread community support, and their Aboriginal midwives were a source of pride. Together, the interviews depict SGMT as an organization that is cherished by the Indigenous women they serve. Although there was some ambivalence about needs being met – which may be indicative of a reluctance to criticize given their support for the idea – the women's experiences were generally positive.

> (A1): Maybe because it's so brand new [*laughs*] and shiny and white and it really feels like a clinic in here… And I didn't actually spend a lot of time at the birth centre because my birth was really fast *[laughs]*. I mean, I still felt like I wasn't – I mean it was lovely so, I don't really have complaints but – yeah.
>
> (A3): I refer a lot of people to Seventh Generation because I've had such a positive experience and I want the next person to have that experience too, right? They're so positive and they're willing to satisfy your needs in any way they can. And… that means a lot to me, right? Because, you know, as Aboriginal people, we stick together and we help each other out as much as we can.
>
> (A6): What was neat to know was that they reserve spots for Aboriginal mothers. I was very lucky to get in short notice with them. I was like 26, 27… or 28 weeks when I came to the midwives. Luckily there was a spot! I know there's long waitlists… I was very happy to get in and to get an Aboriginal midwife.
>
> (A7): I'd rank them pretty high in terms of my ideal.
>
> (A8): As far as cultural experience… and my ideal, I think it was a very good match… […] Just wishing that everyone who wanted to have an Aboriginal midwife could… have that.
>
> (A9): They, you know, I don't wanna … put them down or anything. They tried. If I, I guess if I divulged more information to them, then maybe they would've, extended to all of them, tried to help me a bit more.

Even when their care experiences were less than ideal and/or not what they expected, the women offered constructive criticism and what the analysis team interpreted to be loving feedback. This suggests that the practice has not only instilled loyalty in its clients, but also, that the community has "bought-in" to SGMT as an organization and practice.

> (A2): My main midwife was quite good at saying that we can trust your body and all this other stuff. My other midwife was more "well if it's meant to happen, it'll happen" and I don't think

> that's ever a good thing to say to anybody, especially someone who's dealing with fear. But I know it came from a good place, it's just not the place I needed it.
>
> (A7): The *[late test result]*, like that might've just… well it was just an administrative oversight, right? Like that's not a comment on *[primary midwife]*'s ability to do anything. And then… *[Thinking]*… yeah, the only thing is, and it's just probably just my own personality, like they did so well with so many things. Like I always felt safe in their care, I always… like I never felt the need to like double check their answers on any of my questions
>
> (A8): So it's just that one incident, I would say, where maybe… I'm not even sure how to word it otherwise but… my expectation was a certain amount of attention that I didn't get. But also understanding that there are many other mothers, you know, but this is something that happens. And I come from… a work background where this happens everyday so I get it, but… yeah.
>
> (A9): I think they're doing good as a whole, yeah as a whole. There's just little bits that they need to just kind of expand on.

The balanced nature of the feedback (i.e. identifying strengths as well as areas that need improvement) also suggests that the community believes that SGMT is *capable of* providing culturally safe care. Coupled with their interest and buy-in, this belief in the practice's potential can foster cultural safety. This belief can be powerful because it can inspire communities to voice their opinions and give feedback. By participating in feedback-driven projects such as these, community members are directly involved in the shaping, advancement, and achievement of cultural safety. As such, community can and does foster cultural safety. As stated previously, cultural safety can also foster community.

10. Building community connections. For the women who were not already connected to the Aboriginal community (e.g. through school, employment, etc.), giving birth with SGMT inspired them to connect with the Aboriginal community in new ways. For some, it motivated them to explore additional Indigenous pregnancy, birthing, and post-partum-related initiatives. For others, it deepened their connections to their family, their identity, and/or their sense of belonging and place in Toronto. Again, even for the women whose experiences fell short of their expectations, many followed community pathways that had emerged from their care at SGMT.

> (A1): In the summer I went to a pow wow and… while I was there, I saw my midwife and her family. And then I didn't realize, but [*the receptionist*] was actually dancing and he was in regalia, and I didn't recognize him. When I came into the clinic just after the pow wow, he was telling me how he saw me there. So that makes me feel like, you know, being able to go to these Aboriginal events in the city and to see people who I know makes me feel more connected for sure.
>
> (A2): More so in the… birthing world, so the Aboriginal birthing world. It's made me feel that I could… do more to make things a little bit better. And make sure that people are heard, and people more like us that don't have all the knowledge but are Aboriginal identified could actually… get more from it.
>
> (A5): So yes, but not necessarily because of being at SGMT positively, mostly because now I just, I want to learn more… and fill in the spaces that I thought… I had hoped would get filled in around Aboriginal and birth care through SGMT. So…yes, I'm definitely more involved and I've been seeking out more knowledge and information about my Métis culture since.
>
> (A8): And I think for my mom… who isn't in touch with her Aboriginal culture, I think it was really nice for her to live through it through me… […] Just really celebrating her culture where she felt safe to do it.
>
> (A8): I really wanted to give back to the community, especially when it comes to… pregnancy… anything to do with, yeah. Pregnancy, midwives, healthy babies… yeah. Yeah. I think I do wanna be more a part of that. Or constantly at least a little bit a part of it… Whereas before, I don't know if I had as much interest in that particular realm of being Aboriginal.

Indeed, the women also listed ways in which SGMT can improve on the community aspect of the practice. In addition to offering more community-related resources to clients, the midwives could also help break down some of the barriers that exist around access to health resources and multiple Indigenous identities (similar to promoting health literacy, as discussed).

> (A1): *[Were you able to get the information you needed?]* Not about the broader stuff going on in the community. I didn't find that that was something that was. I guess maybe I didn't specifically ask, but it wasn't also offered.
>
> (A4): It's because I am so White, it's a lot harder to get into a lot of the… it's not the programs that aren't accepting, it's the people, cuz they see me and they go "you're not Native" no matter how… even if I got my great grandma to walk in there and she's full Native, they'd be like "you're not Native," plain and simple. And I understand that, I've been through it my whole life.

From these stories, we can conclude that SGMT certainly has a place in the community. The practice is not only viewed with love and support, but it also capable of connecting women to their communities in new ways. By bringing people together – whether directly, by linking women with local resources, or indirectly, by garnering support and triggering discussion – SGMT both builds and is built by community.

Practice as Home

In this container, I explore the themes that drew heavily on the discussions around the physical environment and culturally safe space. Even though each woman had her own ideas about the "perfect" culturally safe space, the consensus was that culturally safe space is "homey" (theme 11) and inextricably linked to culturally safe relationships (theme 12).

11. Culturally safe space is "homey" space. All of the women described their ideal culturally safe space as "homey" or "home-like," where the definition of "home" varied. For many, the concept of home was associated with privacy, quietness, calmness, control, and the freedom to be able to "be yourself." There was also a tendency to equate homey-ness with a less clinical space. With histories of negative encounters with the mainstream health care system, it is not surprising that the women found less clinical spaces to be more comfortable and respectful.

> (A2): I think the home environment would be my ideal place. […] I think the true privacy, that it really is your space. You know, no matter what you do to a hospital room or to a birthing centre

> room it never really becomes “your” space, but this *[home]* is always going to be your space. And it’s just, you know, you can labour in any position you want, there’s no… medical equipment just hanging in the corners waiting for you. But when you have midwives coming here, you still have… I feel like you have all the medical necessities you need at your disposal should anything go wrong. But you still feel comfortable in your own setting.
>
> (A3): …not being in a cramped up room and feeling enclosed but having that space if you needed to walk or just, you know, do what you gotta do in birth and birthing.
>
> (A5): I think that… I like the color and the artwork and things that make things homier and… less like a clinical space and more of a comfortable space.
>
> (A7): But what I really liked about the house [*old location*] was… it felt less like institutional than the birthing centre in the Seventh Generations building. […] … they needed the space, and it’s a beautiful, brand new facility – it’s really nice. It’s just the only difference would be when you’re like walking up the steps into a house, it’s like as… different from like a doctor’s office as you can get, and whereas now… it’s a building. But even still, they have like, they put a lot of thought into everything.
>
> (A8): *[What is your ideal birthing space?]* Now it would be the birthing centre *[Laughs]* ‘cuz I wanted to feel closed off. I didn’t want to feel intruded upon. Having water as part of my birthing experience was really important to me, so having that, and you know, a place where I could rest in water… just a quiet atmosphere… *[Thinking]* … I mean, you know, just away from… anything that would remind me that I’m in a medical setting, which can be intimidating. (A8)

A few of the definitions of “home” were culturally rooted, with the ideal birthing space resembling family space or traditional territories. Evidently, in order to feel culturally safe, all of the women wanted to feel at home – whether they were in a hospital, clinic, birthing centre, or in their own homes.

> (A1): … so something that would make me feel more culturally… rooted, would be the chance to either accept or offer food or drinks. Not just water, but like if there was… I don’t know, like a

> tea station or something. Something… that makes me feel like I'm going to my granny's house, you know? Or to my auntie's house, or you know? Like where you're just "a cup of tea"…
>
> (A6): I grew up on the reserve, so nature, the bush, the trees, freshwater, and that is… the ideal space I'd like to bring and raise my child into. Rather than the city, but… it's just… I don't know… that's my space where I would go. *[Why is this space so special/culturally safe?]* It's just… what I know, where I grew up, what I experienced. It makes me happy, relaxed, calm.

This idea of "home" as the ideal culturally safe space aligns quite closely with the desire for deep, kin-based relationships discussed above (see theme 3). Evidently, the ideal "culturally safe space" and the ideal "culturally safe relationship" are not so different.

12. Culturally safe space is inextricably linked to culturally safe relationships. When describing their ideal culturally safe space, the women often mentioned the influence that their relationships had on this space. Not only did the midwives have a significant impact on the energy of a space (e.g. improving cultural safety of hospital room), but also, the administrative staff (i.e. Aboriginal people working there) were said to contribute to the safe and welcoming atmosphere at SGMT. Taken together with the importance of kin-based relationships and the relationality embedded in Indigenous worldviews, we can conclude that the spatial and relational dimensions of cultural safety are inseparable.

> (A3): *[Did care differ between locations?]* It's been the same, yeah it's been the same. Cuz I had *[primary midwife]* at both locations, right? She didn't change *[laughs]*.
>
> (A7): …there's… smudge bowls around, so you can smudge if you want to. Like there's… you can see jars of medicines and… there's Aboriginal people working there. So I think there's automatically the environment… it's called Seventh Generation Midwives [*laughs*]! There's so many different – like their logo – there's so many different cues in the environment that it's a safe place, whereas with a hospital it's… very institutionalized, right?
>
> (A7): It's almost like *[primary midwife]* came in and the energy changed in the [hospital] room again, and it was like calm, 'cuz I trusted her. So when she was telling me that things were okay, I believed that things were okay.

> (A8): … I felt very enclosed with my midwife and my husband. I felt like… I didn't even know I was in the hospital. I could've left when they left as well, so I did have nurses afterwards. […] But I think it's because I had my midwives there and… I was sort of protected from that hospital feeling.

For all of the women, cultural safety was about feeling "at home." Like cultural safety, the definitions of "home" varied, only to emerge as a concept that was both relational and spatial. Here, the overlap between all of the containers, themes, and sub-themes is particularly apparent. All things considered, the results from the analysis reveal that for Indigenous women living in the GTA, culturally safe Indigenous midwifery care was determined by the ways in which relationships and communication (components: themes 1-6), the sharing of knowledge and practice (components: themes 6-8), the building of community (components: themes 9-10), and the sense of "home" (components: themes 11-12) within a practice overlap and influence each other. In most cases – although not all – these determinants overlapped favourably, and the women were made to feel culturally safe. The nature and implications of these overlaps will be explored in the section to follow.

Chapter Five

Discussion

The findings from this project offer significant insight towards the ways in which Indigenous women conceptualize "culturally safe maternity care," and the extent to which their experiences at SGMT aligned with these ideals. Diverse in their socioeconomic situations, educational backgrounds, birth stories, and Indigenous identities, the women's definitions of cultural safety varied. However, when taken together, the women's stories and experiences depicted cultural safety as a concept that is determined by one's relationships with their providers, the sharing of knowledge and practice, the building of community, and the feeling of being "at home." When comparing their care at SGMT to their ideal, the majority – although not all – of the women felt that their pregnancy, birthing, and reproductive needs were fully met and that they were made to feel culturally safe. Indeed, all of the women felt that there was room for improvement, offering constructive and loving feedback even if they had experiences that fell short of their expectations. As a practice, SGMT was cherished by all and seen as capable of providing culturally safe care. Below I will explore and discuss the expected findings, unexpected findings, new contributions to the field, their implications for practice, the project's limitations, and, future research directions.

