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

Presentation Transcript

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Hello, today we are presenting the wicked problem of the lack of access to culturally safe maternal care for First Nations Lifegivers who must travel to Kamloops in order to give birth.

First, let's meet the group:

Sarah currently works in primary care at a FNHA virtual clinic. Previously, she worked in acute care in the ICU. She has Indigenous and white settler ancestry, with traditional territory in Treaty 8 in northeastern BC where she was born and raised. She brings multiple nursing and personal perspectives to this issue.

Tina currently works in a virtual primary care clinic providing healthcare services to First Nations people and their families living in BC. She brings a personal perspective to have witnessed firsthand the deep disconnect between our health systems and the needs of Indigenous mothers.

Solstice works in the recovery room at Royal Inland Hospital. She is a settler nurse as a third generation immigrant with Indian and English ancestry. She brings an acute care nursing perspective to this issue.

All three of us live, work and play on unceded, ancestral lands of the T'kemlups te Secwépemc people.

Objective

We will first explain why this issue should be considered a wicked problem. We will go into its contributing and complicating factors. We will then analyze this issue through an interrelational lens. We will discuss different perspectives on this issue. And, we will look at the issue's boundaries and limitations. Finally, we will summarize our analysis on this topic.

Wicked Problem

Since the 1960s, First Nations women living on-reserve in remote or rural communities have been forced to receive maternal health care and deliver their babies in far away urban centres (Bacciaglia et al., 2023). Forced birth evacuations are a longstanding federal policy that displaces Indigenous women from their communities to give birth in urban areas at 36-38 weeks gestation. Those who are evacuated 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, 2020; Radhaa, et al., 2024).

Interrelationships

Interrelationships are about how things connect and the result of these connections. Often the effects of these connections are not immediately apparent (Williams & Van't Hof, 2016). The nature of these connections affects how they interact, for example whether they are strained, good, strong or weak (Williams & Van't Hof, 2016).

In the case of Indigenous birthing practices, I think one of the main interrelationships has to do with colonization. Colonialism continues to shape today's healthcare systems and policies, often in ways that erode trust with Indigenous communities. These policies have limited Indigenous autonomy, forcing reliance on outside systems and further degrading traditional birthing practices (Cidro et al., 2020). This loss of autonomy directly impacts safety and birthing outcomes (Loppie & Wien, 2022). Factors resulting from a history of colonialism continue to uphold colonial ideals and practices. This is a lengthy, complex, and painful interrelationship.

Another key relationship is between healthcare providers and Indigenous patients. When care lacks cultural safety, this can lead to mistrust, negative experiences, and barriers

to accessing services (FNHA, 2024; Government of Canada, 2021). Some patients may avoid care or feel unsafe bringing traditional practices to hospital settings (McNairn & Al-Ani, 2022), which reinforces colonial and racist dynamics within healthcare. These relationships can also have different natures, whether that is good, bad, strained or mistrusting.

There are also structural relationships such as geography, hospital closures, staffing shortages, and systemic racism that interact and influence each other (FNHA, 2024). Together, these factors create feedback loops that add even more complexity to this problem (Williams & van't Hof, 2016).

This web of connections – historical, social, cultural, and systemic – is what makes the lack of culturally safe birthing care for Indigenous families truly a "wicked problem".

Perspectives

To truly understand the wicked problem faced by Indigenous women who must travel to give birth, we need to explore multiple perspectives shaped by cultural values, lived experiences and professional roles (Williams & van't Hof, 2016).

