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Exploring Mi'kmaq Women's Experiences with Gestational Diabetes Mellitus

by

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Dedication

This dissertation is dedicated to the Mi'kmaq women who generously gave of their time and shared their experiences of having gestational diabetes to make this research possible. Their voices are important to make changes in their communities. I also dedicate this research to my loving husband Bill, who continues to support and encourage me, and who generously gave of his time in various ways to help me complete this work. This dissertation is dedicated to my growing family which include my sons Arthur and his wife Tammy, Matthew and his wife Holly, step-daughters Tanya, Yvette, and step-grandchildren Jason and Victoria and her children Mason and Ava who were encouraging and understanding during this academic endeavor. To my mother who died while I was doing the study and my sister Elizabeth who were always present to give me encouragement, I am forever grateful. I am also grateful to my other siblings Michael, Bernard, Gregory and their families who were always interested and supportive of my work.

Abstract

Gestational diabetes mellitus (GDM) is characterized by a carbohydrate intolerance that is diagnosed in pregnancy. In recent years, the incidence of diabetes has increased with one in eight First Nations women reporting the development of this condition. Diabetes is three to five times more common among First Nations people than the general population. Women diagnosed with GDM have an increased risk of developing glucose intolerance later in life, with approximately 50% developing Type II diabetes within 15 years. Hypertensive disorders, higher caesarean section rates, higher rates of spontaneous preterm delivery, pre-eclampsia, and hypoglycemia are some complications associated with this condition. In addition to physiological complications, there are a number of social and political contexts which affect Aboriginal women and their families during pregnancy. Since there is a paucity of research exploring First Nations women's experiences with GDM, a participatory study was conducted for the purpose of providing new knowledge about First Nations women's experiences with GDM. Participatory and Indigenous principles informed and guided this study. Conversational interviews with nine Mi'kmaq women who experienced GDM in addition to talking circles with the participants and other community members were conducted. A hermeneutic phenomenological approach was used to search for essential and peripheral themes and the women's life experiences were interpreted in terms of life existentials of lived space, lived body, lived time, and lived relation as a framework to present the findings. Four themes emerged which included a) Uncovering the Experiences of GDM, b) Barriers Limiting Access to Health Care c) Social Support During Pregnancy, and d)

Feeling Compelled To Take Action. Based on these findings using the social determinants of health (SDOH) as a framework, the women's stories inform health care providers about the complexities of Mi'kmaq women's lives. Implications for policy changes, education, clinical practice, and research are addressed.

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Chapter I

Introduction

Background

The path that led me on this journey.

My experience as a non-Aboriginal Registered Nurse working in maternal child care is that Aboriginal[1] women and families encounter barriers to receive just and equitable maternal-child healthcare services. Thus, my journey has a human rights focus. Despite educated health care providers and extensive research in health care, Aboriginal women continue to experience racism, discrimination, and marginalization in healthcare settings across Canada (Browne, 2005; Browne & Fiske, 2001; Stout, 1996; Whitty-Rogers, 2006). Recognizing racism and injustices embedded in life experiences can provide a beginning point for a health care system to respond that is culturally safe, caring, and humane.

My interest in Aboriginal women and families during the perinatal period grew over time as I worked with them in varying roles as staff nurse, head nurse, and unit manager of a neonatal and maternal child unit. As I reflect upon my early years as a new nursing graduate, I had many memorable experiences as well as challenging times. I began my experience working in a 25-bed Neonatal Intensive Care Unit in Sydney, Nova Scotia-hometown. It was not the best choice in many ways because I was what Benner

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[1] Aboriginal is an inclusive term which refers to First Nations, Inuit, and Metis people (Smylie et al., 2000). In Canada according to Section 35 of the Constitution Act, 1982, Aboriginal peoples are considered any one of the above terms (Government of Saskatchewan, 2012). On the contrary, the term Indigenous is commonly used in a more global context and refers to individuals who were the first people to a particular territory.

(1984) would call a novice nurse and I had to develop expert knowledge and clinical skill in a short period of time as my job entailed caring for moderately and critically ill babies, some requiring respirators to survive.

According to Benner (1984), expert knowledge takes years to develop. At that time I was often afraid and overwhelmed because I was a novice nurse. As a young nurse, it was difficult to anticipate what one was going to encounter. However, I knew that I was accountable and responsible for people's lives and wanted to be certain that I was making the right decisions. Although I was young, I had some insight into my patients' vulnerabilities and often prayed to keep them safe.

It was at this time in my nursing career that I began to care for many Mi'kmaq babies and mothers. My encounters with the parents were frequent, yet I felt a sense of distance between them and myself. Although I tried to communicate in a caring and professional manner, I felt that my knowledge, skills, and understanding of how to communicate effectively with Mi'kmaq mothers and families were inadequate. This lack of effective communication created frustration for me and I believe was the reason why some Mi'kmaq women would not attempt to engage in any dialogue and would limit their time visiting their babies in the Neonatal Intensive Care Unit. Looking back, I realize I was experiencing disembodiment because I was unable to verbally communicate in a way that these women could comprehend, nor did they respond in a manner that I could anticipate. Being young (20 years old) and having limited nursing let alone life experiences, made clinical practice challenging and unsettling. However, I knew there was more to this feeling of incompetence and disconnection than just being inexperienced.

During my early nursing education, curriculum content involving multiculturalism was sparse in the diploma program. Therefore, like many other nurses, I was unaware of differences among various cultures and lacked the knowledge and insight to provide culturally safe care. Every effort was being made to improve my clinical practice and develop a *comfort zone* in communicating with patients, families, and health care providers. Little thought was given to culturally competent and culturally safe care. As I became more knowledgeable in maternal child care nursing and began my baccalaureate of science degree in nursing, my desire to understand culture, from the context of difference, began to grow. My formal education helped me to develop my understanding of diversity, inclusivity, and to be more pro-active and responsive to the changing health care needs of society. Prior to beginning graduate studies, I was involved in initiating a local Native[2] Awareness Committee at a health care setting for the purpose of addressing cultural issues concerning perinatal health. This initiative stemmed from a hospital accreditation recommending that identifying the health needs of the Mi'kmaq population would help improve their health outcomes. When I proposed the plan to develop a Native Awareness Committee, it was warmly received by the Director of Nursing and senior administration. When the call came for volunteers to be members on the committee some experienced nursing staff welcomed the opportunity to join. In

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[2] Native refers to “A term used to refer generally to Aboriginal peoples. The term ‘Aboriginal person’ is preferred to ‘native’ ” (Government of Saskatchewan, 2012, 31).

addition, community health nurses from First Nations communities and the hospital Mi’kmaq Interpreter (who was also a nurse), were among the members of the committee. During this committee work, I learned more about Mi’kmaq culture than I had learned in the previous 20 years working in maternal child nursing. In collaboration with many stakeholders including First Nations communities, a video titled *Epit Aji-Weje tut* (*A Mi’kmaq Childbirth Video*) (The Native Awareness Committee, 2000), was produced. Although the video was thought to be helpful to Mi’kmaq women, as it focused on procedures and protocols in the hospital setting, it also highlighted the hierarchical, unidirectional approach to childbirth experiences and the medicalization of birthing, which demonstrated a powerful message of unequal power relations between Aboriginal women and the health care system (Grant, Giddings, & Beale, 2005).

It was at this time that I realized that policies and procedures developed for Euro-Canadian women during the perinatal period were designed for the dominant culture. Little thought was given to procedures in maternity and newborn care for minority groups such as Mi’kmaq people. At that time, I began to seriously reflect upon my nursing practice and found myself thinking about changes that nurses need to make to ensure Aboriginal women received culturally safe care. The Native Awareness Committee served as a forum for discussing issues concerning perinatal care such as the labor/delivery environment, labor support, and health care professionals responses to Mi’kmaq women’s needs. However, the committee members could only address more general concerns about Mi’kmaq women’s care. More in-depth research was needed to actually reflect upon their lived experiences of childbirth care and gain more insight into what their experiences meant to them. The information passed on from the First Nations community health nurses and my own observations working in the perinatal unit kindled my interest. In my Master of Nursing work (Whitty-Rogers, 2006), I used feminist methodology and an Indigenous framework to explore the childbirth experiences of 11 Mi'kmaq women living in one First Nations community in Nova Scotia. The findings from my study revealed that Mi'kmaq mothers did not consistently receive culturally competent and culturally safe care. They were first-time mothers who were uncertain about what nursing and medical care they could expect. Many of the women reported that supportive care from nurses and other health care providers would have made a difference in their experiences and health outcomes. For instance, Mi'kmaq women may have experienced less fear and less pain in labor if they had received care that was in accordance with their cultural traditions and beliefs.

From my research, it became apparent that Mi'kmaq women valued the time when nurses listened to their concerns and displayed genuine care (Whitty-Rogers, 2006). The nurses who spent time and were truly present for the women were considered "angels" according to one of the participants. Recognizing the effectiveness of listening and demonstrating sincere caring were determined to be important attributes to increasing the level of trust with patients. From the participants' descriptions of their experiences, it became evident that good communication made a significant difference in the women's relationships with the nurses during childbirth.

It quickly became evident that the Mi'kmaq women faced many barriers to childbirth care such as access to health care, language barriers, and racism and discrimination which created a feeling of isolation for them. Some women reported that they did not always feel respected and were often misunderstood in their communication with doctors, nurses, and other healthcare providers. Others reported that their healthcare providers were insensitive to their needs, yet they outwardly did not complain. Instead, they concealed their true feelings. This study helped me to become aware of the hierarchical nature of the health care system. The existence of power relations and social positions between health care providers and patients is critical (Grant et al., 2005), something that some healthcare providers may ignore or may not even be aware of, as their focus may be on what they think is best for patients and families. It is also important to note how nurses and other healthcare providers hold knowledge and assumptions about particular cultures such as Aboriginal people (Browne, 2005). These assumptions tend to stigmatize the individual by reinforcing ideas that Aboriginal women are different than non-Aboriginal women (Browne, 2005). Thus, as Browne (2005) points out culture is perceived as something that is different from the dominant group.

