**Part B: IPB Analysis of a Wicked Problem - Video Transcription**

Inadequate Prenatal Care for Women in Kamloops (0:00-0:11)

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**Slide 1: Inadequate Prenatal Care for Women in Kamloops (0:00-0:11)**

“Welcome to our presentation on inadequate prenatal care for women in Kamloops. This is done by Brianna Grayson, Jane Haywood-Farmer, and Megan Lowe.”

**Slide 2: Land Acknowledgment (0:12-0:31)**

“I acknowledge today that the Kamloops region resides on the traditional, ancestral, and unceded territory of the Tk'emlúps te Secwépemc Nation, and we have the privilege and the honor to live, work, and play here and to learn our Masters in Nursing through Thompson Rivers University on this traditional land.”

**Slide 3: Introduction (0:32-0:58)**

“Our presentation today will discuss the prenatal care deficits that currently reside in the Kamloops and Kamloops surrounding region. We also will conduct an analysis discussing Williams’ IPB analysis of wicked solutions, also known as the “Interrelationship Perspective and Boundary Analysis” related to our wicked problem, the prenatal care, or the lack of parental care in Kamloops, as well as conducting a conclusion on our analysis.”

**Slide 4: Prenatal Care Deficits in Kamloops (0:59-2:20)**

“There's a severe prenatal care deficit in Kamloops currently. Regular prenatal care throughout pregnancy is essential for maternal and newborn health (Government of Canada, 2023). Kamloops is facing an increasing deficit of prenatal care shortages for low- and medium-risk pregnancies. Previously, these women received care from local midwives, independent GPs, or through the Thompson Regional Family Obstetrics Clinic (TRFO). Kamloops, specifically Royal Inland Hospital, is a regional hub for maternity care services in the area (Kamloops Obstetrics, n.d.), yet a shortage of GPs and midwives, declining interest in obstetrical care, midwife shortages, and uneven service distribution have created access gaps. Midwives set up a clinic First Steps to help alleviate the shortage, but only have the capacity to see women during their first and second trimester before referring them to TRFO (First Steps, n.d.). An average of 10 women per month have presented to Royal Inland Hospital over the past year with no prenatal care or only partial care (M. Redmond, personal communication, September 9, 2025). As of September 2025, TRFO announced that it is no longer accepting any referrals and is providing limited care due to lack of physician coverage (TRFO, 2025).”

**Slide 5: Inter-Relationships (2:21-4:48)**

“Now on to discussing the interrelationships and the IPB analysis and how each relationship shapes the inadequate antenatal and postnatal care in Kamloops. So currently in Kamloops, we have what's called a web of fragmented care covering both antenatal and postnatal care, which includes a multidisciplinary team of midwives, GPSs, OBGYNs, and registered nurses, as well as the hospitals, clinics, and administrators, who all currently work in silos. Due to capacity limits, there's no room for issues that arise in maternity care, such as late or no term prenatal care. Understanding how each member of this web interconnects to the services provided is understood through the IPB analysis of interrelationship, because each member works in silos, but all actually play a very important key role in the delivery care model of women in Kamloops (Williams & Van’t Hof, 2016). We need to address the issues, and we must understand the historical hierarchy and power dynamics that are at play here. We need to provide more of an approach to a team based for low/medium-risk pregnancies that would provide a different delivery service needing physician support. When reviewing the Government of Canada guidelines it endorses the collaborative, family centered approach model (Public health agency of Canada, 2023). However, with limited services, we aren't able to provide this model up to the highest standards. Having the power dynamics switch roles and changes the hierarchy has created barriers to this change in Kamloops.

Our system is currently broken, which has become more and more seemingly evident. With rotating providers, lack of shared care plans often results in families having to retell their stories (Heaman et al., 2019). This creates a weaker therapeutic relationship, and often results in more use of labor and delivery and emergency (Heaman et al., 2019). Addressing the Indigenous culture and safety within our region, we often need to address that due to lack of short staff we also often have perpetrated the causes by not acknowledging the practices and knowledges and beliefs of indigenous population, and ignoring this is causing further trauma and colonization (Bacciaglia et al., 2023). In a system that has very minimal care and short staffed, this problem is often really accentuated in these situations. The next step is reinforcing these loops, such as short staffing that leads to delay in care and complications for the resulting emergency use, burnout and often more short staff results in inequities and worse outcomes for prenatal care (Heaman et al., 2019).”