First Nations Women and Families

First Nations women and their families view this issue as a violation of their rights, traditions and dignity (Cidro et al., 2020). Giving birth in unfamiliar settings means that cultural and traditional birthing ceremonies are ignored, leaving women feeling disconnected from their identity. The separation from family and community and experiences of racism contribute to a deep mistrust which discourage Indigenous women from seeking care or advocating for their own needs (Smylie & Phillips-Beck, 2019)

Indigenous Midwives and Birth Workers

Indigenous midwives and birth workers view this issue as a deeply harmful colonial practice which has had a devastating impact on preservation of culture and maternal and newborn health outcomes in Indigenous communities across Canada (National Council of

Indigenous Midwives, 2020). Indigenous midwives and birth workers support Indigenous peoples inherent right to birth on their lands and are working to practice and preserve traditional birthing knowledge, culturally safe community-based birth services and moving birth practice back to First Nations communities.

Government (Federal, Provincial & Territorial)

The government's goal of reducing high maternal and infant mortality rates was rooted in a biomedical risk management framework (Durant et al., 2024). However, this was heavily influenced by colonial goals of assimilation and to eradicate Indigenous Peoples' maternity care practices (Campbell et al., 2025). This assumption that the Eurocentric model was superior, downplayed the negative health outcomes of family separation, exposure to racism and continues to emphasize evacuation as the default solution (Campbell et al., 2025)

Health Authorities and Administrators

Health authorities view medical evacuation as a strategy to reduce risk when rural and remote communities lack trained staff, resources, infrastructure and emergency response (Radhaa et al., 2025). Decisions are influenced by budget, cost and policy, perpetuating systemic barriers to culturally safe care.

Healthcare Providers

Many health care providers lack an understanding of Indigenous birth practices and don't have formal training in cultural safety, anti-racism and trauma-informed practice. Providers have seen, first hand, the negative impact of evacuations and feel caught between clinical judgment and policies where they are bound by liability and protocols (Tomkins, 2024).

Indigenous Leadership (Band Councils, First Nations Organizations)

Indigenous leadership's perspective is rooted in the defense of birth sovereignty, cultural safety, and the right to self-determined healthcare (Smylie & Phillips-Beck, 2019). First Nation communities feel excluded from decision-making in health services and view this issue as a continuation of colonial control over Indigenous bodies, families, and communities (Smylie & Phillips-Beck, 2019).

Boundaries

Boundaries are defined as what and who is included or excluded in a problem, whose values and perspectives count, what relationships are marginalized or hold power (Williams & van 't Hof, 2016).

For our particular problem the interrelationships that are privileged are between the hospital, healthcare providers, Western medical systems, while connections between Indigenous Lifegivers, families, Elders, traditional knowledge holders and midwives are marginalized. Privileging biomedical healthcare disconnects Lifegivers from cultural and community supports, causing isolation and culturally unsafe care (Loppie & Wien, 2022; Smylie et al., 2021).

Dominant government and institutional perspectives medicalize birth for safety and reinforce birth evacuation policies. Indigenous communities view birth as sacred, relational and connected to land and language- but these views are excluded. (FNHA, 2024; National Council of Indigenous Midwives, 2020).

Geographical and jurisdictional boundaries illustrate remote First Nation communities surrounding Kamloops are excluded, while urban centres like Kamloops hospital, where First Nation Lifegivers are sent to give birth, are included. The far isolating travel distances and

overlapping federal and provincial systems restrict autonomy and create service gaps (Cidro et al., 2020; Radhaa et al., 2025).

Overall, these boundaries reflect colonial structures that privilege Western medicine and silence Indigenous knowledge. A community-led approach is required to include Indigenous voices to support the right to self-determination for community maternal care and prevent harm from culturally unsafe practice (FNHA, 2024; National Council of Indigenous Midwives, 2020).

Summary

To summarize, this diagram portrays how interrelationships, perspectives and boundaries shape maternal care for First Nation lifegivers. Interrelationships determine where and how care happens through colonial health policies, geography, mistrust in provider/client relationships and is compounded with chronic staffing shortages (Bacciaglia et al., 2023; Smylie et al., 2021).