Aboriginal people have not always felt respected nor have they been given choices about their health care (Browne, 1995). There is a lack of understanding of Indigenous knowledge and ways of knowing. Much of the information about Aboriginal peoples' encounters in the health care system is considered forbidden information in what Cameron (2006) would describe as the unpresentable in nursing. Cameron refers to the work of Lyotard (1984) in describing the unpresentable as "those things that are not easily presented or actually even present within the discourse" (p. 24). Health care needs cannot be addressed without an understanding of Aboriginal peoples' traditions and cultural beliefs.

Although there are some collaborative efforts and some progress being made in building capacity in Aboriginal communities to improve their health outcomes, there is minimal research in addressing gestational diabetes mellitus (GDM) in Mi'kmaq communities in Nova Scotia. As a result of my Master of Nursing work, I feel a desire and commitment to continue to work with Mi'kmaq women and their communities to explore GDM, which was a serious health issue for many of the participants in my previous study.

Acknowledging self-determination and self-government.

It is important to recognize the strength of Aboriginal women and importance of their roles as such recognition helps to increase their self-determination and self-governance (Native Women's Association of Canada [NWAC], 2007a). The goal of addressing inequities in Aboriginal Peoples cannot be attained until they have the right to self-determination. In addition I believe that potential for self-determination is significantly enhanced through the recognition of the important role that Aboriginal women play in their communities. Self-determination refers to a process where individuals feel in charge of their lives; it provides an opportunity to take control of one's life and for Aboriginal women in this case to have freedom of choice to make decisions about their health, economics, and personal choices that are in their own best interests (National Aboriginal Health Organization [NAHO], 2003). Battiste (2000) states

"Indigenous people have the right of self-determination" (p. 169). In other words, they have the right to determine their political position and to freely develop their economic, social, and cultural environment as they would like it to be (Battiste, 2000; NWAC, 2007a). Makokis (2008) comes to know self-determination through ceremony. Makokis (2008) views self-determination as a way for people to "organize themselves from an anti-colonial framework" (p. 39). From this perspective, Indigenous people use their knowledge, language, teachings, and stories in everyday life (Makokis, 2008).

The Royal Commission on Aboriginal Peoples (RCAP) (1996) asserts that Aboriginal people must have the opportunity to gain back their hope and to know that their rights will be upheld. In order to make the structural changes necessary in their communities, a balance of power between the Canadian government and Aboriginal people is needed; new laws and changes must be accompanied by help in building capacity, hope, and confidence that these changes will bring about better life outcomes for Aboriginal people (RCAP, 1996). Having control over one's personal and cultural identity is considered a critical aspect of self-determination (Warry, 2007). Warry asserts that how Aboriginal people feel about themselves is associated with how they think about their culture.

Self-government occurs when individuals or a nation regulates themselves (NAHO, 2003). It is an integral part of undoing the effects of colonization and acknowledges that Indigenous people are entitled to have control over their lives, land, and resources (NWAC, 2007a). There seems to be a strong connection between regenerating sustainable practices of Indigenous Peoples and self-governance (NWAC, 2007a). Aboriginal peoples have developed their economic resources with the input of their communities and on the basis of social justice. As a result, the Aboriginal focus is to manage their territories and resources themselves using their right to self-government. As well, self-government agreements aim to revitalize their culture, to strengthen capacity, and secure adequate food supply and restore Aboriginal knowledge.

The NWAC (2007a) affirms that developments in self-government must respect cultural traditions and values, which include respecting Aboriginal women. Policy makers and political leaders must be aware that "Aboriginal women are the first teachers" to their children, to their language and to their culture (NWAC, 2007a, p. 4). However, both these ora Currently, Aboriginal women have been underrepresented in Aboriginal governance forums (NWAC, 2007a; Stout, Kipling, & Stout, 2001; RCAP, 1996). Hence, incorporating Aboriginal women's views is imperative in policy development. Self-governance, based on traditional values and roles, will see women taking a key role. Perhaps the first steps to taking a lead role in self-governance are having control (self-determination) in the area of child birth, growth, and development.

Although not all Aboriginal women share similar views on self-determination (Makokis, 2008), their stories and understanding of sacred roles will provide insight into their life experiences. Aboriginal women play an integral role in their community as leaders, caregivers, and protectors of their culture (NWAC, 2007a). It has been my experience that they demonstrate incredible resilience and strength despite serious health disparities. In my Master's work, Mi'kmaq women reported some instances where they experienced marginalization and discrimination, yet some of the women took control by asking questions about the standards of perinatal care, recognizing barriers to care, and putting forth recommendations that could improve their health outcomes and those of their families (Whitty-Rogers, 2006).

Aboriginal women's health.

In 2001, Aboriginal women made up 51% of the Aboriginal population, just slightly under half a million people (Statistics Canada, 2005). The female Aboriginal population is growing much faster than the non-Aboriginal population in Canada. From 1996 to 2001, the number of Aboriginal females increased to 22% as compared to only 4% in the general population. In 2001, 32% of Aboriginal females were younger than 15 years of age, compared to 18% of non-Aboriginal females (Statistics Canada, 2005). In 2000, the First Nations birth rate was 23.4 births per 1,000 of their population, twice the Canadian rate (Health Canada, 2005a). Aboriginal women were more likely to be lone parents (19%), compared to 8% in the non-Aboriginal women population (Statistics Canada, 2005). Teenage mothers made up 20% of First Nations births; whereas the general teen population reported only 5.6% teen births (Health Canada, 2005a). These statistics are important data to consider when exploring GDM with Mi'kmaq women because with a growing population of young women (Health Canada, 2005a), the incidence of this condition is likely to be more prevalent amongst the Aboriginal population (Canadian Diabetes Association, 2008).

Aboriginal women in Canada experience a higher rate of poorer health than the general population, as evidenced by conditions such as hypertension, diabetes and GDM, and cervical cancer which impact their health during childbirth (Assembly of First Nations, 2007; Bourassa, McKay-McNabb, & Hampton, 2004; Health Canada, 1999). Current research reveals that Aboriginal women experience a significantly higher incidence of GDM than the general population (Canadian Diabetes Association, 2008). According to the Canadian Diabetes Association, GDM ranges from 8 to 18% in the Aboriginal population, while the occurrence is significantly lower in non-Aboriginal women ranging from 3.5 to 3.8%. There is great cause for concern because GDM is a serious medical condition that may create complications for women and babies during pregnancy and postpartum, as well as creating potential long-term adverse outcomes for both groups.

Although Aboriginal women aspire to have healthy outcomes for their babies and themselves, many of them recognize the social, economic, and political barriers that impact them receiving equitable and accessible health care. This is equally concerning because Aboriginal women's health is already negatively impacted by the broad determinants of health. The broad determinants of health include: income and social status, social support networks, education, employment and working conditions, physical and social environments, biologic and genetic endowment, personal health practices and skills, healthy child development, gender, culture, and health services (Public Health Agency of Canada [PHAC], 2004a; Raphael, 2006). The Social Determinants of Health (SDOH), which arose from the determinants of health, include but are not limited to conditions of childhood; availability and quality of income, food, housing, and employment; and health and social services (Raphael, 2004, 2006). Essentially, the

SDOH refer to the economic and social conditions that affect the health of individuals, families, and communities (Raphael, 2004). Aboriginal women are a vulnerable and marginalized group who are suffering because there is a lack of political will to address their socioeconomic conditions (NWAC, 2007b). Many Aboriginal women recognize the urgency to address health conditions such as GDM as it often leads to chronic illness later in life, but they report that they rarely receive adequate health care and support to remedy the causes and to treat the health conditions (NWAC, 2007b).

Gestational diabetes mellitus (GDM).

GDM is characterized as a carbohydrate intolerance of varying severity first detected in pregnancy and occurring when the body does not use insulin properly during pregnancy (Health Canada, 2007a; Zeck & McIntyre, 2008). It is one of three types of diabetes (Health Canada, 2007a). Type I diabetes mellitus (DM) refers to when the body makes little or no insulin. When the body produces insulin but is unable to use it effectively, it is known as Type II diabetes mellitus (Health Canada, 2007a). Research has shown that women who develop GDM have a 50% risk of developing Type II diabetes over 15 years (O'Reilly, Bottomly, & Rymer, 2005). GDM is likely to occur in future pregnancies (Wong, Perry, Hockenberry, Lowdermilk, & Wilson, 2006) and the risk of developing GDM increases with age, obesity, family history of Type II diabetes, and in minority populations such as Hispanic, Native American, African American, and Asian groups (Wong et al., 2006).

Globally, the prevalence of diabetes is becoming a major concern. The World Health Organization (WHO) (2008) states that urgent action is needed as diabetes-related deaths will increase by more than 50% in the next decade. A study conducted by Wild, Roglic, Green, Sicree, and King (2004) projects that the rate of diabetes world-wide is going to increase from 171 million in 2000 to 366 million in the year 2030. Furthermore, Wild et al. (2004) report that there are more women than men diagnosed with diabetes. These findings are important because raising awareness and implementing effective health policies to address GDM can assist in preventing Type II diabetes and the complications associated with this chronic illness. This is particularly important for Aboriginal people given the high incidence of GDM within their population.

Pregnancy can be a time for promise, excitement, and happiness for women and families, yet it can create uncertainty and fear of the unknown (Canadian Diabetes Association, 2008; Evans & O’Brien, 2005; Health Canada, 2003; Stainton, Harvey, & McNeil, 1995). When women develop GDM, it places them at risk for maternal and infant complications which can have life altering effects on both groups (Snapp & Donaldson, 2006). Therefore, prompt diagnosis of GDM is critical because without treatment it can lead to higher maternal and infant morbidity (Canadian Diabetes Association, 2008). GDM is associated with higher rates of spontaneous preterm delivery, pre-eclampsia, hypoglycemia, and caesarean section (Cheng & Caughey, 2007). Wong et al. (2006) add that these women are at twice the risk of developing hypertension disorders than those without GDM. GDM also exposes babies to a greater risk of illness, congenital anomalies, spontaneous abortion, intrauterine death, and macrosomia (Zeck &

McIntyre, 2008). These children are at an increased risk of developing obesity and impaired mental achievement (Crowther, Hiller, Moss, McPhee, Jeffries, & Robinson, 2005), as well as developing diabetes later in life (Wong et al., 2006).