Expected findings. Several of the themes and sub-themes that emerged from the analysis process paralleled ideas that have been reported elsewhere. For example, many women felt that cultural safety was contingent on their midwives withholding judgment, avoiding assumptions, and respecting and honouring their diversity as individuals throughout their care. These characteristics have been listed among recommendations made by the Society of Obstetricians and Gynaecologists of Canada (Wilson et al., 2013) and included within existing definitions of "cultural safety" (NAHO, 2008b; Wesche, 2013) and "culture" (Browne et al., 2009; Josewski, 2011; Rasmden, 2002). The women also drew connections between cultural safety and continuity of care. Continuity of care is one of the guiding principles of the

Canadian midwifery model of care (CAM, 2010b) and has been shown to influence maternity care provider choices and preferences (Parry, 2008; Sword et al., 2012). Studies also show that many women deliberately choose midwifery to access a provider who shares in their beliefs about birth, and with whom they can form a deep and personal bond (Parry, 2008; Sword et al., 2012). McCourt and Stevens (2005) argue that the continuous care inherent in midwifery allows these types of relationships to flourish. The findings from this thesis project supports this link, as continuity of care (e.g. having the same provider throughout) emerged alongside developing deep and personalized relationships as key components of culturally safe maternity care. As demonstrated above, for many women, these relationships were enhanced when their midwife had an Indigenous background. This was unsurprising, as the literature shows that Aboriginal women are more likely to access maternity services when Aboriginal women deliver them because “she [*the Aboriginal service provider*] knows how we feel” (Homer et al., 2012; Kelly et al., 2014, p. 159). Burton and Ariss (2014) have also noted that clinician diversity can promote clientele diversity.

Midwife-client relationships are solidified in their strength and continuity when they are supported by the sense that the midwives are “there for you” (McCourt & Stevens, 2005, p. 17). This was observed in the interviews that emphasized emotional support and explored fears, anxieties, and mental stressors. Even though midwifery challenges the medicalization of childbirth (MacDonald, 2007; Shaw, 2013) and the influence of the “risk society” on pregnant and parenting women (i.e. view that constructions of “risk” have become pervasive and continue to amplify in modern Western society; see Beck, 1992), the changes and uncertainties that surround the perinatal period can be stressful for mothers and families. Care transfers between providers (e.g. from a midwife to an obstetrician) can be particularly difficult, as the loss of autonomy and sense of control that accompanies this process can trigger anxiety (Rowe, Kurinzcuk, Locock, & Fitzpatrick, 2012). For Indigenous women and their families, the stressors that surround this profound life event can be exacerbated due to the effects of colonialism and its legacies (e.g. child welfare involvement, living with unresolved grief/trauma, etc.; Olson, 2015; Roy, 2014; Smith et al., 2006). Evidently, it was not surprising that emotional support surfaced as a key component of cultural safety.

Cultural safety was also enhanced when midwives offered emotional support while acting as bridges and advocates for their clients in mainstream health care settings (e.g. hospitals and/or with physicians). This advocacy role has been reported elsewhere, with midwives assuming this task when their clients' autonomy is being threatened or taken away (Burton & Ariss, 2014; FNC, 2009). For some women, being emotionally supported and advocated for transformed the hospital from a culturally unsafe space to a culturally safe space. As noted, all of the women recalled having at least one negative and culturally unsafe encounter with the mainstream health care system – an issue that has been widely explored in the literature (Browne et al., 2000; Denison et al., 2014; Dion Stout et al., 2001; Dodgson & Struthers, 2005; Hanrahan, 2002; Kurtz et al., 2008; Tang et al., 2015; Wesche, 2013; Whitty-Rogers et al., 2006). Clearly, the racism, discrimination, and stereotyping of Indigenous peoples in the Canadian health care system that has been reported for decades persists (Benoit et al., 2003; Browne et al., 2000; Denison et al., 2014; Dion Stout et al., 2001; Dodgson & Struthers, 2005; Hanrahan, 2002; Kurtz et al., 2008; NAHO, 2008a; Senese & Wilson, 2013; Wesche, 2013; Whitty-Rogers et al., 2006). As expected, the women used these negative experiences to make sense of cultural safety; cultural *un*safety remains much easier to consistently define and characterize (Gerlach, 2012). These negative experiences also stress the importance of reorienting public health and health professions towards cultural safety, and dismantling the inequities that create and perpetuate these types of experiences.

In the literature, cultural safety relies on the notion that people who use health services *can* be made to feel "safe and accepted as who they are in terms of their cultural identity and behaviours" (Ball, 2008, para. 1). SGMT agrees, and strives to promote cultural safety by recognizing, respecting, honouring, and nurturing all types of cultural and/or Aboriginal identities within their practice (see Statement on Aboriginal Identity; SGMT, n.d.). One of the ways in which SGMT aims to achieve these goals is by allowing clients to define their own care and choose whether or not they would like to have a culture-based experience. This approach not only reflects the guiding principles of the midwifery model of care (CAM, 2010b), but also, exists to ensure that SGMT is respecting and meeting the diverse needs of all of the women in their care (Burton & Ariss, 2014). Unsurprisingly, it was this Indigenous focus and the option to have a culture-based experience that drew the majority of the women I interviewed to the practice. Even though each woman participant differed in her needs, wishes, and choices, they unanimously agreed that they would have liked to access more Indigenous knowledge and practice (IK & P) at SGMT. This shared desire to connect with and learn from IK & P has been observed in several inner city settings across Canada, wherein many – but not all – urban-based Indigenous peoples appear to maintain and/or connect with their traditional ways of knowing (Browne et al., 2009; Hunter at al., 2006; McCaskill et al., 2011; Restoule, 2008; Silver et al., 2011; Smylie et al., 2009). The women I interviewed were also mindful of the challenges associated with accessing IK & P, recounting the many ways in which knowledge transmission has been interrupted over time (e.g. residential schools; forced adoptions; loss of local health knowledge) and the impacts this has had on their realities. There was also a firm belief in the capacity and responsibility of SGMT to offer guidance around IK & P. This indicates that Indigenous midwives remain "keepers of culture" for the women and communities they serve (Carroll & Benoit, 2004, p. 266).

When interpreted in concert with the renewed provincial support for Aboriginal midwifery (Sousa, 2015), the involvement of Indigenous women in the revitalization of Indigenous midwifery (Carroll & Benoit, 2004), and the increasing demand for midwifery in Ontario (AOM, 2014), the widespread support for SGMT was not wholly expected, but it was certainly understood. Indeed, there were some women whose experiences fell short of their needs and expectations. However, in these cases, criticisms were offered alongside thoughtful, constructive, and caring feedback – concerns that will be investigated in-depth below. As a whole, the balanced feedback suggests a loyalty, buy-in, and vested interest in urban-based Indigenous midwifery that mirrors the growing support for Indigenous-run services in other urban areas (Benoit et al., 2003; Kurtz et al., 2008). Clearly, the Indigenous community in the GTA *wants* SGMT to succeed. Aboriginal client #3, for example, "refer[*s*] a lot of people to

Seventh Generation because [*she's*] had such a positive experience and I want the next person to have that experience too."

Unexpected findings. Before I discuss the contributions that this project makes to Indigenous midwifery and cultural safety research, it is worth exploring some of the *unanticipated* findings. These findings draw attention to emerging issues in midwifery that do not reflect the quality of care provided by SGMT *per se*, but rather, the quality of care provided by midwives in Ontario. While many of these issues may be systemic in nature, they are no less important to cultural safety. First, even though many of the women spoke very highly of their post-partum care, they wished that they had longer and more frequent home visits, and that the post-partum period was extended. The post-partum period is recognized by the WHO (2014c) as a "critical phase" in the lives of mothers and newborns and a key determinant of maternal and infant health (p. 13). Even so, the post-partum period remains the most neglected from a service standpoint in both Canada (Benoit, Stengel, Phillips, Zadoroznyj, & Berry, 2014) and abroad (Fowles & Walker, 2006; WHO, 2014c). With neoliberal policies pushing more post-natal services into the private sector and decision-makers failing to address shortages of human health resources (e.g. midwives), access to culturally safe post-partum care is far from equitable (Benoit et al., 2014). This marks a huge missed opportunity for governments and decision-makers to enhance population health and promote health equity (Ching-Yu et al, 2006).

Another unanticipated finding was the degree of variability both within and between midwives at SGMT. While some women felt that this was an issue of compatibility, others explained how the differences between their midwives' approaches to emotional support and IK & P affected their experiences. Even though maternity care providers have been shown to differ in their capacities to offer emotional support (Sword et al., 2012), the processes around increasing access to and/or sharing IK & P as an Indigenous midwife have yet to be explored. The few women who were unable to access IK & P had some ideas as to why this was the case; gaps were attributed to the clients not knowing what to ask for, perceived assumptions held by the midwives (e.g. assuming that the client would ask for IK & P if they were interested), and rules and protocols around sharing IK & P in a "good way." Indeed, these inconsistencies warrant further exploration, and may be indicative of contradictions that exist between the individual views of Indigenous midwives and the curricula in the Midwifery Education Program in Ontario (also reported in Australia; see Bond, 2005).

The women's experiences with their student-midwives also varied. As illustrated above, student-midwives have the capacity to either help or hinder the continuity of care. Client perspectives on student-midwives in an Indigenous midwifery practice have been seldom explored apart from an Australian study that demonstrated that – without continuous education and exposure – the student's (predominantly non-Indigenous) readiness to deliver culturally secure care to Aboriginal clients would decline over time (Thackrah, Thompson, & Durey, 2015). Here, the women's stories suggest that student-midwives – if sufficiently trained and supervised to share knowledge and practice and offer emotional support in a consistent and culturally safe manner – can enhance the continuity of care. The implications of this finding and the other anticipated and unanticipated findings will be discussed in-depth below.

New contributions. With SGMT being the first urban-based Indigenous midwifery practice in Canada, the findings from this project add new ideas and augment existing works in the fields of cultural safety and Indigenous midwifery research. First among these new ideas is the notion that *culturally safe Indigenous midwifery care is "culturally continuous care."* As established, continuity of care is at the heart of midwifery practice; it facilitates the development of meaningful, trusting, and personalized relationships, and gives women the time they need to learn, ask questions, and feel culturally safe (McCourt & Stevens, 2005). In this context, however, continuity of care also had a cultural dimension. "Cultural continuity" – that is, the other half of "culturally continuous care" – has been described First Nations leaders as "just being who we are" (Oster, Grier, Lightning, Mayan, & Toth, 2014, p. 5). Indeed, definitions of cultural continuity vary, but they generally view culture as a dynamic and diverse concept that is "potentially enduring or continuously linked through processes of historical transformation with an identifiable past of tradition" (Kirmayer et al., 2007, p. 77). In this project, culture-based care was seen as an important prerequisite for cultural safety. For example, the women wanted their relationships with their midwives to be reciprocal and kin-based, both of which reflect long-standing Indigenous values (e.g.

reciprocity) and worldviews (e.g. relationality; Hart, 2010; Hopkins, 2012; Kajner, 2012; Wilson, 2001). These kin-based relationships are reminiscent of the "equal" relationships that Ramsden (2002) describes as foundational to cultural safety. The women also wanted a personal and holistic care experience, where their midwives understood their life situations (e.g. involvement with Child Services) and went above and beyond the Canadian midwifery model of care when needed (e.g. meeting material needs). This suggests that culturally continuous care requires an expanded scope of practice that is more consistent with Indigenous concepts of health and wellbeing (Adelson, 2005) and the traditional roles of Indigenous midwives (Benoit et al., 2006; Carroll & Benoit, 2004; Heritage Community Foundation, n.d.; IWAC, 1995; Ross Leitenberger, 1998). That being said, given the importance of continuity of care and its integration into the midwifery model of care, perhaps the capacity to deliver culturally safe care is embedded into Canadian midwifery practice.

