**Lack of access to culturally safe maternal care for First Nation Lifegivers who must travel to Kamloops and surrounding area to give birth**

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**Wicked Problem**

Indigenous families in Kamloops and surrounding areas face a lack of culturally safe maternal services - a complex challenge that deepens health inequities, forces out-of-community birth evacuations and hinders the intergenerational sharing of traditional birth knowledge (Bacciaglia et al., 2023). There are competing ideas of what is safe maternal care, and systemic colonial policies that resist change. Historically, Indigenous women gave birth in their communities with the help of Indigenous midwives and community members (Bacciaglia et al., 2023). Forced birth evacuations are a longstanding federal policy that displaces Indigenous women from their remote communities to give birth in urban areas at 36-38 weeks gestation. This colonial policy has been in place since the 1970s (National Council of Indigenous Midwives, 2020a). Pregnant First Nation women are evacuated from their community, support systems, culture and land to give birth far away, and oftentimes alone for weeks (Campbell, Green, & Lawford, 2020). Inaccessible culturally safe maternal care prevents Indigenous “lifegivers” and communities from self-determination and contributes to poor health outcomes (Loppie & Wien, 2022).

This issue is complex to solve and is considered a ‘wicked’ problem, since there are multiple intersecting reasons. The original reason for this blanket policy across Canada was to reduce maternal and infant mortality (Murdock et al., 2024). This solution (forced birth evacuations) only addressed medical safety and ignored cultural safety in regards to maternal care. Western medicine often prioritizes the biomedical model and ignores Indigenous traditional knowledge (Loppie & Wien, 2022). Infant and maternal mortality are easily quantifiable, while cultural harm and the impacts of this colonial policy are hard to measure. Despite this decades old policy, infant mortality in First Nations populations in Canada is still twice as high compared to the non-Indigenous population (Smylie, Fell, & Ohlsson, 2010).

Indigenous communities are often remote and rural, and many are not equipped for maternal health and birthing, which the federal government uses to justify this policy (Bacciaglia et al., 2023). Community health centres face chronic staffing shortages and no consistent access to physicians, nurse practitioners, nurses or midwives. Recruiting and retaining Indigenous healthcare workers is even more challenging (First Nations Health Authority, 2024).

This wicked problem shows the intersecting challenges of colonization, outdated federal policy, remote geography, staffing shortages, overlapping jurisdiction, and ongoing cultural harm. These uncertainties make the issue resistant to simple solutions and require multi-faceted, community-led approaches.

**Population**

The population most impacted by the lack of culturally safe maternal care in Kamloops are First Nations women, typically between the ages of 19 and 35, whose age group represents the majority of those receiving maternal health services. Due to the absence of local maternal health services, First Nations women living on-reserve in remote or rural communities are forced to receive maternal health care and deliver their babies in far away urban centres, which removes them from their family, friends, and community (Bacciaglia et al., 2023).

Research has repeatedly shown that the harmful effects of birth evacuation policies cause emotional, physical and financial stress on pregnant First Nation women and people (Radhaa, et al., 2024). Those who are evacuated for birth often find themselves in transitional housing, separated from children and support networks, experiencing financial burden and emotional distress - conditions that increase their vulnerability for being exposed to anti-Indigenous racism in the health care system (National Council of Indigenous Midwives, 2020a).

In addition to First Nations women, families including partners, children, relatives and support networks are impacted, often excluded from the birthing experience.  In First Nations communities, community-based support systems and intergenerational traditions play a vital role in welcoming new life (National Council of Indigenous Midwives, 2020b). Perinatal Services BC (2021) reports that when women are separated from their families to give birth in unfamiliar surroundings, there is an increase in premature births, newborn complications, postpartum depression, unsuccessful breastfeeding, strain on the family, attachment issues and the inability to celebrate the new birth.

Indigenous midwives, doulas and traditional birth workers may also be affected when clients are forced to leave their support systems to give birth. Cidro et al., (2020) reports that the shift of responsibility from community-based traditional roles to external service providers hindered Indigenous birth practices and significantly reduced the role for traditional midwives and birth workers within communities.

**Context**

Culturally unsafe birthing experiences are upheld by a history of colonialism in Canada. Colonialism in Canada is a determinant of health (MacNairn & Al-Ani, 2022). Colonialist ideals have held strong through history, forming racist policies that often still exist today (First Nations Healthy Authority, 2024). These include policies such as the *Indian Act*, forced surgical sterilisation, residential schools, the sixties scoop, and the child welfare system. There is a deep-rooted sense of mistrust for Indigenous peoples seeking healthcare due to Canada’s history of harmful practices (First Nations Healthy Authority, 2024). Colonial policies and institutional racism create barriers to safe environments and basic needs for Indigenous mothers and children (First Nations Healthy Authority, 2024). Many remote Indigenous communities do not have access to birthing facilities and healthcare professionals, forcing travel even for basic prenatal care (NCIM, 2020). This poor geographic distribution of services causes health inequities (Smylie et al., 2021).

Traditionally, Indigenous women were central to their communities (Government of Canada, 2021). Indigenous matriarchs passed down wisdom and customs surrounding birth. This wisdom and social link had a positive influence on childhood development and continuity of culture through generations (First Nations Healthy Authority, 2024). Colonisation introduced patriarchal systems and practices that sought to abolish the respected role of Indigenous women and erode traditional birthing practices in communities (FNHA, 2024; Government of Canada, 2021; NCIM, 2020). Birthing was medicalized and traditional practices were criticized and dismissed (Tomkins, Liu and Campbell, 2024).