In addition to the physiological complications associated with GDM, there are a number of social and political conditions which affect Aboriginal women and their families during pregnancy. Healthcare encounters and the politics that shape encounters for First Nations' women are important to examine as they represent and construct social, economic, political and philosophical relations (Browne & Fiske, 2001). Health care settings are environments where Aboriginal women and families frequently encounter situations related to cultural traditions, beliefs, and values when receiving health care from a dominant group (Browne & Fiske, 2001). Bourassa et al. (2004) maintain that Aboriginal women suffer from past colonization and ongoing processes of colonization that directly affect Aboriginal women's access to ways of improving the conditions of their SDOH and hinder their ability to develop a healthy sense of self. The SDOH determine the physical, social, and personal resources necessary to achieve an optimal level of health (Canadian Nurses Association [can], (2005). Even in the face of our knowledge about the SDOH, Aboriginal women continue to suffer as a result of the lack of government policy and action to improve the social and economic conditions that could lead to improved health outcomes.

O'Neil (1986) points out that the relationship between Aboriginal communities and the dominant culture has evolved as a result of colonialism. Colonialism is defined as "the process by which some nations enrich themselves through political and economic control of other nations" (Macionis & Gerber, 2002, p. 304). Colonization, loss of Aboriginal identity (including traditions, beliefs, and values), and the imposition of Westernized health policies are all factors that have contributed to less than optimal health outcomes for Aboriginal women. The colonizers established hierarchies and governments which recognized Europeans as being superior to Aboriginal people and privileged males over females, adults over children, and progressive behavior over the savage people (Henderson, 2000).

Determinants of Health.

The key determinants of health associated with Aboriginal women's health are important to understand in order to address how they impact Aboriginal Peoples' health concerns including GDM. An international conference on Primary Health Care was held in Alma Ata in 1978 with representatives from 189 countries (McMurray, 2007). At this conference, attendees/participants declared that principles of primary health care were required to diminish health inequalities. These principles include: accessibility, appropriate technology, a focus on health promotion, intersectoral collaboration and public participation (McMurray, 2007). Also, it was proclaimed that health is a human right and that social and economic conditions directly and indirectly affect the health of people (WHO, 2006). Representatives from various countries agreed that governments, health care workers, and other stakeholders need to advocate for improvements in social and economic conditions in order to help people achieve their highest level of health (WHO, 2006). It took another two decades before the key determinants of health were developed through a population health approach to address the socioeconomic conditions in Canada (Federal, Provincial, and Territorial Advisory Committee on Population Health, 1999). Initially, nine determinants of health were identified which included income and social status, social support networks, education, employment and working conditions, physical environments, biology and genetic endowment, personal health practices and coping skills, healthy child development, and health services (Federal, Provincial, and Territorial Advisory Committee on Population Health, 1999). It took another two years for Health Canada to add three more determinants which include gender, culture, and social environment (Potter, Perry, Ross-Kerr & Wood, 2006). During the mid-90s, with changes in the Canadian social and health policies, the SDOH were beginning to gain more recognition as being critical to addressing the social safety net (Potter et al., 2006).

Why are social determinants of health a concern?

The health status of Aboriginal women has been largely attributed to the inequalities in the SDOH (NWAC, 2007b). Smylie et al. (2001) report "lower quality housing, poorer physical environment, lower educational levels, lower socioeconomic status, fewer employment opportunities and weaker community infrastructure contribute to less than optimal health" (p. 3). Medical and socioeconomic conditions present barriers to Aboriginal women's health in health conditions such as GDM.

According to Raphael (2004), "Canada's shortcomings in addressing the SDOH are unexpected and a concern given the amount of theoretical and general knowledge known about socioeconomic conditions associated with health" (p. 2). Moreover, Raphael (2004) points out that the SDOH have a greater impact on health and illness than the traditional biomedical model and the behavioral approach. Although there is a significant body of literature on the state of various SDOH, policy-makers, public, and media are not well informed in this area (Raphael, 2006; NWAC, 2007b). Current research tends to focus on the incidence of disease rates and mortality rather than the processes underlying the measures of peoples' health (Richmond & Ross, 2009). The SDOH are major concerns for Aboriginal women living in rural areas in First Nations communities (Shah, 2004). The SDOH may directly and/or indirectly affect Aboriginal women receiving prenatal care. Lack of prenatal care for Aboriginal women with GDM can have serious adverse effects on the mothers and babies.

Aboriginal women lack access to health care providers and in particular Aboriginal health care providers (NWAC, 2007b). The SDOH that contribute to this problem include isolation and a shortage of medical, nursing, and midwifery services in Canada. Aboriginal women have to accept substandard obstetrical care (NAHO, 2006). Community health nurses do not always provide formal prenatal classes to Aboriginal women, a service that non-Aboriginal women take for granted (Whitty-Rogers, 2006; C. Jesty, RN, Aboriginal Community Health Nurse, personal communication, May 24, 2008; Community Health Nurse, personal communication, July 2, 2008). There is some informal one-on-one prenatal education but it does not always provide sufficient information to cover pregnancy-related issues. Although Aboriginal women have tried to convince policy makers and politicians that sameness does not mean equality and that

Aboriginal culture and gender differences must be considered in all policies and programs, there is still extensive work to be done.

Despite the commitment to address health inequalities, Canada's health services have failed to provide gender-sensitive inclusive health care programs and policies for Aboriginal women (NWAC, 2007b). For example, in Nova Scotia diabetic programs have not included gender-sensitive inclusive programs. Within the Aboriginal population, "women are worse off than men" (NWAC, 2007b, p. 5). This situation illustrates "the intersection of race and gender—a double disadvantage which creates unhealthy life and work experiences, continual instances of discrimination and huge gaps in the health of Aboriginal women" (NWAC, 2007b, p. 5).

Gender, as a determinant of health, is considered complex as it includes the economic, social, and cultural attributes associated with being male or female (Native Women's Association of Canada, 2007b). Aboriginal women learn these roles at an early age through family members and elders in the communities.

According to Horne, Donner, and Thurston (1999), gender differences in health services including access to care are not only affected by biological differences but also by socio-economic conditions and cultural issues. For instance, access to health care can present many challenges for women living in rural areas (NAHO, 2006). This is further compounded for Aboriginal women as many do not have cars and there is generally no public transportation (NAHO, 2006), yet women with GDM require more frequent monitoring and follow-up during pregnancy.

Culture is another important determinant of health for Aboriginal women (PHAC, 2004a). For instance, Aboriginal people have a higher prevalence of chronic diseases such as diabetes and heart disease than the general Canadian population. Some individuals and communities may have added health risks related to their socio-economic environment when it is governed by dominant cultural values and policies that continue to marginalize and stigmatize Aboriginal people. This often results in Aboriginal people being unable to access culturally competent and culturally sensitive health care (NWAC, 2007b; PHAC, 2004a). Hall, Stevens, and Meleis (1994) state that "access to care and culturally competent nursing decisions for vulnerable populations require conceptual frameworks and research methods that recognize and incorporate gender, sexual orientation, racial, cultural, social, political, and economic diversity" (p. 24). Understanding marginalization will help nurses to be aware of and comprehend the linkages between vulnerability and health (Hall et al, 1994). Developing and expanding nursing knowledge about vulnerable populations and how knowledge is linked to health care of diverse populations is critical. Meleis (1996) defines culturally competent care as "care that takes into account issues related to diversity, marginalization, and vulnerability due to culture, race, gender and sexual orientation" (p. 2). The changing trends in society and in health care acknowledge the need for culturally competent care (Meleis, 1996).

Purpose of the Study

The primary purpose of the study is to explore and gain insight into the experiences of Mi'kmaq women with GDM in two First Nations communities in Nova

Scotia. Also, the aim of the study is to explore how these experiences have been shaped and impacted by a variety of SDOH and existing health policies. The objectives of this study include: 1) to explore with Mi'kmaq women and community members, including Elders, how to begin a conversation about GDM; 2) to gather the stories of Mi'kmaq women's experiences with GDM through conversation and dialogue; 3) to explore in collaboration with the women the meanings and implications of the women's experiences of GDM; 4) to mobilize possible actions in relation to decisions around GDM within each community.

Research Questions

The following research questions are addressed in my study: 1) What are the experiences of Mi'kmaq women with GDM? 2) How are these experiences affected by a variety of SDOH? 3) From the perspective of the women, what are possible actions that can help Mi'kmaq women mobilize to respond to their needs with GDM?

Significance of the Study

In First Nations communities in Nova Scotia, Mi'kmaq women receive some of their prenatal care in the health centers in their communities, while some prenatal care is provided in non-Aboriginal health care facilities away from their communities. When women develop GDM, they require more frequent follow-up by specialists such as obstetricians, endocrinologists, nutritionists, diabetic educators, and others. They may even require hospitalization in a regional or tertiary care center located a distance from their communities. This situation is similar to other Aboriginal people in Canada who often receive health care at a distance from their home communities and often by non-Aboriginal health care professionals (Baker & Daigle, 2000). When women have to be admitted to a health care facility, providing a family-centered environment can be challenging (British Columbia Reproductive Care Program, 2002). These situations can create anxiety, depression, and less than optimal family functioning because the women are separated from families and in unfamiliar surroundings (Leichtentritt, Blumenthal, Elyassi, & Rotmensch, 2005).

In Canada, minority groups such as the Mi'kmaq often receive health care from health care providers who have beliefs, values, and attitudes different than their own (Baker & Daigle, 2000; Sokoloski, 1995). Some First Nations women view pregnancy as a natural and normal life event, requiring neither medical intervention nor prenatal care (Sokoloski, 1995). Holding different cultural views may contribute to First Nations women's lack of understanding about pregnancy concerns related to GDM. Cultural differences in how one understands the meaning of health, economic, and social conditions must be public health priorities if we are to adequately address health disparities in the Aboriginal population in Canada (Adelson, 2005).