The findings also reveal that *culturally safe Indigenous midwifery care is as much about having access to IK & P as it is about having access to practical reproductive health knowledge and resources.* Put differently, it was equally important for the women to be given the choice to learn about and/or incorporate IK & P into their care, as it was to receive comprehensive informational support around pregnancy, birth, and the post-partum. Certainly, the IK & P component was a defining feature of cultural safety; offering access to IK & P was shown to affirm, validate, and support Indigenous identities and ways of knowing (see also Bond, 2005; Møller, 2011). Similarly, when women were given the practical information they needed, they were made to feel secure, comfortable, in control, and capable of managing the uncertainties around childbearing. Cultural safety was also enhanced (or undermined) by the ways in which the interface between IK & P and practical reproductive health knowledge and resources were navigated. The latter was often equated with Western/Euro-Canadian/biomedical approaches in mainstream health care settings, and as such this interface aligned with the longstanding "debate" between Indigenous knowledge and science (Durie, 2004). Even though the integration (but not their fusion; Durie, 2004) of these two approaches may help clients feel more safe and respected in a health care setting (McCubbin, 2006), this task can prove challenging. Misconceptions about the validity and legitimacy of Indigenous knowledge persist (Durie, 2004), limiting the extent to which Indigenous and non-Indigenous peoples can successfully navigate this interface in a health care setting. A few of the women alluded to this interface, recalling their encounters with competing definitions of “normality” and reiterating the importance of ensuring equal access to IK & P and practical reproductive health knowledges and resources for all. With “normality” being tied to constructions of “risk” (Coxon, Sandall, & Fulop, 2014), and “equal access for all” being tied to health literacy and equity (Lambert et al., 2014; Smylie et al., 2006), these complex issues undoubtedly operate at this interface. Ermine and colleagues (2004) liken this interface to Roger Poole’s notion of “ethical space.” The authors conceptualize ethical space as a “meeting place of worldviews where excess baggage of interests and hidden agendas are left behind” (p. 46) and propose that its navigation begins with recognizing the validity of Indigenous knowledge and its equal standing with Western knowledge (Ermine et al., 2004). Ethical space is also a space of “future possibility” (Ermine et al., 2004, p. 43); it is likely that the women who shared their experiences with cultural transmission (e.g. passing knowledge onto children; reconnecting with IK & P in urban centre) and scholars such as Durie (2004) and Senese and Wilson (2013) would agree. Altogether, the women’s stories indicate that SGMT is advancing this interface or ethical space by respecting, creating space, and providing access to multiple forms of knowledge and practice. As noted by one interviewee, all providers should aim to “[treat] cultural things as normal” (Aboriginal client #7) in order to promote cultural safety and ensure that Indigenous and Western approaches come together in a “good way.”

Culturally safe Indigenous midwifery care was not limited to the midwife-client relationship – it also had a *community dimension.* Almost all of the women felt that their experiences at SGMT (whether negative or positive) had inspired them to connect with their communities in new ways. This trend presents SGMT as a safe place where women are free to express themselves, explore their cultural identities, and ask questions without judgment. Senese and Wilson (2013) show that when Aboriginal peoples are given the opportunity to reconnect with their cultural identities in urban spaces, they are strengthened in their abilities to overcome challenges around access and discrimination in the community.

Culturally safe care can create these types of opportunities. With pregnancy itself being described as an opportunity for change (Smith et al., 2006) and childbirth being seen as a turning point for individual and community health (Van Wagner et al., 2007), it is arguable that the benefits of reconnecting women with their cultural identities are even more profound in a midwifery context.

Culturally safe care is also about a sense of belonging. When the women saw their midwives outside of SGMT, or when their midwives shared information about local activities and programs, they felt more connected to the SGMT community and to the Indigenous community as a whole. Understanding the link between community connectedness and cultural safety requires an understanding of Ingold's (2000) "spheres of nurture." Chambers (2008) describes these "spheres of nurture" as the inter-relational networks that "encompass the land, water and sky and all the beings who dwell in those realms" (p. 116). Here, identity and place are not separate entities, but one in the same (Ingold as cited in Olson, 2015). In this view, the SGMT community and the Indigenous community in Toronto can function as nourishing places for women that "constitute their identity, knowledgeability, and the environments in which they live" (Ingold, 2000, p. 133). As such, when women feel connected to their communities, they are made to feel secure in their identities as urban Indigenous women and ultimately culturally safe.

The findings from this project also indicate that *culturally safe Indigenous midwifery care is care that makes women feel "at home."* As shown above, "home" and "homey-ness" took on multiple meanings. As a concept that is inextricably linked to identity and place, "home" cannot be universally defined (Berman et al., 2009; Robertson, 2007; Ruttan, LaBoucane-Benson, & Munro, 2008). However, what makes the concept of "home" so relevant to cultural safety is that it is an idea and a place where "there is no sense of otherness, where there is at last community" (Zandy as cited in Robertson, 2007, p. 527). Reflecting on the transcripts, it becomes abundantly clear that all of the women – whether their ideal space was less clinical, less regulated, more private, or reminiscent of "…the bush, the trees, freshwater…" (Aboriginal client #6) – felt culturally safe when they were free from marginalization and Otherization. These narratives on "home" also resonate with Ingold's (2000) "spheres of nurture." Robertson (2007) explains that the sense of "being-at-home" is not necessarily bound to a single location;

it can extend to include communities, cities, and/or nations. This suggests that meanings of "home" are located within the same types of inter-relational networks that Chambers (2008) equates with "spheres of nurture." Theme 12 sought to capture this interconnectedness. Creating the sense of "being-at-home" in Indigenous midwifery begins with recognizing, honouring, respecting, and supporting women in their various identities, experiences, choices, and life situations. Most of the women felt SGMT performed strongly in these areas, although there is certainly room for improvement, among other things.

Implications of the findings. As a project that merges two relatively under-researched fields of study (i.e. Indigenous midwifery and cultural safety in Canada), the findings have several implications for research and practice. Nested within the first-ever evaluation of Canada's only urban-based Indigenous midwifery practice, this project is the first to document client experiences in this context. It is also the first to present evidence that supports the value and benefits of urban-based Indigenous midwives. The findings are highly relevant to Indigenous midwives as well as to other health care providers, researchers, decision-makers, and communities who cross paths with Indigenous health.

From a research standpoint, these findings fill a number of gaps in the literature. In addition to confirming that SGMT can and does provide culturally safe care, the findings provide clear evidence of the health-promoting effects of cultural safety. When the women received culturally continuous care that made them feel "at home," connected to the community, and supported in their identities as Indigenous women, they experienced a wide range of benefits to their physical (e.g. effective pain relief), emotional (e.g. increased satisfaction with care), spiritual (e.g. being empowered, strengthened in Indigenous identities), and mental health and well being (e.g. learning to manage anxiety). Culturally *un*safe encounters, on the other hand, had damaging effects on their health and well being; these accounts reinforce the importance of cultural safety and preventability of cultural *un*safety. The benefits of culturally safe care were also shown to extend towards families (e.g. facilitating cultural transmission) and communities (e.g. enhancing connectedness and relational identities). This speaks to the ripple effect of cultural safety that one Aboriginal midwife attributes to Aboriginal midwives themselves: "you have one birth, one woman's life you affect, that affects her whole family, and then it affects her clan and then on to her nation, and then it's the whole Aboriginal community – we have a voice again" (Burton & Ariss, 2014, p. 274). Together, these positive outcomes validate the work of the midwives at SGMT and the applicability of "cultural safety" in Canada. These outcomes may also be a useful starting point for researchers looking to identify measurable indicators of culturally safe care.

Since the majority of the women gave birth in the hospital, their experiences with cultural safety reveal that it is possible to deliver culturally safe care in mainstream health care settings. Here, the midwives were pivotal; by advocating for their clients and building bridges between providers, the midwives would transform the hospital into a culturally safe space. That being said, cultural safety should not be limited to midwives or Indigenous midwives. While it may be more difficult for non-Indigenous providers to develop relationships with Indigenous clients that are built on shared understandings and experiences, the findings from this project show that it is indeed possible. Aboriginal client #8 felt that her "non-Aboriginal midwife practiced culture care just as much as [*her*] Aboriginal one, maybe even more. She might have been even more sensitive because she wasn't [*Aboriginal*]." All maternity care providers can bring cultural safety to the forefront of their care by respecting multiple worldviews, recognizing the challenges that women face, and accepting that these challenges may be different from their own lived experiences (Burton & Ariss, 2014; NCNZ, 2011). Maternity care providers – and arguably, all health care providers and public health practitioners – can also learn from the tenets of culturally safe care that were presented above. For example, while it may be inappropriate for a non-Indigenous obstetrician to share IK & P with their Indigenous client, they could promote cultural safety by withholding judgment, directing that client to community organizations/resources, and collaborating with the client and said organizations/resources to successfully navigate that "ethical space."

This project also has implications for the midwifery community in that it sheds light on the roles and responsibilities of Indigenous midwives and offers insight towards "who or what is an Indigenous midwife?" As previously discussed, "culturally continuous care" was contingent on a scope of practice that closely resembled traditional models of Indigenous midwifery care (e.g. caring for families across the life span, carrying on and sharing traditional teachings, etc.; NAHO, 2008a; NWAC, 2007a; Ross

Leitenberger, 1998; Vallianatos et al., 2006). Culturally safe care was also contingent on having access to both IK & P and practical reproductive health knowledge and information. When united, these two ideas suggest that the scope of contemporary Indigenous midwifery practice extends beyond more traditional approaches to include a navigation of the interface between Indigenous and Western knowledge systems. Accordingly, Indigenous midwives are still ensuring the survival of local knowledge and the integrity of one's connection to the land (NWAC, 2007; Carroll & Benoit, 2004), but in an urban context where local knowledges and communities are increasingly diverse and complex. With the persistence of biomedical dominance, racism, and colonial stereotypes in the mainstream health care system, navigating this interface can be challenging for Indigenous midwives. In the words of Aboriginal client #7, "collecting traditional knowledge is not an easy task just on it's own." With this interface presenting as a key determinant of cultural safety, the need to support Indigenous midwives in their navigation of this interface becomes even more pressing.

Another interesting idea that emerged from this project is that Indigenous midwives practice trauma-informed care, albeit unconsciously. This is congruent with the NACM's core value of "healing" whereby Aboriginal midwives draw on their knowledges, traditions, and languages to enhance the "capacity of a community to heal from historical and ongoing traumas, addictions, and violences" (2012c, pt. 1). By living and bearing witness to the experiences of the women they serve, the Indigenous midwives at SGMT are part of the community in an "intimate way" (Wolfe as cited in AOM, 2012, p. 9). Building on shared understandings and experiences, Indigenous midwives are capable of validating their client's trauma and meeting them where they are at – two key tenets of trauma-informed practice (Arthur et al., 2013). While there were certainly variations in the extent to which each Indigenous midwife delivered trauma-informed care, there was this idea and assumption that the "Indigenous midwife", simply by being Indigenous herself, "gets it" (Aboriginal client #9). The facilitation of cultural transmission and the inclusion of family members in the care experience suggests that Indigenous midwifery, while woman-centered, also has a family focus. Given the role that parenting has in transmitting trauma (Sotero, 2006), this focus functions as another route by which Indigenous midwives practice trauma-informed care. Following the “ripple effect”, it is also arguable that, by practicing trauma-informed care, Indigenous midwives are helping entire communities heal from trauma. As a practice that is equally concerned with “reframing identity” (Olson, 2015, p. 151), culturally safe Indigenous midwifery care is inextricably linked to bigger projects, such as community healing and self-determination (Carroll & Benoit, 2007). Trauma-informed care can only advance these broader goals if practitioners (e.g. Indigenous midwives) take steps to mitigate the professional impacts that can accompany this type of work (e.g. burnout, compassion fatigue, vicarious trauma; Arthur et al., 2013). For example, vicarious trauma – or the effect that working with trauma survivors has on helpers/providers – can manifest as low motivation and confidence, decreased productivity, poor communication, apathy, tardiness, exhaustion, among others (Arthur et al., 2013). In order to prevent burnout, vicarious trauma, and the like, Indigenous midwives need interpersonal support and holistic self-care (Harrison & Westwood, 2009). Research investigating self-care and support strategies for Indigenous midwives in the context of trauma-informed practice would be invaluable here.