Resources to combat the negative effects of culturally unsafe care include the resurgence and reclamation of traditional birthing roles and practices in communities (First Nations Healthy Authority, 2024). The resilience of Indigenous communities in maintaining these practices cannot be overlooked when considering cultural safety. Indigenous midwives are invaluable to strengthening cultural safety and care outcomes (Tomkins, Liu & Campbell, 2024). They are skilled health workers and leaders in keeping ceremony and culture alive (NCIM, 2020). The truth and reconciliation committee (2015) calls for recognition of the value of Indigenous healing practices. These calls to action along with the *In Plain Sight* report (2020) bring a sense of duty for healthcare systems to prioritize the restoration of traditional birthing practices in Indigenous communities.

Constraints include Canada’s Western and predominantly biomedical focused healthcare system that upholds racist policies (First Nations Healthy Authority, 2024). These systems continue to undermine Indigenous knowledge and create power imbalances. Financial constraints are widespread in healthcare (Dangerfield, 2023). Though cultural safety has been shown to improve health outcomes and access to care (First Nations Healthy Authority, 2024), putting evidence into practice is slow.

**Create an Indigenous Maternal Liaison position in Kamloops Hospital - Sarah McElroy**

 Creating an Indigenous Maternal Liaison (ILM) at Royal Inland Hospital in Kamloops to help “lifegivers” receive culturally appropriate maternal care while accessing services in the hospital. A maternal liaison could create a sense of community for First Nations women who are giving birth alone or with little support and help de-medicalize giving birth. This hospital position could connect “lifegivers” with perinatal supports, Elders, ceremony, and culturally significant gifts for this sacred time. Ideally the Indigenous Maternal Liaison would have knowledge of the surrounding area, the Indigenous communities and culture. The liaison could work in partnership with the Kamloops Friendship Centre, local band and other culturally relevant community supports.

Effectiveness could be evaluated through voluntary and anonymous patient surveys who utilized the ILM, and how satisfied they were with their care. Funding for this position could come in partnership with FNHA, Interior Health or RIH Foundation potentially. The current climate with Interior Health is a focus on front-line care positions while eliminating 91 administrative jobs according to the current CEO (CFJC Today Staff, 2025). According to Turpel-Lafond (2020), the *In Plain Sight* report directly recommends roles like this in healthcare to support culturally safe care and address systemic racism in B.C. healthcare.

**Build an anti-racism toolkit for practitioners at the bedside - Solstice Toews**

Cultivating anti-racism in healthcare is a key step to decreasing the health inequities that First Nations life givers experience. Tomkins, Liu and Campbell (2024) underscore the importance of settler practitioners building culturally safe, anti-racist relationships with Indigenous patients. While there are anti-racism resources on Interior Health’s insidenet, BCCNM’s and BCNU’s webpages, and websites outside of the health authority, it can be difficult for busy practitioners to find and use them. Registered nurses need a clear path forward when it comes to providing anti-racist care.

As such, amalgamating existing resources into one simple toolkit could be a solution to practitioners engaging in culturally safe, anti-racist care. The Indigenous cultural safety and humility team at IH confirmed that no such toolkit currently exists for Interior health staff (personal communication, September 23, 2025). Yamada et al. (2015) state that toolkits may be an effective way to facilitate evidence use in practice to improve a variety of outcomes in healthcare settings.

This process could be timely as a lot of information exists for nurses regarding anti-racist care. However, the cost would not be high as existing evidence and resources would be used. The Indigenous cultural safety and humility team at IH states that a toolkit is something they would consider developing (personal communication, September 23, 2025). There are many toolkits that could be used as guides for developing one specific to IH and maternal care. For example, the Native Women’s Association of Canada (n.d.) has a racism toolkit for healthcare. Anti-racist practices share similarities no matter the work environment, but having a toolkit that includes education around Indigenous birthing practices and Canada’s history of disenfranchising life-givers would be helpful for nurses interacting specifically with these patients.

**Create a virtual space where expectant moms can share information, support one another and access resources - Tina Brown**

Entering into motherhood can be stressful and even the most well-prepared women can find themselves overwhelmed by uncertainty and challenges. These include loneliness, disconnection from community, and isolation from family and culture. Indigenous women being away from their community has been shown to exacerbate existing poor pregnancy and infant health incomes (Varcoe et al., 2013).

Peer support interventions have been shown to effectively prevent perinatal mental health conditions and play a significant role in enhancing maternal health services (Liblub et. al., 2024). Peiyu (2023) writes that by engaging with an online community, users can get instant access to peer support, advice, emotional reassurance, which can greatly reduce feelings of isolation. The primary purpose of the virtual space would be to offer expectant and new Indigenous mother's, a supportive space for peer connection, resource sharing and emotional encouragement. Inclusion will be centered on Indigenous women planning to give birth in Kamloops, as well as birth workers, doulas and allies to create an online community that upholds cultural safety and shared wisdom.

Guidelines would be established to create a safe, supportive and culturally grounded virtual space using member input on features and rules. Partnering with Indigenous organizations to co-create protocols that align with surrounding Indigenous community priorities and coordinating with nurses, social workers or community health representatives from surrounding bands and patient navigators to increase awareness and improve uptake. Choosing the right platform, where it is easily accessible, one that has widespread use, built in event tools and polls, privacy controls, moderation tools and is able to incorporate First Nation imagery onto the platform.

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