Health planning to address GDM for Aboriginal women requires an approach that takes into consideration not only their health status but also the SDOH that impact upon their lives. Aboriginal women's needs and concerns have been under represented in previous research studies. Including Aboriginal women in research studies to establish key priorities and strategies is an effective way of promoting Aboriginal health (Stout, et al., 2001). The RCAP (1996) recommended that governments and organizations give Aboriginal women fair opportunity to participate in areas that effect the health and healing of their population.

Since there is a paucity of research available in which researchers inquire into the experiences of Mi’kmaq women with GDM, it is anticipated that the knowledge and insights generated from this study will assist Mi’kmaq women and their communities, as well as healthcare providers, gain deeper insights. The results of this research helped the Mi’kmaq women who participated to understand their health and build capacity so that they could begin developing appropriate actions to improve their health and maintain their Mi’kmaq culture. The significance of the impact of the SDOH on Mi’kmaq women’s health, the need for culturally competent and culturally safe care, and the importance of working using a participatory approach are some of the areas that can inform policy development for Aboriginal women’s health in Canada.

Chapter II

Literature Review

Over the past several decades, great steps have been taken to ensure women and infants have healthy outcomes (Public Health Agency of Canada, 2007; Solchany, 2001). In Canada, the health of mothers and infants is considered among the best in the world yet health disparities exist (Public Health Agency of Canada, 2007). The primary factors that are thought to be associated with health disparities include: socio-economic status, Aboriginal identity, gender, and geographic location (NWAC, 2007b; Public Health Agency of Canada, 2007). During pregnancy, health problems may escalate, especially for Aboriginal women because they are a vulnerable and marginalized group and many of them already have substandard living conditions related to low income, lack of education, access issues, and discrimination (NWAC, 2007b).

Health as a Human Right

Health is a human right; "human rights refer to entitlements, freedoms, or privileges to which all people are entitled" (Oberle & Bouchal, 2009, p. 165). Although many would argue that there is equity in the health care system, this is not always the case. Inequities are evident in minority populations such as Aboriginal people, where women in particular experience marginalization and discrimination. There are inequities in the health care system that create barriers to health such as access to transportation to attend health care appointments, no/or limited child care services and language barriers (McGibbon, 2009; Whitty-Rogers, 2006). These barriers impact health outcomes related to the hierarchical system that is often driven by policies entrenched in colonial ideology (Browne, 2005). McGibbon (2009) claims “explicit attention to policy-sustained inequity requires a human rights approach to health system change” (p. 318). Although there have been some improvements in the health status of Aboriginal people and an ongoing endeavor has been to ensure the provision of culturally sensitive health care is provided, there continue to be health disparities and barriers to healthcare in Canada (Browne, Smye, & Varcoe, 2005; Canadian Institute for Health Information, 2004; Stout, Kipling, & Stout, 2001).

Recently, there has been a concerted societal effort to link health and human rights (McGibbon, 2009). The relationship between health and human rights has occurred through national and international unity and general concern for human lives (McGibbon & Etowa, 2009). Health is a universal human right based on not being discriminated against by race, national or ethnic origin, colour, religion, sex, age, or mental or physical disability (Austin, 2001; Constitution Act, 1982). The connection between health and human rights is endorsed by the Canadian Nurses Association (CNA) (2004). The CNA position statement supports the Charter of Rights and Freedoms and the United Nations Universal Declaration of Human Rights. The CNA (2004) recognizes that by promoting human rights they will contribute to improving people’s health by conveying that unacceptable behavior to clients, families, and communities will not be tolerated.

Health care providers such as nurses have an ethical responsibility to provide the highest quality of care to patients, families, and communities. The Code of Ethics for

Registered Nurses is used to guide nurses in ethical practice (CNA, 2008). This document assists nurses by guiding their decisions, relationships, and responsibilities with patients in accordance with nursing standards of care and entry level competencies of registered nurses. Patients must always be treated with respect and dignity (CNA, 2008). Austin (2001) maintains that we all have an obligation to help each other. The human rights model can improve the lives of Aboriginal women as it offers a way to consider complex issues in health care ethics (Austin, 2001).

Austin (2001) points out that the human rights paradigm has been criticized as being individualized and is premised on the fact that there is a universal humanness. From some people's perspective, individualism can be construed as situating persons outside their community as opposed to being part of their community. For example, Marx (1844) maintains that from an individualistic perspective, man is an imaginary figure and therefore loses his real life status. A universal humanness implies that we do not have a "universal human community" (Austin, 2001, p. 191). From a relativistic perspective, moral values developed in communities cannot be judged by people outside their cultures. This human rights paradigm comes from a western stance that is not necessarily shared by eastern world views (Austin, 2001). Although well intentioned, the human rights' phenomena may not be as effective as it was intended. Austin purports that human rights within the realm of health care ethics, a newer concept, may be an approach to addressing some of these challenges and criticisms. This means that health care providers need to understand the relationship between health and human rights and the consequences if people do not receive the health care they are entitled to (Austin, 2001). Raising awareness about the need for equitable health care so that people can have a healthy life is paramount.

The International Council of Nurses (ICN) (2009) also takes the stance that everyone has a right to health. Despite enormous efforts to attain the highest standard of health for all human beings, the goals for Universal Declaration of Human Rights and World Health Organization (WHO) has not been achieved for millions of people in today’s society. Many believe the reason for not fulfilling the obligation to attain health for all is embedded in some major issues such as poverty, discrimination, and social exclusion. Nurses have a responsibility to ensure high quality healthcare is provided according to the Code of Ethics for Nursing and Standards of Nursing Care. The ICN (2009) asserts that “nurses face a dual loyalty” both to their professional responsibility and obligations to their employer” (4).

Likewise, the Aboriginal Nurses Association of Canada (ANAC, 2007) denotes the need, for equitable health care for Aboriginal women and families as it is a basic human right and need for everyone. Providing equitable health care is a responsibility of health care providers. Not only were Aboriginal peoples deprived of their access to health care but also their home and cultural traditions. As well, Aboriginal Peoples lost their language, an act which is viewed as “criminalized” (ANAC, 2007, p. 5). The ANAC calls for the development of cultural safety in practice to prepare and guide nurses working in Aboriginal communities. Safety in health care must be addressed from the social, political, health, cultural and economic needs of Aboriginal Peoples.

McCoy, Labonte, and Orbiniski (2006) argue that health care professionals in Canada have a moral and legal obligation to ensure that the Canadian government fulfills its responsibility to universal human rights, with one of the rights being health. With growing poverty, the Human Immunodeficiency Virus infection/Acquired Immunodeficiency Syndrome (HIV/AIDS) epidemic, and the widening gap between the rich and the poor, we all have a responsibility to address these social and economic concerns. For example, McCoy et al. (2006) call for the public health community to use their skills and values to address issues concerning poverty, and work toward developing a more humane and accountable society.

Warry (2007) urges us to confront misinformation and cultural ignorance within our own culture and that of others. Aboriginal people's basic right to justice and right to democratic processes must be acknowledged and respected when institutional practices may discount their cultural traditions and values. Embracing cultural diversity encourages acceptance of cultural traditions, values, and beliefs (Warry). For example, Warry asserts that an Aboriginal person with cancer may prefer to use Indigenous remedies and cancer treatments (such as chemotherapy) simultaneously. Following childbirth, an Aboriginal mother may prefer to take the placenta home and bury it in a special place in her own community. Although these examples may not be the so called "accepted protocols" or "practices" generally followed in healthcare institutions, these requests require dialogue and consideration as a way of honoring and respecting human rights and respecting cultural traditions, beliefs, and values. For health care providers such as nurses, having an understanding of human rights will hopefully bring a more in-depth understanding of the impact of colonialism and a need for change to address the serious healthcare disparities for Aboriginal women and families.

Overview of Colonialism

Wasekeesikaw (2006) defines colonialism as having power over the other person. This means that a "foreign power or nation superimposes its values and institutions upon another nation for exploitation" (Ing, 2005, p. 6). Colonialism is thought to have originated from the encounter between Native people and Europeans whose ultimate aim was to find cheap natural resources (O'Neil, 1986). Before the arrival of the European settlers, Aboriginal people had their own government and healthcare system (Wasekeesikaw, 2006). According to Smylie et al. (2000), prior to colonization, Aboriginal communities were flourishing in the Americas. Aboriginal people lived off the land hunting and fishing and enjoyed a natural way of life. Initially, the relationships between Aboriginal people and the British and French were respectful and congenial however, greed and philosophical differences in Canada led to the beginning of colonial practices, thereby gradually diminishing the once courteous and respected affiliation. After confederation in 1867, the Canadian government began displacing Aboriginal people from their land to make room for new European settlers. With the land occupation and invasion of Europeans, Aboriginal people developed new diseases and experienced wars and slavery (Smylie et al., 2000). As a result of the economic and ecological changes, they became dependent on the colonial system to subsist (O'Neil, 1986). New governmental policies came into being to "protect, civilize and assimilate the First Peoples into Canadian Society" (Wasekeesikaw, 2006, p. 417). Over time, this political process affected their physical, psychological, and spiritual health. Concurrent policy changes had serious disruptive and oppressive effects on Aboriginal Peoples, much worse than some realized and/or anticipated (Warry, 2007; Wasekeesikaw, 2006). Moffit (2004) supports this notion saying that power plays a key role in colonialism as it creates a hierarchy of domination.