Central to the advancement of cultural safety is ensuring that health care providers receive adequate, relevant, and continuous training and support from educators. As a result, this project has implications for those who design midwifery, medical, and other health professions curricula. For example, some of the interviewees mentioned the complexities that come with the sharing of Indigenous knowledge and practice: what if the Indigenous midwife does not have IK & P to share? What if they do not feel comfortable sharing IK & P? What if traditional protocols prevent them from sharing? How can we support midwives in initiating interactions around IK & P? Evidently, there is a need to address these challenges within mainstream and Indigenous midwifery curricula, and to investigate these topics in a research context (for Future Research Directions, see below). Moreover, being situated within a biomedically-oriented system with an admission preference for students with college/university backgrounds, Ontario’s Midwifery Education Program similar to nursing educations in Canada and abroad whether their focus is on educating Indigenous health professionals or not may not appropriately cover Indigenous topics, despite their best intentions (Bond, 2005; Møller, 2011). Therefore, there is also a need to critically examine existing programs and courses in relation to Indigenous content. It also appears that the midwives at SGMT need more training and support around health literacy and counseling/emotional/mental health care. The former is unsurprising, as research indicates a general lack of awareness around health literacy among health care professionals (Corrarino, 2013). Even so, given its links to the "ethical space" and underlying health inequities, health literacy and its accompanying responsibilities cannot be overlooked. The latter, on the other hand, is particularly important given the prevalence of mental health issues and unresolved trauma in various populations of Indigenous women (Skye, 2010). Incidentally, conventional measures and indicators of mental health may not be able to accurately capture the impacts and realities of historical and intergenerational trauma. As such, it is imperative that Midwifery Education Programs look to British Columbia's Trauma-Informed Practice Guide (Arthur et al., 2013) as well as Indigenous knowledge sources for guidance. Decision-makers must be careful here; there is a tendency to overstate the deficits and adverse experiences around mental health in the Indigenous community. Perhaps an Indigenous, trauma-informed approach to mental health education and support would help providers and researchers reorient their focus towards coping, resiliencies, and reality. This project also draws attention to the importance of supporting student-midwives – and ensuring that their involvement does not compromise quality of care or leave women feeling like they saw their student-midwife too often (e.g. Aboriginal client #2) – and creating opportunities for midwife self-care. Indeed, all of the issues raised require further exploration.

Limitations. Even though these findings are valuable, they do not come without limitations. First and foremost, they cannot be generalized to the entire population of Indigenous women in the GTA, or to other urban-based groups of Indigenous women. Studies show that women who seek midwifery care tend to have certain views about childbirth and the medicalization of care (Parry, 2008; Shaw, 2013). These views may or may not be shared by women who have obstetrician- or physician-led care. With the majority of births in Ontario being attended by obstetricians (84.7%; BORN Ontario, 2013) and the number of pregnant Indigenous women who are categorized as "high risk" (Yee et al., 2011), the definitions of cultural safety presented here cannot and should not be universally applied to all Indigenous women in the GTA. This was not the purpose of the project, however. What can be generalized from this project is the importance of creating opportunities for Indigenous women to define and evaluate cultural safety for themselves.

Similarly, during the selection and recruitment process, the midwives had to overcome some unforeseen barriers. Many of the women who were included in the original purposive sample could not be reached because their contact information at SGMT was insufficient (e.g. phone no longer in service) or outdated (e.g. they had moved since last receiving care). The challenges that come with higher mobility and the popularity of cellphones are difficult to control for and avoid. However, it is possible that because of these limitations some voices may have been underrepresented in the interviews. For example, although the midwives did their best to obtain a representative sample, the women reported higher levels of educational attainment than expected. Returning to the 2006 Census data for Ontario and 2011 NHS data for Toronto, it appears that women with no certificate degree/diploma or a high school diploma were underrepresented and woman with university or graduate degrees were overrepresented in the sample. The proportion of women with college diplomas in this sample (2/9 participants = ~22%) was similar to the proportions reported in the literature (StatsCan, 2006b; StatsCan, 2011b). As such, it is possible that these conclusions are biased towards more educated Indigenous women in the GTA. Other voices that may have been underrepresented in the interviews include Inuit women (0/9 participants self-identified as Inuit), Indigenous women under the age of 30 and over the age of 37 (age range: 30-37), and Indigenous women who had planned home births (8/9 participants delivered in hospital). Even though the distribution of Indigenous identities in the sample was fairly consistent with the results of the NHS (StatsCan, 2011b), the absence of Inuit women is worth noting. In addition, although age-specific data for Indigenous women living in Toronto is not available, the age range of participants was quite small, suggesting a potential bias towards older clients. Indeed, it is important to note that this sample was obtained from a list of SGMT clientele, rather than from a list of all the Indigenous women in the GTA. As such, this skew towards older and more educated women may reflect the reach of the practice.

The recruitment process – although linked more closely with contact management systems and external factors – may have contributed to the underrepresentation of certain individuals, such as those from hard-to-reach populations (e.g. homeless women, recently incarcerated women, other women living in precarious situations, etc.). Because participants were selected and recruited by those who were being evaluated (i.e. Indigenous midwives and staff), there is a chance that the sample may be biased towards more favorable experiences, or towards women who were more likely to share. However, the midwives and WLH research team discussed this issue and appropriate mitigation strategies in detail (e.g. creating large lists, considering multiple criteria, and refining lists to reflect diversity of clientele) prior to selection. Because the midwives and staff were the only individuals with the level of knowledge and rapport required to create and recruit a purposive sample, their involvement in these stages of the research process was both inevitable and appropriate. Moreover, given the diversity of experiences (both positive and negative), backgrounds, and personality types that were captured in the interviews, it appears that the mitigation strategies were effective.

It is also important to consider the limitations of the analysis process. The analysis team consisted of a seasoned Indigenous researcher and authority figure in the community (Dr. Janet Smylie), an Indigenous community member (Shannon Simpson), and a novice non-Indigenous student researcher (myself). The collaborative, iterative, and consensus-based methods were undoubtedly helpful in promoting the accurate and respectful interpretation of the transcripts. Even so, although the sample was skewed towards more educated Indigenous women, the high level of educational attainment among the analysis team members may have yielded some interpretations that did not match the views of the women. It was hoped that these issues would be resolved via member checking (Carlson, 2010). Each participant was asked whether they would like to receive a copy of their transcript to review prior to analysis. I discussed this option while reviewing the Information Letter (see Appendix D) and presented the question to them after obtaining written consent, but only two out of nine participants expressed a desire to review their transcript. If I were to repeat this project, I would pose this question again after the end of the interview; perhaps they wished to change their minds and review the transcripts but did not know how to ask me. Alternatively, seeing as the women were (new) mothers, perhaps I could have offered to send them the recording (if they so chose) instead of a written transcript to make the revision process more accessible (e.g. may find it easier to listen than write while breastfeeding). Giving participants more options to participate in transcript review is an excellent way to avoid traps in member checking (Carlson, 2010). Returning to the analysis process, if I were to repeat this project, I would try to assemble a larger and more diverse analysis team in order to enrich the interpretation and generation of themes. Yet, giving community members the training, time to offer feedback, and compensation that they would need to undertake thematic analysis as per Smylie and colleagues (2009) would be cost, time, and resource-intensive.

Future research directions. Researchers interested in cultural safety and/or Indigenous midwifery could build on the findings from this thesis project by investigating the logistics of delivering culture-based care. Interviews with Indigenous midwives, local knowledge keepers, and community members could be conducted to clarify protocols and determine best practices around the safe and respectful sharing of knowledge and practice. This could give Indigenous midwives the direction around initiating interactions about IK & P that they need. This could also help clarify the specific needs of Indigenous midwives in relation to IK & P. It is anticipated that the interviews that were conducted with the midwives at SGMT for the larger study will offer some insight in this regard. Researchers could also reproduce this project in rural, remote, and northern settings. This would not only enrich local understandings of culturally safe Indigenous midwifery care, but also, allow for comparisons between practices. This type of data would lend further insight to the roles and responsibilities of Indigenous midwives, their scope of practice, and how place and identity intersect with cultural safety in different areas (e.g. urban vs. rural vs. remote vs. northern). Inter-practice comparisons could also help public health policy makers and other key decision-makers enhance the consistency of Indigenous midwifery and refine measures of cultural safety. Carroll and Benoit (2004) agree that communities would benefit from more standardized Indigenous midwifery services that allow for full autonomy and control.

Other research avenues worth pursuing could include an examination of the influence that constructions of “risk” and “normality” have on the negotiation of the interface between Indigenous and Western knowledge systems. Both have been shown to affect choices around childbirth (Coxon et al., 2014), and could potentially help Indigenous midwives navigate the “ethical space”. Here, interviews that are structured and designed from within a similar Indigenous research paradigm could be used. Research focusing on the education of Indigenous midwives in Euro-Canadian versus Indigenous systems could also be useful, as the introduction of “Indigenous health” initiatives (e.g. curriculum) into European-Canadian systems can be fraught with contradictions that influence practice (Bond, 2005). Curriculum-related research could also elucidate the nature of trauma-informed practice within an Indigenous midwifery context to help pinpoint strengths and areas that need improvement, and to deepen our understanding of who becomes an Indigenous and why. Alternatively, researchers could approach the interface from the other side, analyzing how other Indigenous and non-Indigenous maternity care providers’ perspectives on the interface impact the cultural safety of women’s care experiences.

It will be interesting to see how these findings compare to those from the non-Aboriginal client interviews that I conducted as part of my commitment to reciprocity in my research relationship with SGMT and the WLH. The similarities and differences between both groups’ meanings of and experiences with cultural safety will undoubtedly lead to more research questions. For example, I recall hearing more concerns about the student-midwives from the non-Aboriginal group than from the Aboriginal group. This may indicate that the women had different expectations or experiences around their continuity of care. Other differences may emerge between the community dimensions of cultural safety. As noted, Indigenous midwifery is tied to broader visions such as self-determination. Communities could benefit from research that establishes the clear links between cultural safety, Indigenous midwifery, self-determination, health outcomes, and health equity. These types of links could provide strong evidence supporting the full implementation of the *Declaration* in Canada.

Conclusion

In this thesis, I attempted to paint a picture of SGMT and culturally safe Indigenous midwifery care that was as true to the Indigenous women's lived experiences as possible. Indeed, their experiences with the practice were as diverse as their backgrounds, but together they agreed that SGMT is doing well. Their widespread support – when interpreted alongside their stories of cultural safety at the practice – presents a compelling argument for the expansion and continued support of Indigenous midwifery in urban areas. Additionally, by demonstrating the benefits of cultural safety and its place within the mainstream health care system, this project reveals that cultural safety is both applicable and meaningful in a Canadian health care context. The insights on Indigenous midwives are also highly relevant. Presented as practitioners of trauma-informed care and navigators of the "ethical space," Indigenous midwives are undoubtedly promoting health in their communities in profound, comprehensive, and new ways. Even though these findings come with their challenges (e.g. necessary revisions to midwifery curricula; challenging biomedical dominance; procuring funding for further research), they are welcome additions to the literature that give governments, public health practitioners, researchers, and decision-makers little reason to doubt in the value of Indigenous midwifery, Indigenous research methods, and Indigenous-led health care. It is hoped that this project will inspire further research and – by showing the importance of accessible, culturally safe, and high-quality health care – help cities like Toronto achieve health equity.

If there is one thing that this research journey has taught me it is that Indigenous peoples and communities have invariably shaped and continue to shape who I am, who I will be, and how I think about health, knowledge, and community. I am so grateful for having been given the opportunity to work with the WLH and the midwives at SGMT, as I have learned lessons, developed skills, and built relationships with people that will guide me as I move onto the next chapter. Although I am still figuring out what it is I bring to the Indigenous health table on a larger scale, I have realized that my "unsure-ness" and sense of discovery has served the project well. It is not always a bad thing to be an outsider. In fact, from working collaboratively, I have learned firsthand that "outsider" perspectives can help shape and enrich the final product. I have also come to terms with the unpredictable nature of Indigenous CBPR, although it was not always easy. I had to grow accustomed to a feast-or-famine workload, which was frustrating at times. Yet, with the help and guidance of the WLH research team, my supervisor, my committee members, and my peers, I was able to put things back into perspective. This was my Master’s project, my metaphorical “first child”; my fears, anxieties, and uncertainties were “normal” since I was a first-time researcher. Once I came to that realization, and once the themes started to materialize, everything else fell into place. So once again, I ask myself “why Indigenous peoples?” In English, the word “midwife” literally translates into “with woman.” I think that I completed this project to work *with* women, to relay their stories, and to provide an avenue by which their voices are heard. Now, at the end of the journey, I wonder: is research for me? While I certainly hope so, I often find myself thinking about the women I interviewed. How are they doing? How are their families? Will I ever see them again? Have I and we successfully communicated their stories? The role of the graduate student researcher certainly has its limits. As I move forward – surrounded by even more questions – I have made peace with the uncertainties. All I know is that whether my post-MPH future involves program planning, community-based research, or perhaps a career in midwifery, I will carry all the stories, lessons, knowledge, relationships, and questions that came from my work in the Indigenous health research world with me as I walk through life.

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Appendices

A: Definition of Terms

Aboriginal peoples. A collective name for the original peoples of North America and their descendants. The Canadian constitution recognizes three groups of Aboriginal peoples: Indians (commonly referred to as First Nations), Métis, and Inuit (Government of Canada, 2013). This term will be used when discussing SGMT and their clients in keeping with their terminology. This term will also be used when it was employed in the literature cited.