Perspectives differ- First Nation lifegivers and communities view birth and maternal care as sacred, and relational, and current policies as violating their rights, leading to mistrust and isolation (Campbell et al., 2025; Cidro et al., 2020; Smylie & Phillips-Beck, 2019). Healthcare systems resources and focus is on medical safety of maternal care, usually in urban settings (Durant et al., 2024; Government of Canada, 2018).

Boundaries reveal who's included and excluded- healthcare systems, colonial policies, and providers are prioritized while Indigenous lifegivers, families and traditional knowledge are often silenced (Williams & van 't Hof, 2016; First Nations Health Authority, 2024; Tomkins et al., 2024).

Where all these concepts overlap, the impact reveals culturally unsafe care for First Nation lifegivers (Smylie et al., 2021; National Council of Indigenous Midwives, 2020). Maternal care is medicalized, lifegivers are isolated which lead to feelings of mistrust- even

though the intent is to have healthy maternal and infant outcomes. Community-led approaches and input to prevent culturally unsafe care is important moving forward (Campbell et al., 2025; Tomkins et al., 2024; MacNairn & Al-Ani, 2022).

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Group Member	Task and Contribution (%)
Tina Brown	Research (20%) Writing (20%) Recording (20%) Editing (20%) Presentation formatting (20%)
Solstice Toews	Research (20%) Scholarly writing (20%) Recording (20%) Editing (20%) Presentation formatting (20%)
Sarah McElroy	Research (20%) Scholarly writing (20%) Recording (20%) Editing (20%) Presentation formatting (20%)

AI Use in Assignment Development: Checklist for Group Assignment

Artificial Intelligence: A Guide for Students - Research Guides at Thompson Rivers University Library can be accessed via this link
https://libguides.tru.ca/artificialintelligence/home

Planning and Research

- Did your group use AI tools to brainstorm or generate topic ideas? No
  If yes, please describe the tools used and how they shaped your topic selection.
- Did your group use AI to summarize or explain academic sources? Yes.
  If yes, explain which sources were processed and how AI helped with comprehension.
  Used Open AI (chat gpt) to help break down the meaning of inter-relationships,

perspectives and boundaries in wicked problems and give some examples. This helped make the concept more concrete and expand our idea of what a relationship meant (ie relationship also means between two concepts or historical features, not just plates like the government and healthcare providers).

- Did your group rely on AI to find or recommend sources or references? No.
  If yes, specify the tools and how they influenced your research direction.

Writing and Drafting

- Did your group use AI to generate any part of the written content (for example, paragraphs, summaries, outlines)? No.
  If yes, indicate which sections were AI-generated and how they were integrated.
- Did your group use AI to rephrase or improve writing (for example, grammar, tone, clarity)? Yes.
  If yes, describe the extent of revisions and the tools used. Open AI was used to shorten the interrelationship and boundary slide presentation and make minor edits for clarity and grammar. Once put through AI, the slide presentation was edited again to the writer's personal liking and style.
- Did your group use AI to translate content from another language? No.
  If yes, mention the original language and the translation tool used.

Data and Analysis

- Did your group use AI to analyze data or generate visualizations (for example, charts, graphs)?yes
- If yes, explain the type of data and how AI contributed to the analysis.
    - Open AI was used to recommend what visual would be best to summarize IPB analysis, Venn diagram was recommended and the writer prepared their own diagram.

Creative and Visual Work

- Did your group use AI to create images, diagrams, or design elements? No.
  If yes, specify the tools and the purpose of the visuals.
- Did your group use AI to generate code or scripts for interactive or digital components? No.
  If yes, explain the functionality and how it was implemented.

Critical Thinking and Originality

- Did your group critically evaluate and revise AI-generated content before including it? Yes.
  If yes, describe your revision process and how you ensured originality. AI was only used to edit already original content and was then revised again. All references had already been put in place to ensure truth.
- Did your group ensure that the final submission reflects your own understanding and voice? Yes.
  If yes, explain how you balanced AI assistance with personal input. All content was original while AI simply helped with editing. No thoughts or creative input was taken from AI.