The Indian Act in 1876 was aimed at forcing Aboriginal communities to adopt European values; to assimilate (Ing, 2006; Warry, 2007; Wasekeesikaw, 2006). The Indian Act, although an "antiquated piece of legislation," still has assimilation as a main goal today (Warry, 2007, p. 33). According to Warry (2007), the most apparent assimilation policy was enfranchisement where individuals could receive rights of citizenship if they gave up their Indian status. Residential school practices were another serious assimilation strategy. There are three generations of First Nations people living today who attended residential schools (Ing, 2006). Children were separated from their parents to fulfill the purpose of assimilation which included trying to coerce them into abandoning their cultural practices and values, and joining mainstream society, an act that many consider a form of institutional racism (Ing, 2006). In residential schools, First Nations children were forbidden to speak their language (Ing, 2006). Isabelle Knockwood (2001), a residential school survivor, recalls numerous injustices inflicted on her and other Mi'kmaq children at the Indian Residential School in Shubenacadie, Nova Scotia. Often, children were silenced through "psychological intimidation" (Knockwood, 2001, p. 10). Knockwood described how a woman watched her brother being beaten by a nun but she was terrified to speak out or try to stop the violence. Knockwood (2001) recalled her feelings of betrayal when she got older as the people who carried out the cruel acts were called Father, Sister or Mother Superior, the “very” words that were special to her. Acts of social injustice carried out by influential citizens in high positions of authority in religion and government in Canada are totally inexcusable. These children, now parents and grandparents, continue to suffer in silence. According to Knockwood (2001) and Ing (2005), the treatment at the residential schools has had devastating and detrimental effects on Aboriginal Peoples affecting their parenting skills and overall psychological well-being.

Children who were separated from their families often lost their cultural identity. As a result, parenting skills have not been passed from generation to generation because of many years of separation between children and parents. Steckley and Cummings (2008) acknowledge the value that Aboriginal Peoples place on oral tradition in the form of stories that passed down their teachings to their children. Based on residential schooling experiences, one would wonder about the impact of separation from their parents as the children grew up without receiving these valuable teachings.

Colonization attempted, but failed, to destroy Aboriginal worldviews and Indigenous knowledge (Bear, 2000). Although many were silent victims, they resisted colonization and are now restoring their Indigenous knowledge (Battiste, 2000). However, Bear (2000) claims that the effects of colonization left Aboriginal people with unclear views about their people. They do not embrace Eurocentric views but rather incorporate accurate knowledge of their heritage (Bear, 2000). Indigenous people are now harmonizing their knowledge with Eurocentric knowledge for the purpose of trying to heal and bring back their cultural identity (Battiste, 2000).

Social, political, and economic conditions arising from colonization have created health inequities for Aboriginal women in Canada (Browne, 2005). Colonialism, the Indian Act, and assimilation practices such as residential schools and policies regarding Indian status are among the major assimilation strategies that have had serious disruptive and devastating effects on Aboriginal people in Canada (Bourassa, et al., 2004; Warry, 2007). Despite many atrocities, Aboriginal cultural traditions and values survive.

Although there has been public acknowledgement by the Canadian government of the injustices done to Aboriginal Peoples as a result of colonization, there is still evidence of racism and marginalization in the daily lives of many people in their communities (Adelson, 2005; Battiste & Henderson, 2012; Stout et al., 2001). While the effects of marginalization and racism are apparent in different ways such as in healthcare institutions when Aboriginal women are ignored and or treated unprofessionally (Browne & Fiske, 2001), the health statistics report is without a doubt a major indicator, demonstrating the poor health status of Aboriginal people as compared to non-Aboriginal people. Some would go as far as saying that Aboriginal women’s and men’s health profiles are in keeping with the developing world (Stout et al., 2001). Similarly, the United Nations (2007) recognizes that Indigenous people have suffered many historic injustices as a result of colonialism. The ICN (2009) points out that Indigenous people have suffered from colonialism and have been burdened by policies aimed at trying to assimilate them.

Based on colonial practices, it is not surprising that Aboriginal women feel marginalized and discriminated against on many fronts such as education, health, and politics. Some of the most difficult issues that affect Aboriginal women are associated with paternalism, power differences between patients and families, and cultural misunderstandings in health care settings (Browne, 2005). Browne and Fiske (2001) clearly demonstrate the stereotyping of some First Nations women by health care providers. Browne (2005) calls for the need to situate Aboriginal women's lives within the sociopolitical and historical context.

The ANAC (2007) agrees with others that the negative results of colonization such as exposure to diseases and being forced into living a poor lifestyle (poverty, marginalization, and relocation) continues to have harmful effects on Aboriginal communities. What is most concerning is that many health care providers in Canada lack awareness of the historical, social, and political context of health care and importance of sensitivity to the issue when caring for Aboriginal people. Lacking knowledge of colonialism, health care providers often underestimate the complexity of the situation and attribute Aboriginal culture with poverty (ANAC, 2007; Papps & Ramsden, 1996).

In healthcare, cultural safety is an important concept to consider and understand because it provides "a critical lens to examine health care interactions between the Maori people and white settlers" (Anderson et al, 2003, p. 197). Cultural safety is concerned with examining the structural inequalities, limited opportunities, and unequal access to health care (Anderson, et al., 2003). It is a powerful concept that can be used to challenge unequal power relations in health care and the greater society (ANAC, 2007).

Hence, the ANAC (2007) urges health care providers such as nurses and physicians to recognize and understand the many gifts and resources of Aboriginal people.

Introduction to the Mi’kmaq People

The Constitution Act (1982) states that the term “Aboriginal” refers to First Nations, Inuit, and Métis people in Canada. Aboriginal people use their specific tribal names such as Mi’kmaq, Cree, or Ojibwa to identify themselves (Smylie et al., 2000). According to Davis (1997) the name “Micmac” is derived from the word “nikmaq” meaning “my kin-friends” (p. 23). Over the years, the spelling has changed now to the more contemporary form called “Mi’kmaq.” Their linguistic group is known as the Algonquian group (Baker, 1998). The name Mi’kmaq, formerly known as the Micmac, is preferred by their own people (Paul, 2006). The term Micmac has been in existence for approximately 350 years. The Micmac people were known as the “Souriquois, ‘the salt water men’,” according to the French settlers in order to differentiate them from the Iroquois who occupied “the fresh water country” (p. 4). The Mi’kmaq people have occupied the northeastern part of North America for approximately 5000–10000 years (Paul, 2006). Prior to the Europeans arriving and settling in North America, the Mi’kmaq had a culture that was rooted in “three principles: the supremacy of the Great Spirit, respect for Mother Earth and people power” (p. 7). They had great respect for these principles and had a good standard of living in healthy, thriving, and congenial communities. They were known as a sharing and autonomous society with well-established human rights and no such thing as intolerance. People were not separated by class based on their color, race, religion, or wealth as was prevalent in European societies (Paul, 2006). The Mi'kmaq language was commonly used until the middle of the 20th century (Baker, 1998). Despite colonial intentions to eliminate this language, it is still spoken in some First Nations communities today (Baker, 1998). Also, it is important to note is that Mi'kmaq people speak more slowly than non-Aboriginal people and tend to take more time to respond when communicating with other cultures.

During the past 500 years of European-Native history, changes in the social and economic settings of Mi'kmaq people created a decline in Aboriginal health status (Travers & Paul, 1998). Prior to the settlement of Europeans, Mi'kmaq people had an abundance of food from a number of sources (Paul, 2006; Travers & Paul, 1998). During the spring, they lived near the water and obtained food such as fish, shell fish, sea birds, nuts, and berries. The fall season was a time when the camps moved inland to prepare for the winter hunt. Annual bear and moose hunts were festive events in their communities. Much of this everyday life has changed as hunting, for instance, is becoming obsolete, but in Northern communities this practice is still a vital part of their economy (Warry, 2007).

The Mi'kmaq people continue to be creative storytellers (Paul, 2006). Storytelling was used to celebrate their heroes for the purpose of entertaining and educating the communities. Oral traditions continue to be highly regarded in Mi'kmaq culture as well as other Aboriginal cultures (Battiste, 2000). Wilson (2001) notes that storytelling provides a way of developing a relationship with another person, as the person telling the story engages with the person listening to the story, thereby establishing and maintaining a strong relationship between each other.

Other Mi’kmaq talents include their beautiful art work such as carvings, paintings, quill work, and baskets (Paul, 2006). Contemporary Mi’kmaq art work is prominent in Nova Scotia art galleries and other forums as well as being seen across Canada and internationally. It is an artistic ability that they are proud to possess.

Rather than resorting to physical force, psychology was generally used to sway Mi’kmaq people to abide by Nation laws (Paul, 2006). They were known to be generous and courteous to everyone. Being kind was the expected norm and nothing less was accepted (Paul, 2006). Criminal punishment and the death penalty were rarely an option. This peaceful approach was frowned upon by the Europeans as they viewed this behavior as being too lenient. The European approach was aggressive and they used force as a means to conform.

Health was an important focus and responsibility of Mi’kmaq people (Paul, 2006). Anyone with physical or mental health problems was well cared for. The medicine men used potions and poultices to take care of physical ailments. Information about remedies was passed from one generation to the next. Recently there has been renewed interest in these traditional remedies (Baker, 1998). Mental health problems were rarely an issue and this was attributed to protected and stable lifestyles. Today, approximately $30 million is allocated for mental health crisis programs to provide assessments and counseling to First Nations people and to raise awareness about mental illness and suicide in Canada (Health Canada, 2007b).

The family remains an important unit in Mi’kmaq communities (Baker, 1998). Although divorce was forbidden, separation and common law arrangements existed in their communities. Today, the family structure is similar to mainstream society where there are single-parent, blended, nuclear, and extended families. While men hunted and fished, the women’s roles were primarily in food preparation, taking care of the home, and raising the children. The elders are held in highest regard as they are considered the members of the community with the greatest wisdom.

Religious and spiritual beliefs are an integral part of daily life (Morrison & Wilson, 1995). The majority of Mi’kmaq people identify their religion as Roman Catholic (Baker, 1998). Mi’kmaq people believe in a Supreme Being or Creator. They also believe in supernatural powers, the most significant being the “Glooscap.” Shamans are Mi’kmaq people who have special powers and could foresee the future. Traditional beliefs in mystical powers that were alive in the early 20th century were virtually absent by 1950. However, there has been a revival of traditional spirituality in recent years. Sweat lodges, a traditional form of healing based on the creation story, hold ceremonies in the form of chanting and meditating to restore health and are regaining interest as a traditional healing practice (Baker, 1998). The sweet grass ceremony is another creation story where people gather to pray or begin events (Baker, 1998). Traditional drumming is symbolic of life, with the drum acting like a heartbeat (Baker, 1998). Some Mi’kmaq people use the Medicine Wheel for treatment programs by assigning emotions and spirituality and the physical part of the self to the four quadrants (Battiste, 2000). The aim is to attain balance between all quadrants (Baker, 1998), similar to other Aboriginal people.