Bands. Local governance structures that were created by the Government of Canada within the *Indian Act* to oversee activity on reserves (Senese & Wilson, 2013).

Colonialism. Dating from the fifteenth century onwards, European colonialism involves the brutal establishment of European sovereignty on non-European territory. It is not only about material accumulation; it requires the production of ideologies that justify the theft and violent practices at its root (Said as cited in Cannon & Sunseri, 2011, p. 273). Colonialism is not satisfied merely with holding a people in its grip and emptying the native's brain of all form and context; rather, it turns to the past of the oppressed people, and distorts, disfigures, and destroys it (Fanon as cited in Alfred & Corntassel, 2005, p. 602). In many ways, colonialism is an ongoing narrative in which the Settler's power is the fundamental reference and assumption, inherently limiting Indigenous freedom and imposing a view of the world that is but an outcome or perspective on that power (Alfred & Corntassel, 2005, p. 601).

Colonization. A process of conquest whereby one nation establishes a colony on another nation's territory with the intent of taking power, land, and resources (Said as cited in Cannon & Sunseri, 2011, p. 273).

Decolonization. A process of struggle whereby colonized nations and peoples reject colonial authority and (re)establish freedom, recognized self-determining governing systems and self-determined existence on their territories (Cannon & Sunseri, 2011, p. 276). A decolonizing process involving critical examination and dismantling of individual and systemic assumptions and power relationships, including the suppression of Indigenous systems of knowledge, is required to improve the health of Indigenous communities (Smylie et al., 2009, p. 437-438).

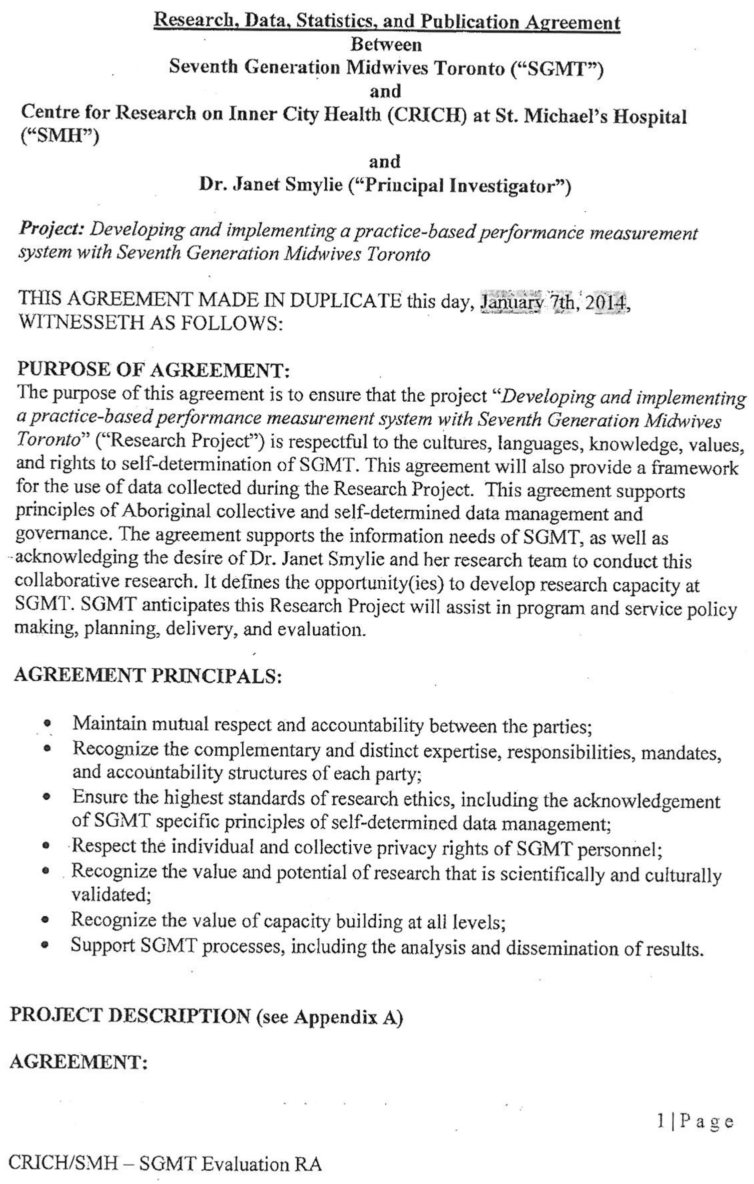
Indigenous peoples. A term that is inclusive of all people who self-identify as Aboriginal, Indigenous, First Nations, Indian, Indigenous, Inuit and/or Métis in Canada, as well as global Indigenous peoples (Well Living House, n.d.). This term will be used in contexts where "Aboriginal peoples" does not apply.

"Othering". A process that occurs when society sorts people into two categories: the reference group and the "other". Women who bear their "otherness" in more than one way suffer from multiple oppressions, leaving them more vulnerable to assaults on their wellbeing than if they suffered from one form of oppression (Bourassa et al., 2004, p. 24). Colonialism depends on the oppression of one group by another, beginning with "Othering" (Gerrard & Javed, as cited in Bourassa et al., 2004, p. 24).

Reserve. Land set aside for and controlled by the Government of Canada "on behalf of Indians" or Status First Nations peoples. The *Constitution Act* and the *Indian Act* legalized the removal of First Nations communities from their homelands to reserves (Smylie, 2009, p. 286).

Self-determination. The right of all peoples to determine their own destiny. International and human rights norms contained in many instruments to which Canada is a signatory clearly provide for the protection of group rights and also underscore the right of all peoples to self-determination (Monture-Okanee & Turpel as cited in Cannon & Sunseri, 2011, p.278).

B: Research Agreement



Research, Data, Statistics, and Publication Agreement

Between
Seventh Generation Midwives Toronto ("SGMT")
and
Centre for Research on Inner City Health (CRICH) at St. Michael's Hospital ("SMH")
and
Dr. Janet Smylie ("Principal Investigator")

Project: *Developing and implementing a practice-based performance measurement system with Seventh Generation Midwives Toronto*

THIS AGREEMENT MADE IN DUPLICATE this day, January 7th, 2014, WITNESSETH AS FOLLOWS:

PURPOSE OF AGREEMENT:
The purpose of this agreement is to ensure that the project "*Developing and implementing a practice-based performance measurement system with Seventh Generation Midwives Toronto*" ("Research Project") is respectful to the cultures, languages, knowledge, values, and rights to self-determination of SGMT. This agreement will also provide a framework for the use of data collected during the Research Project. This agreement supports principles of Aboriginal collective and self-determined data management and governance. The agreement supports the information needs of SGMT, as well as acknowledging the desire of Dr. Janet Smylie and her research team to conduct this collaborative research. It defines the opportunity(ies) to develop research capacity at SGMT. SGMT anticipates this Research Project will assist in program and service policy making, planning, delivery, and evaluation.

AGREEMENT PRINCIPALS:

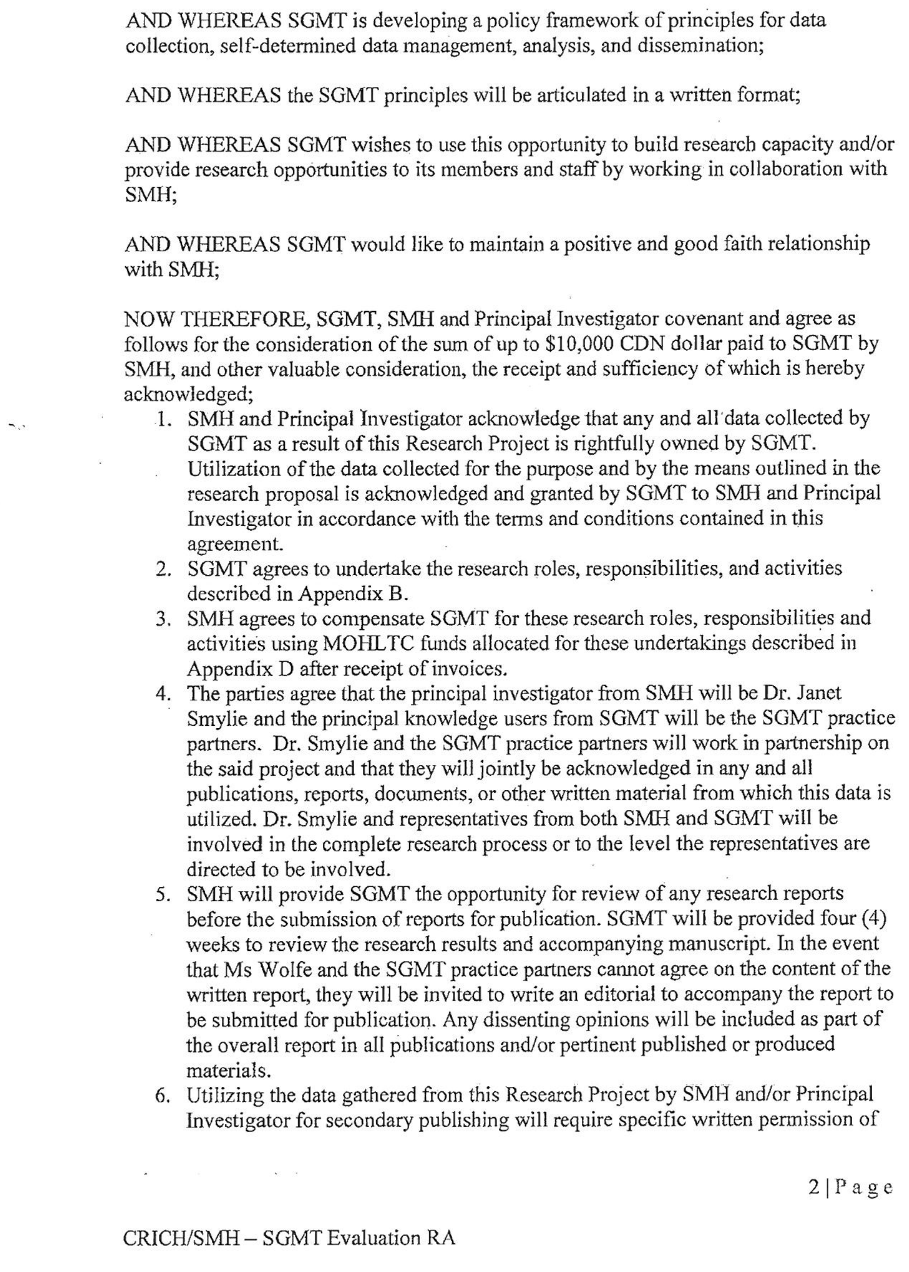
- Maintain mutual respect and accountability between the parties;
- Recognize the complementary and distinct expertise, responsibilities, mandates, and accountability structures of each party;
- Ensure the highest standards of research ethics, including the acknowledgement of SGMT specific principles of self-determined data management;
- Respect the individual and collective privacy rights of SGMT personnel;
- Recognize the value and potential of research that is scientifically and culturally validated;
- Recognize the value of capacity building at all levels;
- Support SGMT processes, including the analysis and dissemination of results.