**Slide 6: Perspectives Analysis (4:49-7:14)**

“The perspective analysis looks beyond relationships to understand a problem more thoroughly as people interpret an issue differently, depending on their perspective (Williams & Van’t Hof, 2016). What constitutes safe, high quality, accessible, culturally appropriate prenatal care, this may differ between healthcare professionals, patients, and administrators. Medical professionals, including OBs, GPs, NPs, and midwives have different training backgrounds, scope of practice, and clinical philosophies. What constitutes safe and high-quality care may differ between them (Korst et al., 2018). For example, OBs may prioritize evidence-based guidelines that emphasize technology, while midwives may also consider continuity of care, holistic care, and patient empowerment. While some professionals may advocate for flexibility community integrated or culturally specific models, others will focus on hospital-based care (Korst et al., 2018). Some patients may also be focused on modern technology and hospital-based care, whereas others may consider care in their own communities, home based care, or care provided by someone from their own culture as a priority. Safety often extends beyond clinical outcomes to include respect, absence of discrimination, and support of traditional practice (McNeil et al., 2025). Administration may focus more on using standardized metrics to judge quality of care, rather than considering patients' voices. They may be inclined to support policies that improve access in measurable ways instead (Jones et al., 2017).

Differing prioritization of efficiency, patient flow, and workforce distribution also exists. Healthcare providers and administration may be at odds in this area. Administration needs to balance patient outcomes with budget constraints and efficiency. They may choose to focus greatly on how best to streamline patient flow while ensuring most financially feasible workforce coverage (Jones et al., 2017). Healthcare providers may also be concerned with patient flow, but focused on quality of care that they can deliver their patients while mitigating burnout (Boulton et al., 2024). Considering the difference between various healthcare providers and administration is key when coming up with these solutions by explicitly analyzing all perspectives, William’s IPB framework makes visible the conflicts and gaps in existing approaches and underscores the need to system wide adaptive strategies.”

**Slide 7: Boundaries (7:15-8:44)**

“Boundaries are inevitable because time, resources, and knowledge are always limited. What matters is where we choose to draw them, deciding what's included as relevant and what's excluded. If key stakeholders or resources are left out the system we design may be incomplete or unrealistic. No system analysis can include everything. Our time, resources, and knowledge are always finite, so boundaries are unavoidable. Acknowledging limits up front keeps the analysis grounded and prevents overstating what solutions can achieve (Williams & Van’t Hof, 2016). For our analysis, we focus specifically on women with low- and medium-risk pregnancies in Kamloops and surrounding catchment areas. By making this choice explicit, we ensure our analysis is practical, targeted, and directly connected to the heart of the wicked problem (Kornelsen et al., 2021). Inside the boundary are the main service providers and clinics, as well as health authority structures. Outside the boundary are high risk pregnancies, private or alternative care, and broader social determinants of health. These are important too, but beyond the scope of this project. By drawing this boundary, we targeted the core prenatal care gaps while recognizing that other system factors still influence outcomes. Boundary setting isn't about ignoring complexity, it's about making thoughtful, deliberate choices and being transparent about what's beyond the scope (Williams & Van’t Hof, 2016).”

**Slide 8: Conclusion (8:45-10:10)**

“In conclusion, the IPB framework helps us to see how inadequate prenatal care in Kamloops is not the result of one issue, but a web of interconnected factors. From the interrelationship perspective, workforce shortages, fragmented care, and colonial impacts all interact to create ongoing service gaps and inequities (Bacciaglia et al., 2023; Heaman et al., 2019). These relationships reveal that solutions must be coordinated across disciplines rather than handled in silos (Williams & Van’t Hof, 2016). From the perspective lens, we see how patients, providers, and administrators each define quality care differently. Some focus on safety and evidence-based practices, while others prioritize continuity, cultural safety, or sustainability (Korst et al., 2018). Understanding these diverse viewpoints is key to developing equitable and lasting change. Finally, through boundary setting, our group focused on low- and medium-risk pregnancies within Kamloops and its rural catchment. This focus allowed us to target the core access gaps while recognizing that broader social and systemic issues remain beyond our scope (Williams & Van’t Hof, 2016). Together, these components show that improving prenatal care access requires system wide collaboration, attention to equity, and transparent boundary choices. Without this integrated approach solutions risk remaining fragmented, just like the system itself (First Nations Health Authority, 2020; Staples et al., 2023).”