Mi’kmaq people did not experience a shortage of food or live in poverty because of their communal practices (Paul, 2006). All members of their community, including the sick and old, were taken care of and never left impoverished. They had a healthy diet and a low level of stress because of their personal safety net. Today, Mi’kmaq communities in Nova Scotia continue to eat some traditional foods (Willows, 2005)- moose; fish such as eels, salmon, and trout; and bannock. However, much of their diet is made up of market foods. Substituting traditional foods with market foods is thought to be a reason for low iron, folacin, calcium, vitamin D, vitamin A, fiber, fruit, and vegetables in their diet, as well as a high sugar and fat intake (Willows, 2005). Many believe the transition from traditional to market foods is a multidimensional and complex process with socio-economic and environmental factors that require further investigation (Willows, 2005). Over time, Mi’kmaq people have adapted to many social, economic, and political changes since the arrival of Europeans (Baker, 1998). Despite colonial pressures and western traditions, they have managed to preserve their cultural heritage.

The Mi’kmaq communities are now governed by a formal band structure (Baker, 1998). One band may potentially be responsible for more than one reserve. The band chief and council are elected to office every 2 years. Band members have to live on the reserve and be 18 years of age or older to be eligible to vote.

Aboriginal Women's Health

Approximately 1,000,000 people identify themselves as Aboriginal in Canada (Smith, Edwards, Varcoe, Martens, & Davies, 2006). In Canada, the largest number of Aboriginal women resides in Ontario, making up 97,000 in 2001 (Statistics Canada, 2005). At that time, 20% of Aboriginal women lived in Ontario, 17% in British Columbia, 16% in Alberta, 15% Manitoba, 13% Saskatchewan, 8% in Quebec, and 5% in the Atlantic provinces and in one of the Northwest Territories (Statistics Canada, 2005). The majority of Aboriginal women live off reserve making up 72% in 2001, while 28% live on reserves in Canada (Statistics Canada, 2005). In Nova Scotia, the majority of Aboriginal women live on reserves.

According to Phillips (1995), "women's health involves women's emotional, social, cultural, spiritual and physical well-being, and is determined by the social, cultural, political and economic context of women's lives as well as by biology" (p. 507). Aboriginal women share similar views on health (Battiste, 2000). Over the past 30 years, the health of Aboriginal women has continued to improve even though health disparities exist between Aboriginal and non-Aboriginal people (Health Canada, 1999; Health Council of Canada, 2011). The Canada Prenatal Nutrition Program, funded by the government of Canada, has two streams: one being the First Nations Inuit Health (FNIH) of Health Canada and the other being the Public Health Agency of Canada. The Canada Prenatal Nutrition Program has delivered programs to Canadian women for over a decade (Public Health Agency of Canada, 2007). The FNIH program is focused on improving the dietary habits of pregnant and breastfeeding First Nations and Inuit women and increase their knowledge on nutrition (PHAC, 2007). In First Nations communities in Nova Scotia, community health nurses are educated in maternal child care and provide perinatal education to women and their families. The community health nurses work at the health centers in each of the First Nations communities where other health services are provided.

Despite improvement in their health, Aboriginal women still experience serious health problems which they are well aware of and deeply concerned about. For example, they have higher rates of suicide, incarceration, substance abuse, spousal abuse, sexually transmitted diseases, cardiac disease, diabetes, and other chronic diseases, and lower life expectancy than the general population (Anderson, 2005; Health Canada, 2005a; Stout et al., 2001). Stout (2005) identifies additional health conditions experienced by Aboriginal women such as high rates of HIV/AIDS, and obesity. The life expectancy is lower among Aboriginal women, 76.8 years as compared to 82 years for non-Aboriginal women (Statistics Canada, 2005). Anderson (2005) concurs, “this is the legacy of colonization, lived out through the day-to-day lives of contemporary women,” (p. 8) which requires that Aboriginal women gain an in-depth understanding of their ancestors’ healthy living practices and an opportunity to reclaim their Aboriginal identity.

Aboriginal women, however, have now placed their emphasis on healing as a way by which individual and collective development can occur in harmony with the environment (Health Canada, 2004; Native Women’s Association of Canada, 2007d). With the control of health care services being given to First Nations communities and increasing acceptance of traditional forms of medicine, there is some optimism about the future direction of Aboriginal women's health in Canada.

Social Determinants of Health and Aboriginal Women's Health

Income is a major SDOH as it is needed to provide basic physical needs such as food, housing, and clothing for women and their children (NWAC, 2007b). Most Aboriginal women live in poverty. The average annual income of Aboriginal women in 2000 was $ 16,519, while the Aboriginal men's average income include was $ 21,958. In comparison, non-Aboriginal women's income was $22, 885, while non-Aboriginal men's salary was $36, 865 (NWAC, 2007b). A recent study conducted in Nova Scotia examined whether perinatal and infant outcomes varied by family income and other socioeconomic factors. The researchers found that GDM was significantly higher among women in lower income families than those in higher family income groups (Joseph, Listen, Dodds, Dahlgren, & Allen, 2007). The study highlights the significant relationship between income and healthy maternal and infant health.

Another factor associated with income, although not singled out as a separate SDOH, is transportation. Transportation becomes a challenge as most Aboriginal women do not own cars, yet much of their healthcare during pregnancy and at birth requires that they travel to health specialists and healthcare institutions outside their communities (Whitty-Rogers, 2006). Therefore, hiring someone to take them to their appointments can be expensive and inconvenient, especially if specialists and services are a long distance from their communities.

Social exclusion is another important SDOH that requires considerable attention (CNA, 2005; Raphael, Bryant, & Curry-Stevens, 2004). Social exclusion is defined as the “inability of certain groups to participate fully in Canadian life due to structural inequalities in access to social, economic, political, and cultural resources” as a result of such reasons as race, class, gender or sexual preference (Galabuzi, 2004, p. 238). Social exclusion provides a helpful way of seeing how some SDOH such as low income, inadequate housing, and food are interrelated and affect people’s health. Social exclusion denies people goods and services and an opportunity to participate in society (Raphael, n.d.). Although these are not choices people make individually, they often find themselves living in less than optimal conditions which are often the case for Aboriginal women. Raphael (n.d.) claims that unemployment and job insecurity are two reasons why social exclusion exists, a common occurrence for this population. Individuals who live in poverty do not have the same resources as those who have a good income (Raphael, 2007). For instance, when Aboriginal women are unemployed, they may not have the income needed to purchase the nutritional food necessary for maintaining healthy pregnancies. Healthy foods are particularly important for women with GDM to maintain glucose control during pregnancy. Also, it may mean that they will not have transportation to receive prenatal care, thus denying women appropriate prenatal care, a service that is meant to be accessible to all women. Therefore, it is not surprising that social exclusion has a serious impact on their health.

Aboriginal women are very aware of gender inequality. They attribute gender inequality to colonization and the paternalistic controls imposed on their communities for the past 200 years (NWAC, 2007b). Prior to colonialism, equity was not a concern. Aboriginal women were held in high regard, and highly respected by everyone, and made decisions. Colonization created a hierarchical environment within Aboriginal communities. The Indian Act brought forward assimilation practices such residential schools and loss of Indian status for the Aboriginal woman who married a non-Aboriginal man (Warry, 2007). On the other hand, if an Aboriginal man married a non-Aboriginal woman, she gained all the rights and entitlements of being a band number. During this transition, Aboriginal men tended to take control over their communities. This change often created dysfunctional relationships resulting in violence and despair. Gradually, as Aboriginal women became more assertive and educated, Aboriginal men began to recognize some of the family changes that were needed but the negative effects have continued to create inequality for Aboriginal women, contributing to their poor health status.

Culturally competent health care is necessary to improve health services and outcomes for clients and families (ANAC, 2007; Campinha-Bacote, 1999, Meleis; 1996). Healthcare providers must demonstrate a genuine desire to work with diverse clients (Campinha-Bacote, 1999). Given the range of diversity, it is impossible to be knowledgeable about all cultures (McGibbon & Etowa, 2009; Willis, 1999). However, having a basic awareness of cultures and cultural sensitivity are minimum expectations of health care providers (Willis, 2009). Raising consciousness about cultural awareness increases the chances that clients will receive culturally competent care (Purnell, 2005). Results of research conducted with some Mi’kmaq women revealed that they did not receive culturally competent care. Negative encounters with some doctors and nurses made these women feel devalued and angry (Whitty-Rogers, 2006).

Some First Nations women are aware of the value traditional knowledge has in validating their cultural identity and helping them move forward in their personal growth (Anderson, 2004) and improving relations with health care providers (Browne & Fiske, 2001). Traditional knowledge is often passed down through generations from female elders (Browne & Fiske, 2001). However, not all Aboriginal women are aware of traditional knowledge and therefore cannot value its importance if they are not aware of it. Loss of traditional knowledge is a result of colonization and needs to be restored (NAHO, 2003).

Callister (2001) asserts that women's healthcare beliefs and behaviors about having a baby are deeply rooted in their cultural context and reflect women's identity. Women's cultural practices, traditions, and values are complex and depend on factors such as support and acculturation into a dominant culture (Callister, 2001). Although individuals share a common birthplace, their cultural traditions may not be similar. Similarly, Sokoloski's (1995) qualitative study of First Nations women in a Canadian urban center revealed pregnancy as a very natural, normal, spiritual event, requiring neither medical intervention during pregnancy and birth nor attending to prenatal care. Traditional beliefs about pregnancy are part of their culture.

Pregnancy

During the past several decades, there has been a strong focus on improving health outcomes for pregnant women and their babies (Solchany, 2001). Much effort has been aimed at educating women and families as to “what to do” and “what not to do” in preparation for and during pregnancy in order to have a successful childbirth (Solchany, 2001). Essentially pregnancy is an important time in women’s lives where the emphasis is on taking care of themselves as they are adjusting to physical and psychological changes and the transition to becoming a mother (PHAC, 2002).