PROJECT DESCRIPTION (see Appendix A)

AGREEMENT:

1 | Page

CRICH/SMH – SGMT Evaluation RA



AND WHEREAS SGMT is developing a policy framework of principles for data collection, self-determined data management, analysis, and dissemination;

AND WHEREAS the SGMT principles will be articulated in a written format;

AND WHEREAS SGMT wishes to use this opportunity to build research capacity and/or provide research opportunities to its members and staff by working in collaboration with SMH;

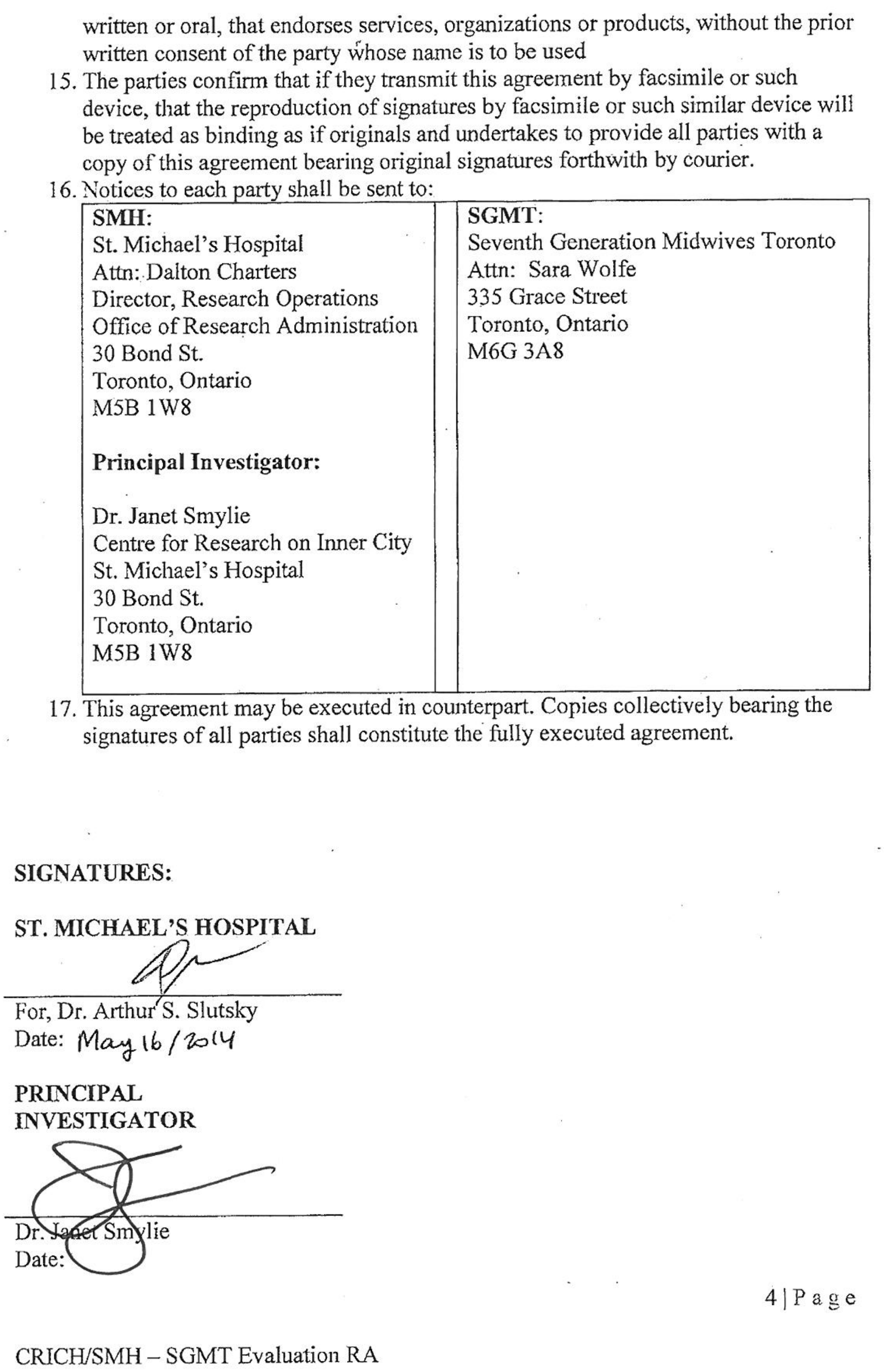
AND WHEREAS SGMT would like to maintain a positive and good faith relationship with SMH;

NOW THEREFORE, SGMT, SMH and Principal Investigator covenant and agree as follows for the consideration of the sum of up to $10,000 CDN dollar paid to SGMT by SMH, and other valuable consideration, the receipt and sufficiency of which is hereby acknowledged;

1. SMH and Principal Investigator acknowledge that any and all data collected by SGMT as a result of this Research Project is rightfully owned by SGMT. Utilization of the data collected for the purpose and by the means outlined in the research proposal is acknowledged and granted by SGMT to SMH and Principal Investigator in accordance with the terms and conditions contained in this agreement.
2. SGMT agrees to undertake the research roles, responsibilities, and activities described in Appendix B.
3. SMH agrees to compensate SGMT for these research roles, responsibilities and activities using MOHLTC funds allocated for these undertakings described in Appendix D after receipt of invoices.
4. The parties agree that the principal investigator from SMH will be Dr. Janet Smylie and the principal knowledge users from SGMT will be the SGMT practice partners. Dr. Smylie and the SGMT practice partners will work in partnership on the said project and that they will jointly be acknowledged in any and all publications, reports, documents, or other written material from which this data is utilized. Dr. Smylie and representatives from both SMH and SGMT will be involved in the complete research process or to the level the representatives are directed to be involved.
5. SMH will provide SGMT the opportunity for review of any research reports before the submission of reports for publication. SGMT will be provided four (4) weeks to review the research results and accompanying manuscript. In the event that Ms Wolfe and the SGMT practice partners cannot agree on the content of the written report, they will be invited to write an editorial to accompany the report to be submitted for publication. Any dissenting opinions will be included as part of the overall report in all publications and/or pertinent published or produced materials.
6. Utilizing the data gathered from this Research Project by SMH and/or Principal Investigator for secondary publishing will require specific written permission of

SGMT. SMH and Principal Investigator are to protect the data and act as stewards of this data on behalf of the rightful owner.

7. SGMT are the rightful owners of all data collected. SMH and/or Principal Investigator will require SGMT consent to maintain a copy of the collected data with Dr. Smylie's databank. SMH and Principal Investigator will be required to protect the data from unauthorized use and act as stewards on behalf of the rightful owner. SGMT have provided prior consent to Dr. Janet Smylie of the Centre for Research on Inner City Health at St. Michael's Hospital to maintain a copy of the collected data generated by this project in accordance with the study protocol, attached hereto as Appendix F, reviewed and approved by SMH research ethics board("SMH REB") and SGMT management for the purpose of publishing research reports as set out herein and having access to a copy of the source collected data of such research reports
8. This agreement is in force from the date of the last authorizing signature below.
9. Any party may terminate this agreement in the event of a material breach by any other party, or for any reason upon sixty (60) days written notice to the other parties.
10. The parties agree that this agreement is irrevocable and shall ensure to the benefit of and be binding upon their employees, administrators and legal and personal representatives.
11. The parties represent that they understand and agree to the terms contained within this agreement and such performance will not be unreasonably withheld.
12. SMH and Principal Investigator declare that they have been given the opportunity to obtain independent legal advice with respect to the details of the terms evidenced by this agreement and confirms that they are executing this agreement freely and voluntarily.
    (a) SGMT, SMH and Principal Investigator agree to perform their respective study activities in accordance with the research proposal as approved by the SMH REB, and all applicable laws, regulations and guidelines, including without limitation, the 2nd edition of the Tri-Council Policy Statement, "Ethical Conduct for Research Involving Humans", published by the Canadian Institutes of Health Research, the Natural Sciences and Engineering Research Council of Canada and the Social Sciences and Humanities Research Council of Canada dated December 2010, as amended from time to time, and the Canadian Institutes of Health Research Guidelines, "Guidelines for Health Research Involving Aboriginal People", all as amended from time to time
13. SGMT, SMH and Principal Investigator confirm their respect for the privacy of individual participants in the Research Project. SGMT, SMH and Principal Investigator agree to follow applicable privacy laws including, but limited to, *Personal Information Protection and Electronic Documents Act* ("PIPEDA") and Ontario's *Personal Health Information Protection Act* ("PHIPA"), and regulations and to notify each other if either receives a complaint about breach of privacy
14. Neither party shall use the name of the other party or its staff in any publication, news release, promotion, advertisement, or other public announcement, whether



written or oral, that endorses services, organizations or products, without the prior written consent of the party whose name is to be used

15. The parties confirm that if they transmit this agreement by facsimile or such device, that the reproduction of signatures by facsimile or such similar device will be treated as binding as if originals and undertakes to provide all parties with a copy of this agreement bearing original signatures forthwith by courier.
16. Notices to each party shall be sent to:

SMH:	**SGMT:**
St. Michael's Hospital Attn: Dalton Charters Director, Research Operations Office of Research Administration 30 Bond St. Toronto, Ontario M5B 1W8 **Principal Investigator:** Dr. Janet Smylie Centre for Research on Inner City St. Michael's Hospital 30 Bond St. Toronto, Ontario M5B 1W8	Seventh Generation Midwives Toronto Attn: Sara Wolfe 335 Grace Street Toronto, Ontario M6G 3A8

17. This agreement may be executed in counterpart. Copies collectively bearing the signatures of all parties shall constitute the fully executed agreement.

SIGNATURES:

ST. MICHAEL'S HOSPITAL

For, Dr. Arthur S. Slutsky
Date: May 16/2014

PRINCIPAL INVESTIGATOR

Dr. Janet Smylie
Date:

SEVENTH GENERATION MIDWIVES TORONTO

Ms Sara Wolfe, RM, *signing on behalf of Seventh Generation Midwives Toronto*
Date: 5/15/2014

APPENDIX A: PROJECT DESCRIPTION

Goal:

Building upon our existing research partnership and platform, SGMT would like to work with Well Living House CRICH to develop and implement a culturally relevant and evidence based evaluation system for their community based midwifery practice.

Objectives:

Working with SGMT partners, and with feedback from the WLH council of grandparents and SGMT community advisory board and drawing on best practices in Indigenous health services evaluation (can ref JS's work here):

a) Develop a comprehensive logic model that links together SGMT's core resources, activities, outputs, outcomes, and goals.

b) Identify and prioritize key assessment measures for core logic model outcomes.

c) Support SGMT in developing and implementing the processes and data systems to collect and compile these outcome measures over a three month trial period.

d) Support SGMT in a review of the compiled data outputs; feedback into their clinical practice activities; and refinement of their new practice based performance measurement system.

Methods:

We will use a realist informed case study design for our evaluation and draw on both quantitative and qualitative data. Dr. Smylie will lead the evaluation with the support of post-doctoral fellows Dr. Allan, Dr. Firestone, and Dr. Snyder and research associate Bernice Downey. This evaluation will additionally draw on the expertise the WLH Counsel of Grandparents.

Step 1 will be to meet with SGMT and develop an evaluation logic model, key evaluation questions, and further develop the evaluation methods. Step 2 will be to identify the indicators and then collect these measures using mixed quantitative and qualitative methods. While the methods of data collection will be finalized once the indicators have been identified, it will almost certainly include a mix of aggregated SGMT client record data as well as key informant interviews with SGMT clients, midwives and staff. Step 3 will be to organize and analyze the collected data and refine ongoing evaluation phases. Step 4 will be to document and disseminate the evaluation findings in community reports and academic articles.

Deliverables:

A. SGMT service evaluation logic model

B. Finalized set of indicators for SGMT service evaluation

C. Amalgamated report on indicators over pilot period

D. Final report including revised logic model, recommendations for planning and practice arriving from pilot report and suggestions for ongoing indicator collection.

E. Preparation and submission of scholarly article

F. Preparation and dissemination of community fact sheets

APPENDIX B: SMGT RESEARCH ROLES, RESPONSIBILITIES, AND ACTIVITIES

Project Governance Duties and Activities:

1. Guide project direction and provide project input to the service evaluation logic model, evaluation questions, and evaluation methods through attendance at higher level project and project planning meetings, including 4-6 half day workshops.
2. Govern and give input to written project materials including input to and vetting of all project publications in a timely manner.