In all cultures, pregnancy is generally considered a time for celebration and anticipation as women and families patiently wait to see their babies (Callister, 2001; Lauderdale & Greener, 1995). Generally, women require minimal interventions during pregnancy and birth; however, prenatal complications can occur quickly and require immediate medical attention (Kendrick & Simpson, 2001). Some pregnancies may become high-risk and require hospitalization (Leichtentritt, Blumenthal, Elysassi, & Rotmensch, 2005). A high-risk pregnancy is defined as “one in which a current disorder, pregnancy-related complication, or external factor jeopardizes the health of the mother, the fetus or both” (Pillitteri, 2003, p. 329). In fact, medical complications that are aggravated by existing chronic conditions such as diabetes and hypertension can leave the mother with less capacity to function, and perhaps affect future pregnancies (Pillitteri, 2003).

Medicalization of pregnancy and birth.

Aboriginal women's traditional experiences of pregnancy and childbirth have changed significantly during the 20th century (NWAC, 2007c). Prior to the middle of the 20th century, Aboriginal women living in rural areas gave birth in their communities surrounded by families and friends and midwives (Couchie & Sanderson, 2007). Over the past 50 years, Aboriginal women deliver their babies in healthcare institutions often by non-Aboriginal health care providers. Although some of their prenatal care is provided by Aboriginal and non-Aboriginal nurses in their communities, women with complicated pregnancies (such as having GDM) require more extensive follow-up by medical and nursing specialists outside their communities. Another issue is that health care providers do not ensure fully informed consent of Aboriginal women for their medical treatment (NWAC, 2007c). Providing information in "lay terms" about potential or recommended treatments or medications for women and the possible risks associated, and allowing women to make informed decisions about their care, is urgently needed. Many years ago, birth was considered a social and cultural community experience. Since then, pregnancy and birth have become a medical event (Jordan, 1983) which is often in conflict with Aboriginal women's views about pregnancy and birth (Sokoloski, 1995).

Medicalization continues to be the fundamental philosophy underlying many current health care policies, practices, and programs in the Aboriginal population (RCAP, 1996). Based on Western scientific beliefs about health and illness, there continues to be a movement to "medicalize social problems as arising from individual lifestyles, cultural differences or biological predisposition - rather than from impoverished social and economic circumstances, marginalization and oppressive internal colonial politics" (Browne & Smye, 2002, p. 29). Although biomedical models have been successful in lowering morbidity and mortality rates, their focus on epidemiology often overlooks gender issues and the social, historical, and cultural aspects of health and illness (Meleis & Im, 2002). Biomedical models tend to endorse the medicalization of women and their bodies, creating feelings of vulnerability, therefore promoting loss of control over managing the whole wellness-illness continuum (Meleis & Im, 2002). According to Couchie and Sanderson (2007), Aboriginal communities and healthcare providers must work collaboratively to address concerns about existing maternity practices.

GDM in Aboriginal Women

Loss of Aboriginal identity, a loss of traditions, beliefs, and values, and westernized health policies imposed on Aboriginal women are factors that have contributed to the root cause of Aboriginal people's poor health status today (Browne et al., 2005). For instance, prior to the 1950s, Type II diabetes was a rare health problem for the Aboriginal population (Young, Reading, Elias, & O'Neil, 2000). However, over the past two decades a significant increase has been seen in communities that have maintained records of evidence. For example, in Sioux Look-Out Zone of Northwestern Ontario, the prevalence of diabetes increased by 45% over 10 years. In Saskatchewan, diabetes rates doubled from 1980 to 1990 (Young, 2003).

Current literature reveals that GDM and Type I and Type II diabetes are higher in the Aboriginal population than the general population (Assembly of First Nations, 2007;

Health Canada, 1999). The increasing incidence of GDM is concerning because research has shown that it is highly correlated with Type II diabetes later in life (Feig, Zinman, Wang, & Hux, 2008; Kim, Newton, & Knopp, 2002; O'Reilly, Bottomley, & Rymer, 2005; Rodrigues, Robinson, & Gray-Donald, 1999; Wong et al., 2006). Diabetes is a serious chronic disease with a number of causes associated with interactions of genetic susceptibility and environmental factors (Health Canada, 2005b; Public Health Agency of Canada, 2003). Many believe that Aboriginal people are more likely to be genetically inclined to store energy from their diet because of the nomadic lifestyle of their ancestors. Changes in diet from traditional foods to market foods high in sugar and fat coupled with sedentary lifestyles resulting in obesity are the major contributing factors associated with diabetes (Health Canada, 2002; PHAC, 2003).

Current research has tended to focus on the prevalence rate (Wild, Roglic, Green, Sicree, & King, 2004), complications or management protocols for GDM (Crowther, Hiller, Moss, McPhee, Jeffries, & Robinson, 2005), and/or cause and risk factors for Type II diabetes mellitus (Young, Reading, Elias, & O'Neil, 2000). Although epidemiology is important, information on the meaning of the experiences of GDM for Aboriginal women and strategies to address this condition have received much less attention.

Dyack, Klomp, Tan, Turnell, and Boctor (2002) conducted a prospective study on all women during childbirth at the Saskatoon Royal University Hospital. A comparative study of Aboriginal and non-Aboriginal women with GDM examined the possible differences in the prevalence rates, risk factors, and general outcomes. The authors report that the most striking finding was that Aboriginal ethnicity was an independent predictor of GDM even without risk factors for GDM. Ethnicity and the basal metabolic index were key components in the relationship as those Aboriginal women who were overweight had a significantly higher risk of GDM compared to the overweight women in the general population. Another important finding was that as age increased in both groups, GDM increased, but it became more prevalent in the younger age group in the Aboriginal population.

A cross-sectional study looking at the prevalence of GDM in nine Cree women in James Bay, Northern Quebec was conducted by Rodrigues et al. (1999). The findings revealed that the inland communities had a higher incidence of GDM (18.0%) than the coastal communities (12.8%), which may be reflective of their lifestyle practices. Cree women were older, had multiple pregnancies, weighed more before pregnancy, and had higher birth-weight babies than women who did not have GDM. The authors concluded that the James Bay Cree community in Northern Quebec had twice the incidence of GDM than women in the Northern American population and the second highest rate in Aboriginal Peoples' in the world. This finding is concerning since over half of these women will develop Type II diabetes later in life (Feiget al., 2008; Kim et al., 2002; O'Reilly et al., 2005; Rodrigues et al., 1999; Wong et al., 2006).

A prospective intervention study by Gray-Donald, Robinson, Collier, David, Renaud, and Rodrigues (2000) was conducted to address the high prevalence of GDM and Type II diabetes among the Cree of James Bay, Quebec. Food and activity interventions during pregnancy had only a minor effect on diet. Discussion with the Cree women revealed “that being plump is desirable,” and physical activity during pregnancy is not encouraged (Gray-Donald et al., 2000, p. 1250). However, older community members considered decreased physical activity a newer phenomenon. Exercise during pregnancy plays a key role in healthy outcomes for mothers and infants. For instance, Snapp and Donaldson (2008) conducted a study to assess the association of maternal exercise and adverse maternal and or infant outcomes with women diagnosed with GDM. The findings of the study revealed that moderate physical activity, walking for 30 minutes three times a week, may lower the incidence of large gestational age infants. Large gestational infants refers to an “an infant whose birth weight falls above the above the 90th percentile on intrauterine growth charts” (Wong et al., 2006, p. 796). In GDM, maternal metabolic substrates, which include glucose, amino acids and free fatty acids, enter the placenta circulation and increase fetal blood concentrations. This chemical action fuels fetal hormone secretion of insulin which in turn increases the rate of fetal growth (Snapp & Donaldson, 2008). The authors have built on previous studies that identified glucose control and a decrease in circulating levels of insulin in women with GDM who exercised regularly.

Prompt diagnosis and management of GDM is critical as there is sound scientific evidence that glycemic control increases health outcomes for mothers and infants. However, some studies have shown that there is inconsistency in screening for GDM as compared to the recommended standards of care outlined by the Canadian Diabetes Association (Cleary, Ludwig, Riese, & Grant, 2006). For example, a chart audit study conducted by Cleary et al. (2006) on Aboriginal women in a northern community in

Manitoba revealed that the screening process for GDM was not consistent with clinical practice guidelines for healthcare providers. Educational sessions to improve screening protocols were given to physicians and other health care providers such as public health nurses to review recommended screening standards. The education session included the importance of screening high-risk women between 24 and 28 weeks gestation, while screening in women with a number of risk factors should be done in the first trimester. Although there was an increased awareness for adhering to screening protocols during pregnancy, a number of Aboriginal women did not receive the recommended screening. Thus, the protocols were not always followed despite the education sessions.

A qualitative study conducted by Neufeld and Marchessault (2006) gathered the perceptions of two generations of Aboriginal women on causes associated with diabetes during pregnancy in a southern Manitoba Saulteaux community. The participants were Aboriginal women, 14 of the participants were grandmothers and 14 women were of child-bearing age. Both groups of Aboriginal women interviewed associated sugar and processed food to diabetes during pregnancy. Grandmothers, however, linked decreased activity and increasing maternal weight to GDM while the mothers expressed concern that stress was a primary factor in causing diabetes during pregnancy. This study highlighted the importance of listening to Aboriginal women's experiences and the importance of considering the complexity of developing interventions that may help to decrease the incidence of GDM. Participants in this study were concerned with preventative measures such as traditional foods (for example wild meat and wild plants).

Helping women to change their lifestyles needs to be carefully thought through as the historical context of their experiences plays a major role in their understanding of GDM.

In my qualitative study on Mi'kmaq women's childbirth experiences, 5 out of the 11 women reported they were diagnosed with GDM (Whitty-Rogers, 2006). The participants described their fear of dying because many of their family members died with complications associated with this health condition. These women were also afraid that their babies may die for similar reasons. A major finding in my study was lack of knowledge about diabetes. Many Mi'kmaq women expressed that they would have benefited from more information from nurses, physicians, and other health care providers during pregnancy and birth.