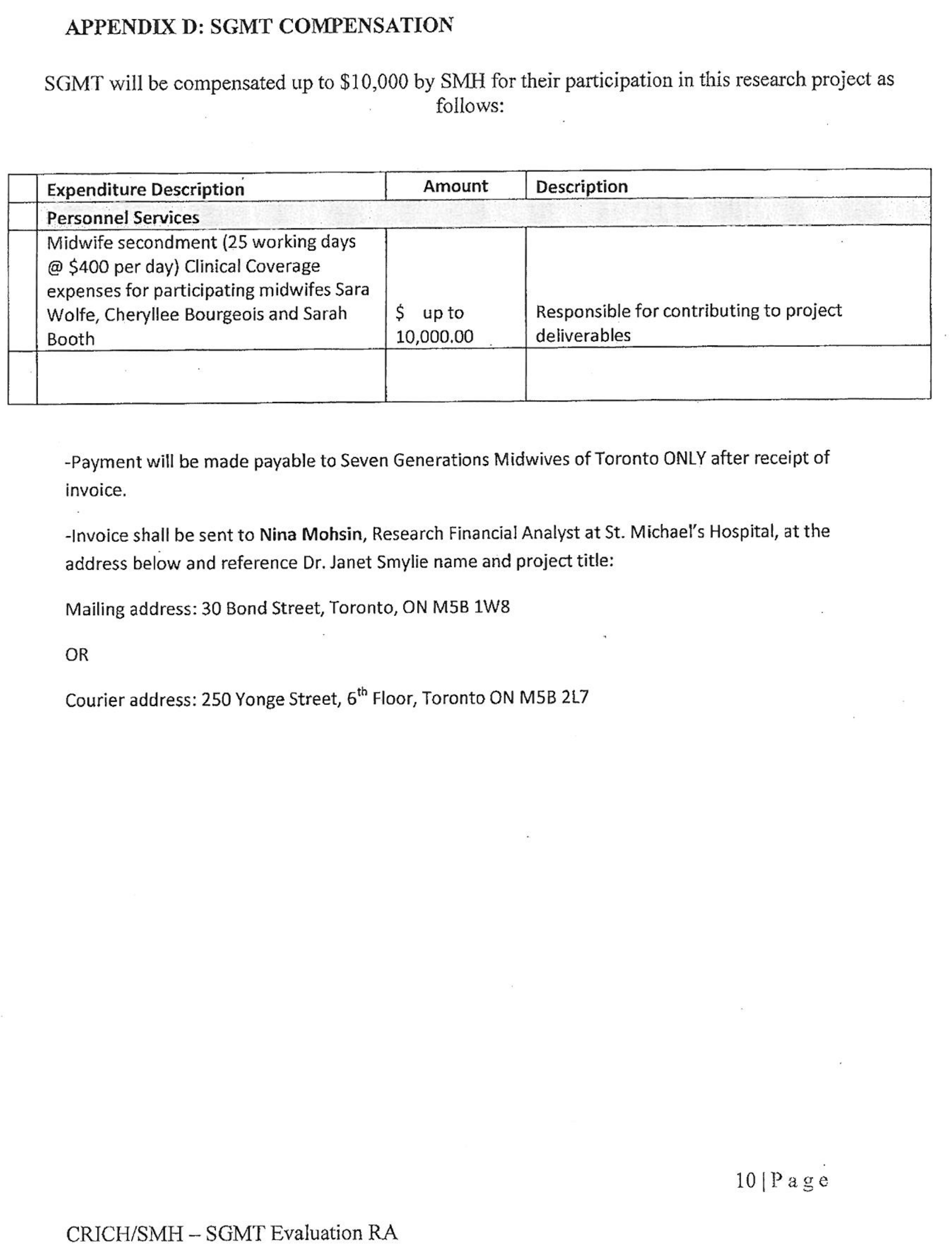
Project Implementation Duties and Activities:

3. Co-develop the final set of indicators for SGMT service evaluation.
4. Retrieve, clean (include removing nominal information), and support the analysis and charting of SGMT client data for the amalgamated report on indicators.
5. Contribute to final project report including preparing the first draft of recommendations.
6. Co-write community fact sheets.

APPENDIX C: CRICH/SMH RESEARCH ROLES, RESPONSIBILITIES, AND ACTIVITIES

The CRICH/SMH research team, under the direction and leadership of Dr. Janet Smylie will work in partnership with SGMT and with the participation of SMGT research team members to:

1. Coordinate the development of service evaluation logic mode.
2. Assist with determining final set of indicators for SGMT service evaluation.
3. Develop an amalgamated report on indicators.
4. Develop a final report including revised logic model, recommendations for planning and practice arriving from pilot report and suggestions for ongoing indicator collection.
5. Preparation and submission of scholarly article.
6. Develop and disseminate community fact sheets.



APPENDIX D: SGMT COMPENSATION

SGMT will be compensated up to $10,000 by SMH for their participation in this research project as follows:

	Expenditure Description	Amount	Description
	Personnel Services		
	Midwife secondment (25 working days @ $400 per day) Clinical Coverage expenses for participating midwifes Sara Wolfe, Cheryllee Bourgeois and Sarah Booth	$ up to 10,000.00	Responsible for contributing to project deliverables

-Payment will be made payable to Seven Generations Midwives of Toronto ONLY after receipt of invoice.

-Invoice shall be sent to **Nina Mohsin**, Research Financial Analyst at St. Michael's Hospital, at the address below and reference Dr. Janet Smylie name and project title:

Mailing address: 30 Bond Street, Toronto, ON M5B 1W8

OR

Courier address: 250 Yonge Street, 6th Floor, Toronto ON M5B 2L7

APPENDIX E: COMPLETE PROJECT BUDGET

Note: Staffing and midwifery secondment expenditures may vary according to actual workload.

	Expenditure Description	Amount	Description
	Personnel Services		
1	Marcie Snyder (Research Associate - 20 working days @$400 per day	$ 7,600.00	Responsible for leading the evaluation
	Billie Allan (Research Associate 20 working days @ $400 per day)	$ 7,600.00	Responsible for leading the evaluation
3	Janet Smylie (Research Scientist) 5 working days @ $1000 per day	$ 5,000.00	
4	Research Collaborators (Council of Grandparents 3 x 2 days)	$ 5,000.00	Research Collaborators responsible for providing feedback on SMGT's comprehensive logic model, final set of indicators for SGMT service evaluation.
5	Midwife secondment (25 working days @ $400 per day) Clinical Coverage expenses for participating midwifes Sara Wolfe, Cheryllee Bourgeois and Sarah Booth	$ 10,000.00	Responsible for contributing to project deliverables
	Laura Senese (Research Coordinator II 0.25 FTE)	$ 11,519.50	Responsible for project coordination - sending Research Collaborators project materials, scheduling meetings and coordinating travel arrangements
	Total Personnel Services	**$ 46,719.50**	
	Other Expenses		
6	Travel & Accommodations	$ 2,790.00	Includes return airfare (2 flights), mileage and 2 nights accommodation for Research Collaborators x 3
7	Per diums	$ 490.50	Meal per diums for Research Collaborators x 3
	Total Other Expenses	**$ 3,280.50**	
	Grand Total	**$ 50,000.00**	

APPENDIX F: Study Protocol

Research Protocol

Goals and Objectives

Building upon our existing research partnership and platform, SGMT will work with the Well Living House at the Centre for Research on Inner City Health (CRICH) to develop and implement a culturally relevant and evidence-based evaluation system for their community based midwifery practice. Specifically, our research objectives are to:

a) Develop a comprehensive logic model that links together SGMT's core resources, activities, outputs, outcomes, and goals.

b) Identify and prioritize key assessment measures for core logic model outcomes.

c) Support SGMT in developing and implementing the processes and data systems to collect and compile these outcome measures over a three month trial period.

d) Support SGMT in a review of the compiled data outputs; feedback into their clinical practice activities; and refinement of their new practice based performance measurement system.

The research will be conducted in 4 stages. Step 1 will be to meet with SGMT and develop an evaluation logic model, key evaluation questions, and further develop the evaluation methods. Step 2 will be to identify the indicators and then collect these measures using mixed quantitative and qualitative methods. Data collection methods will include a mix of aggregated SGMT client record data as well as key informant interviews with SGMT clients, midwives and staff. Step 3 will be to organize and analyze the collected data and refine ongoing evaluation phases. Step 4 will be to document and disseminate the evaluation findings in community reports and academic articles.

Research Questions

There are 4 primary research questions driving this project:

1. What are the maternal, child and family birth outcomes from SGMT clients?
2. What are the key prenatal birthing and reproductive health needs of SMGT clients and how are they meeting these needs?
3. Is SMGT contributing to changes in attitudes and behaviours regarding Aboriginal peoples, knowledge and practice?
4. How do our clients define culturally secure care and is SGMT providing it?

Methods

Community-based Participatory Action Research

In keeping with current standards in Aboriginal health research, we will use a community-based participatory action approach which draws on our own research experiences as well as successful models and recommendations regarding community-based participatory Indigenous health research. Our approach will promote balance in the relationships between the Aboriginal community partner Seventh Generation Midwives of Toronto, academic research team and the broader community.

We will use a realist informed case study design for our evaluation and draw on both quantitative and qualitative data. Dr. Smylie will lead the evaluation with the support of post-doctoral fellows and research associates at the WLH. This evaluation will additionally draw on the expertise the WLH Counsel of Grandparents.

Data Sources

We will draw from the following data sources:

1. Client administrative data (legacy data plus BORN reports)
2. Key informant interviews (10 midwives/staff; 10 Aboriginal clients who have completed course of care in past year; 10 non-Aboriginal clients who have completed course of care in past year)
3. Pre-post care questionnaires with SGMT clients (50 with Aboriginal clients and 50 with non-Aboriginal clients, over a 1 year period)

We estimate that we will reach saturation with 10 qualitative key informant interviews with midwives/staff; 10 Aboriginal clients who have completed course of care in past year; and 10 non-Aboriginal clients who have completed course of care in past year. For the pre-post care questionnaires we aim for a minimum of 100 (50 with Aboriginal clients and 50 with non-Aboriginal clients) over 1 year. A sample size of 100 pre-post questionnaires will support statistical analysis and pre-post t-tests.

Community-Based Participatory Action Approach and KT

In keeping with current standards in Aboriginal health research, we will use a community-based participatory action approach which draws on our own research experiences as well as successful models and recommendations regarding community-based participatory Indigenous health research. Our approach will promote balance in the relationships between the Aboriginal community partner Seventh Generation Midwives of Toronto, academic research team members, Aboriginal community participants and the Council of Grandparents throughout the research process, from initiation to dissemination. A research agreement will be negotiated between the academic research team based at St. Michael's Hospital and Seventh Generation Midwives Toronto. This agreement will draw on a research agreement between these two agencies that were in place for the recently completed Indigenous Knowledge Networks for Infant, Child, and Family health project, and will explicitly address issues of project governance, community expectations, benefits, ownership, control, access, and possession of information, and dissemination of project results.

C: Interview Guide

Developing and implementing a practice-based performance measurement system with Seventh Generation Midwives Toronto (SGMT)

ABORIGINAL CLIENT INTERVIEW GUIDE

Introduction

Thank you so much for taking the time to speak with me today. Seventh Generation Midwives Toronto (SGMT) wants to hear about your experiences and how they can provide the best care possible. I would like to remind you that this interview will be digitally recorded. All information will be kept confidential. The digital recording will be securely destroyed after being transcribed.

Do you have any questions or concerns before we get started?

Interview Questions

First of all, I was hoping to learn a little bit more about yourself and your history with midwifery care.

1. What number baby is this?
2. Did you have a midwife for prior pregnancy/birth?
3. Did you have an SGMT midwife for prior pregnancy/birth?
4. How old are you?
5. How far did you get in school? (no high school, some high school, graduated high school, some college/university, graduated college/university)
6. Who lives with you?

These next questions focus on your health care experiences at SGMT.

1. Why did you choose SGMT for your care?
2. What kinds of support did you need during your pregnancy/birth/post-partum?
3. What specific things were you hoping SGMT would provide?
4. Were these needs met?
5. Were there prenatal, birthing and/or reproductive needs that were not met? Which ones?
6. Did you have an Aboriginal midwife or Aboriginal student midwife as part of your care team?

These next questions focus on culturally safe care.

Imagine a relationship with a caregiver in which you feel comfortable, respected and able to be yourself.

1. How would it look?
2. What are the things that the caregiver does to make you feel comfortable and respected and able to be yourself?
3. What about the space where the care is being provided? How does it look?
4. What are the things in the space that make you feel comfortable and respected and able to be yourself?
5. a) Think now about your care experience at SGMT: how did your care compare with what you have just described?
   b) How did the physical space of SGMT impact your care experience and compare to your ideal?

This final set of questions focus on identity and knowledge sharing.

1. Do you identify as Aboriginal? How do you identify?
2. Are there times you don't tell people you are Aboriginal?
3. Did the midwife share any specific examples of indigenous/Aboriginal teachings or stories during care? If yes, can you share some examples?
4. How did you feel about this (the sharing/not sharing teachings)?
5. What about ceremonies? If yes, can you share some examples?
6. How did you feel about this?
7. Would you have wanted the midwives to share more?
8. What are your suggestions for a good way for the midwives could share this type of knowledge and practice?
9. Has your understanding of being Aboriginal changed since becoming a client at SGMT? If yes, how?
10. How or did or didn't your care at SGMT influence or change your family relationships?
11. Has your involvement in Aboriginal community events, programs or services changed since becoming a client at SGMT? If yes, how?

This concludes the interview. Did you have anything else you would like to share about what we covered today?

Chi miigwetch (thank you) for your generosity in sharing your knowledge and experience, we are very grateful.

D: Information Letter

CLIENT INTERVIEW: LETTER OF INFORMATION AND CONSENT TO PARTICIPATE IN A RESEARCH PROJECT

Study Title
Developing and implementing a practice-based performance measurement system with Seventh Generation Midwives Toronto

Lead Investigator
Dr. Janet Smylie
Well Living House, Centre for Research on Inner City Health (CRICH), St. Michaels' Hospital
Phone: 416-864-6060 ext. 77380 (Monday – Friday 9am-4pm)
Email: janet.smylie@utoronto.ca

Research Associate
Sara Wolfe
Seventh Generation Midwives Toronto (SGMT)
Phone: 416-786-3192 (Monday – Friday 9am-4pm)
Email: sara.sgmt@gmail.com

Co-Investigators
Cheryllee Bourgeois, SGMT
Alana Kibbe, SGMT
Sadie Booth, SGMT
Billie Allan, Well Living House, CRICH, St. Michael's Hospital
Michelle Firestone, Well Living House, CRICH, St. Michael's Hospital
Marcie Snyder, Well Living House, CRICH, St. Michael's Hospital

Student Researchers
Ashleigh Cheung, Master's student, University College London
Dr. Sarah Hawkes, Master's supervisor, University College London
Mackenzie Churchill, Master's student, Lakehead University
Dr. Helle Moeller, Master's supervisor, Lakehead University

Partner Organizations
Seventh Generation Midwives Toronto (SGMT)

Funding Sponsor
This study is funded by the Ontario Ministry of Health and Long Term Care.

Introduction
This project is co-led by Dr. Janet Smylie and Sara Wolfe RM. The goal of this study is to develop and implement culturally relevant ways to understand and measure how and why the Seventh Generation Midwives Toronto based midwifery practice works.

Well Living House at Centre for Research on Inner City Health (CRICH) at St. Michael's Hospital and Seventh Generation Midwives Toronto are conducting this research study. Before agreeing to take part in this study, it is important that you read and understand the information in this consent form.

The following information describes the reasons why we are doing this research. It also tells you how we are going to do the research. It will also tell you how the research study might be harmful or helpful to you. This information describes how you can tell us you do not want to take part in the study or how you can leave the study at any time. Being part of this research study is voluntary. If you have any questions or worries about this study, please tell the interviewer before you start the interview. Make sure you understand everything on this form before you sign it.

Background and Purpose of the Research Project

This project will build upon an existing community based participatory partnership with Seventh Generation Midwives of Toronto to develop and put into place a culturally relevant system to understand and measure how and why their community based midwifery practice works. This project will address the pressing need to develop an effective and relevant way to measure the work of SGMT to ensure they are meeting the health needs of the clients and families they serve. A component of this project is a student project conducted by Ashleigh Cheung, who will be supervised by Dr. Sarah Hawkes, a professor at the University College London, and Mackenzie Churchill, who will be supervised by Dr. Helle Moeller, a professor at Lakehead University.

Description of the Research and Procedures

Interview:
If you agree and consent to participate in this study, you will be asked to participate in a one-on-one interview. There will be 20 one-on-one interviews with SGMT clients conducted as a part of this study. (There are 50 before and after client surveys and 10 staff interviews taking place as the other portions of this study).

You will be asked questions about your pregnancy and birthing needs, where and how SGMT is meeting these needs, how you define culturally safe care, and finally, how SGMT is contributing to changes and attitudes and behaviours regarding Aboriginal peoples, knowledge, and practices. This interview will take no longer than 1.5.

Interviews will be conducted in a private office at the SGMT birthing centre; however, you can also choose to have the interview at home, by telephone, or at another convenient place. You can also choose the day and time of this interview.

The researcher would like to digitally record the interview and make notes during the interview.

Potential Risks
There are not really any risks to participating in this study. But, during the interview you might start feeling uncomfortable with some of the questions. You may skip any question(s) you do not want to answer.

Potential Benefits
There is no direct benefit to you in participating in this study. However, it is hoped that this study will benefit other women, infants, and families that access SGMT services in the future, because they would have developed and put into place a culturally relevant system for understanding and measuring how and why their community based midwifery practice works.

Alternatives to Participation

If you choose not to participate in this study, you will continue to receive care from SGMT. You are under no obligation to participate.

Protecting Your Information

Confidentiality will be respected and information attached to your name will not be released or published without your okay unless required by law, such as disclosing abuse or risk of harm to yourself or others.

Study notes will be stored in a locked cabinet and office at CRICH offices and for a period of 10 years and then will be destroyed. Digital recordings will be kept in a locked cabinet in a locked office in CRICH. Digital recordings will be destroyed immediately after the interview has been transcribed and verified. The final copies of your interview will be kept by the Principal Investigator at St. Michael's Hospital in a secure location. Anyone who wants to see your transcripts will need to make a request to the Principal Investigator who is responsible for making sure your information is protected from anyone using it without permission.

The Research Ethics Board at St. Michael's Hospital may need to review records for monitoring purposes. As part of this review, someone may contact you from the Research Ethics Board to discuss your experiences during the study.

If the results of this study are published or presented at conferences, seminars or other public places, no information that could identify you will be released outside of the names of organizations that were reviewed by the study.

Study Results

The information from your interview will be used to develop and put into place a culturally relevant system for understanding and measuring how and why SGMT's community based midwifery practice works. If you are interested, study results can be available through contacting the Lead Investigator and or the Research Associate. Study results can take up to 8 to 12 months to be available.

Costs to Participation and Reimbursement

Participating in this study may result in added costs to you (such as travel expenses). You will be reimbursed a maximum of $25 and provided a small gift of appreciation.

Participation and Withdrawal

Participation in this research study is voluntary. You can refuse to participate in this study, or leave this study at any time. If you decide to participate in this study you can change your mind without giving a reason, and you may decline to answer any question during that interview. If you choose to no longer take part in the study, the information you had provided will be removed from the study and destroyed.

Research Ethics Board Contact

If you have any questions regarding your rights as a research participant, you may contact the Chair of the St. Michael's Research Ethics Board at (416) 864-6060 ext. 2557 during business hours.

Study Contact

If you want more information or have questions about the research study, please contact the study's Research Manager, Conrad Prince, at 416-864-6060 ext. 77454 or by email at princec@smh.ca. You may also contact the study's Research Associate, Sara Wolfe at 416-864-6060 ext. 77453 or by email at swolfe@smh.ca during business hours Wednesday to Friday.

E: Client Consent Form

CLIENT CONSENT FORM

Study Title: Developing and implementing a practice-based performance measurement system with Seventh Generation Midwives Toronto

The research study has been explained to me, and my questions have been answered to my satisfaction. I have the right not to participate and the right to withdraw from the study at any time. The potential harms and benefits of participating in this research study have been explained to me. I have been told that I have not waived my legal rights nor released the investigators, sponsors, or involved institutions from their legal and professional responsibilities. I know that I may ask now, or in the future, any questions I have about the study. I have been told that data relating to me will be kept confidential and that no information will be disclosed without my permission unless required by law. I have been given sufficient time to read the above information. I consent to participate, and will be given a signed copy of this consent form.

____________________________	____________________________	______________
Name of Participant (Print)	Signature of Participant	Date

I have explained the study to the above participant the nature and purpose, the potential benefits, and possible risks associated with taking in this research study.

____________________________	____________________________	______________
Name of Participant Obtaining Consent (Print)	Signature of Person Obtaining Consent	Date

F: Verbal Consent Checklist

CLIENT VERBAL CONSENT CHECKLIST

This document will be used to obtain verbal consent from those who have limited literacy. It will also be used to ensure cultural appropriateness as there may be participants who would prefer not to provide written consent (for example due to suspicion at a research interview, or being uncomfortable with written English). All participants will be provided with a copy of the consent form.

1. **Personal Introduction** *(meet and greet the potential subject)*

   ☐ Study staff name
   Hello, my name is....
   ☐ PI's name
   I work with Dr. Janet Smylie, who is running a research study....
   ☐ How potential subject was identified/why contacted
   I am contacting you because you have expressed interest in participating in our interview and or conducting a survey....
   Would you be willing to hear more about this?

2. **About Research Studies**

   ☐ Research is different from routine services and activities (treatment, training, evaluation).

   ☐ Being a research subject is optional and voluntary, and participation may not benefit you directly.

Being a research subject is optional and voluntary, and participation may not benefit you directly.

☐ Research studies follow careful plans
I can tell you what we plan to do if you take part…
ONLY FOR INTERVIEW: *The interview session will be digitally-recorded with your permission*

- *When I've explained the study and answered your questions, you can decide whether you want to be part of the study.*
- *Do you have any questions so far?*
- *Would you like to hear about our study?*

1. **About This Study** *(begin describing this specific study and the participant's potential role)*

   a) The purpose of this study is to develop and implement a culturally relevant and evidence based evaluation system for Seventh Generation Midwives Toronto based midwifery practice.
   b) ***INTERVIEW:*** *Role of participant:* You are invited to participate in a one on one interviews, which will be conducted by research team members from the Well Living House.
   c) ***SURVEY:*** *Role of participant:* you are invited to participate in a survey, which will be conducted with a research team member from Well Living House.
   d) ***INTERVIEW:*** The duration of the interview will be no longer than 1.5 hours.
   e) ***SURVEY:*** The duration of the survey will be no longer than 30 minutes
   f) You will be asked questions about your prenatal, birthing and reproductive health needs where and how SGMT is meeting these needs, how you define culturally secure care and finally some questions about how SGMT is contributing to changes in attitudes and behaviours regarding Aboriginal people, knowledge and practice.

Confidentiality privacy disclosure: Your privacy will be respected and no information that tells your identity will be released or published without your okay unless required by law, such as telling about abuse or risk of harm to yourself or others**.**

INTERVIEW: The digital recording and study records will be securely stored and handled at all times. The digital recording of the interview will be securely destroyed after the information has been transcribed. Your information (data) either in paper forms or electronic files will be kept securely stored at all times. All study data will be securely disposed of no longer than 10 years after the end of the study.

SURVEY: The survey will be securely stored and handled at all times. Your survey will be kept securely stored at all times. All study data will be securely disposed of no longer than 10 years after the end the study.

The Research Team will keep all of your answers confidential. No one will listen to your recording or have access to the notes other than the research team and the St. Michael's Hospital Research Ethics Office whose access to the study records, will be only to watch over how the study is going.

- *Do you have any questions about this study?*
- *Would you like to hear more so you can decide whether to take part?*

2. **More About Participating in this Study** *(present additional information about study participation)*

   a) ***Risks.***
   We do not believe that you will have any problems by being a part of the study. But some questions might make you feel uncomfortable. You can skip any question you don't want to answer.
   None of the information that you provide will affect your access to services at SMH or at SGMT.

If you share any personal opinions or experiences that are unique to you and might make it known who you are, we will paraphrase so that your anonymity is not compromised.

b) ***Potential Benefits*** *(not including participant payment).*
There is no direct benefit to you in participating in this study. However, it is hoped that this study will benefit other women, infants, and families that access SMGT services in the future, because they would have developed and put into place a culturally relevant and evidence based evaluation system for their community based midwifery practice evaluation

c) ***Withdrawal from the Study***
Participation in this research study is voluntary. You can choose not to participate in this study, or leave this study at any time. You can change you mind without giving a reason. If you choose not to take part in the study, the information you had provided will be removed from the study and destroyed.

d) ***Payments to the Participant***
You will be given $25 and a small gift of a to thank you for taking part the research interview.

- *Do you have any questions about this study or your participation*
- *Are you ready to decide whether or not to participate?*

1. **Informed Consent** *(seek the potential participants voluntary informed consent to participate)*

a) Whom to contact about:
   - The study, and/or withdrawal of authorization to use/share PHI (provide PI name and contact information).
   - The participants rights (someone to contact **the** Chair of the St. Michael's Research Ethics Board)

b) The participant has the right to ask questions at any time

c) The participant has the right to decline to participate or to withdraw consent at any time without penalty or loss of benefits.

- *Do you want to volunteer to participate in this study?*

G: Verbal Consent Form

CLIENT CONSENT FORM – DECLARATION OF ASSISTANCE

Study Title: Developing and implementing a practice-based performance measurement system with Seventh Generation Midwives Toronto

Study Participant's Name (Print): ____________________________________

ASSISTANCE DECLARATION ☐ _______ Initials (check and initial here if not applicable)

The participant was assisted during the consent process as follows (check, as applicable):

- ○ The consent form was read to the participant, and the person signing below attests that the study was accurately explained to, and apparently understood by, the participant and consent to participate was freely given by the participant.

___________________________	____________________________	______________
Name of Participant Obtaining Consent (Print)	Signature of Person Obtaining Consent	Date

Person Assisting: ____
Relationship to Study Participant (specify): ____
Language: ____
Contact Information: ____

H: Honorarium Receipt

Honorarium Receipt

I verify that I received $25.00 & small gift from the study interviewer, to compensate me for my time for participating in the **Developing and implementing a practice-based performance measurement system with Seventh Generation Midwives Toronto research study**.

____
Printed Name

____
Signature

____
Date

____
Place