Indigenous Knowledge

Understanding Indigenous knowledge helps one appreciate the richness of Indigenous languages, worldviews, teachings, and experiences. Although not necessarily acknowledged by mainstream society, Indigenous knowledge has always existed (Battiste, 2000). Indigenous knowledge is sometimes referred to as 'Traditional knowledge' or 'Aboriginal knowledge'. In the Constitution of Canada, Indigenous knowledge, languages, and legacy are protected by Aboriginal and treaty rights (Battiste & Henderson, 2000). Indigenous knowledge is "a learned way of looking at the world that may have very different forms of acquisitions, transmission, and manifestation for Indigenous peoples" (Battiste & Henderson, 2000, p. 48). NAHO (2003) refers to Indigenous knowledge as communal, holistic, and spiritual information and understanding that is an integral part of human existence. Thus, Indigenous knowledge is not separate from Aboriginal women's lives but rather it is connected to physical, emotional, mental, social and spiritual well-being (NAHO, 2003). Without this knowledge, Aboriginal women may not feel they can maintain their health when all of their systems are out of balance.

Indigenous knowledge may inform the development of culturally appropriate institutions to address issues around economic, health and social conditions that Aboriginal people encounter (Warry, 2007). In fact, acknowledging and privileging Indigenous knowledge is a way of rejecting colonialism (Warry, 2007). According to Berkes (1999), Indigenous knowledge provides the means to shift power relations between Indigenous peoples and governments, in a way that empowers Indigenous people and gives them political control.

Indigenous knowledge is transmitted through oral traditions. Indigenous languages provide a way of understanding Indigenous people's experiences and are critical for continued existence of their culture. Battiste and Henderson (2000) concur that languages hold their knowledge and teachings; therefore they consider their languages a form of spirituality. Additionally, language provides a connection to the ecosystem, which is a knowing that comes from valuing people in the world. For instance, the Mi'kmaq language reflects how they live, how they treat people and how the world fits into life (Battiste & Henderson, 2000).

Current Policies, Programs & Practices

Current policies, programs, and health care practices in Canada affect access to health care which is a concern for Aboriginal women with GDM who already experience greater economic, social, cultural, and political inequalities than the general population (Adelson, 2005). According to the Canada Health Act (1984) everyone in Canada should have reasonable access to medically necessary hospitals, doctors, and health services (Health Canada, 2008; Petrucka, et al., 2010). Reasonable access refers to “residents of a province or territory are entitled to have access on uniform terms and conditions to insured health services at the setting ‘where’ the services are provided and ‘as’ the services are available in that setting” (Health Canada, 2008, p. 5). Many policymakers, politicians, and others believe that since the Canada Health Act is in place, Canadians have access to health care services; however this is often a fallacy. A beginning point to understanding the complexity of the term “access to health care” is to examine some gaps in and barriers to Aboriginal women receiving prenatal care. This section will attempt to identify some of the gaps/barriers in services facing many Mi’kmaq women in Nova Scotia and other Aboriginal women in various parts of Canada.

Access to health care is a major barrier for First Nations women with GDM (NAHO, 2006). The current healthcare system is structured in a manner in which Aboriginal women who require specialized services for prenatal care or postpartum care must travel outside their community (NAHO, 2006). Generally, family physicians are hired for First Nations health centers but they may not be present in the communities when women need medical care. Typically, their time is divided between hospitals and

First Nations communities. Although there are policies in place to ensure physicians will provide high–level maternal child care to these women, if the physician is not available, some First Nation's women are deterred and do not seek health care. Often First Nations people mistakenly interpret health workers absence as a lack of caring and neglect.

Continuity of care is another major issue for many First Nations women (NAHO, 2006). Although the Association of Women's Health, Obstetric and Neonatal Nurses (2009) recommends continuity of care for pregnant women, this recommendation is not always a reality for Aboriginal women. Continuity of care means that women are cared for by the same health care providers throughout their pregnancy. When there is lack of continuity of care, many First Nations women experience anxiety and frustration (NAHO, 2006). Frequently they are referred to different healthcare providers who are unfamiliar with their health history. Additionally, lack of continuity of care may mean that these women are reluctant to continue with scheduled prenatal follow-up.

Lack of transportation presents another barrier to health services for First Nations women as many of them do not have money to pay for transportation or own their own cars (NAHO, 2006). Research has shown that low-income women find transportation, long waiting times, and family and social issues to be factors influencing prenatal care (Bloom et al., 2004). Mi'kmaq women identified lack of transportation as a major obstacle to obtaining prenatal and intrapartum care in the tertiary health care setting, located 45 minutes from their community (Whitty-Rogers, 2006).

Jurisdictional issues are sometimes an issue because both federal and provincial funding are involved, and the co-operation between both funders may create systemic gaps in health care services. For example, when First Nations women are discharged from the hospital after having their baby, they are often sent home without the on-reserve providers being notified. Breastfeeding is another important reason for close follow-up because education and support from healthcare providers can help the women establish their breastfeeding (Martens, 2002). Although Aboriginal women are given the option to use the services off the reserve on weekends and weekdays, they have to travel to a hospital, which for some may be a long drive, if they even have access to transportation.

Communication has proven to be another barrier to health services for Aboriginal women. Perinatal care is based on evidence-informed practice, where nurses, physicians, and other health care providers strive to provide the highest quality care, yet some Aboriginal women report that they do not receive culturally competent health care which includes consideration for language and communication. As a result, this lack of communication seems to be counter-productive to First Nations women receiving appropriate health care. For example, although health care providers state/imply that they have communicated with First Nations women and families through the use of discussion, educational material, and demonstration, this does not mean that the women understand what is being said. Effective communication requires that health care providers put forth a genuine effort to understand what the client is saying (Callister, 2001). Davidhizar and Giger (1998) suggest that although communication barriers exist when people speak the same language, these barriers become greater when people speak different languages such as Mi'kmaq. Therefore, nonverbal and verbal communication become equally important and need to be considered during interactions with clients (Davidhizar & Giger, 1998).

Conclusion

The literature review demonstrates that there are several factors that impact Aboriginal women with GDM. Many of the barriers to health care are rooted in the determinants of health, specifically the SDOH. Aboriginal women's less than optimal living conditions and poorer health than the general population stem from colonialism and assimilation practices. Research has shown that health inequities occur as a result of social, economic, cultural, and political inequities which lead to illness and suffering for Aboriginal people (Adelson, 2005; Browne & Smye, 2002; Browne & Fiske, 2001). Consensus among scholars is that although there are inadequacies in the health care system, inequities in health are rooted in the historical relations between Aboriginal Peoples and the Canadian nation (Adelson, 2005) and are sustained by current health practices. In other words, current health inequities are not the result of inherited traits of Aboriginal people.

Although there have been some attempts to improve Aboriginal Peoples' health through construction of health centers in their communities and programs to address health needs such as the Canadian Prenatal program, there are still issues around access to care, marginalization, and discrimination for them. During pregnancy, women need ongoing prenatal follow-up and culturally competent care to help to ensure healthy outcomes for mothers and babies. Policies, programs, and healthcare practices are important areas to examine with Mi’kmaq women to determine how we may be more effective in meeting their needs as Aboriginal women continue to experience greater economic, social, cultural, and political inequalities than the general population (Adelson, 2005).

Chapter III

Methodology and Method

Critical Ontology

My nursing journey has helped me understand Aboriginal ways of life and the impact of colonialism and assimilation on Aboriginal women in particular. Prior to my Master of Nursing work, I began to develop working relationships/partnerships with Aboriginal communities in Nova Scotia. I feel a sense of connection that we are building trusting relationships; I feel welcome and accepted in First Nations communities in my role as a nurse educator and as a person wanting to help to improve health outcomes with Aboriginal people.

Gradually, I understand my middle class "White privilege position" as something I am not proud or ashamed of and something I cannot change. Recognizing the importance of Whiteness is essential for Indigenous and non-Indigenous scholars to understand when engaging in Indigenous research (Wilson, 2003). According to Wilson (2003), "as part of their 'white privilege' there has seldom been a requirement to see each other's ways of being and doing or even to recognize that other ways exist" (p. 161). The term White has often been associated with European ancestry (McDermott & Samson, 2005). Some people believe the term Whiteness indicates that one holds a privileged position in society (Katz, 2005; McDermott & Samson, 2005), where privilege equates power. The work of Foucault helps me understand this notion of "power limits" (Dzurec, 1989, p. 492). In this limiting role, power is maintained at all levels in society through daily interactions with others. As a White nurse researcher I have to be cognizant of power relations when conducting research with Aboriginal women because it can be seen as another form of domination and oppression.

A critical ontology vision perspective helped me to connect with Aboriginal people in different ways where new ways of being and different ways of connecting will continue to shape my way of thinking (Kincheloe, 2006). By using a critical ontological approach, I was able to understand myself more and how my beliefs and values have been influenced by my culture and society. This process helped to raise self-awareness and give me more insight into how and why my beliefs have been influenced by religion, gender, race, sexual orientation, and politics in the western world (Kincheloe, 2006). It provided future direction so that I can move beyond my current state of being, as critical ontology is concerned with the epistemology and ontological power of being different (Kincheloe, 2006). People begin to develop an ontological vision about ethics, politics, and inner feelings to help them navigate the system and to discover ways of being human. Using this approach helped me to see the world more from the Aboriginal women’s perspectives and may assist in creating a synergy where the results of collaboration between First Nations participants and communities and me come together and bring a new dimension and a richness to the experience. It will help to free my thinking from Cartesianism, which separates me from everyday surroundings, opposite to the way Aboriginal people see themselves connected to the cosmos. As Kincheloe (2006) points out, Indigenous knowledge emerges within the ontological realm. This means that Aboriginal people can come to understand their state of being and who they are from an ontological perspective. It is not until they know where they have come from, the role of colonization, experiences of marginalization, and the issues around intergenerational trauma that they can understand themselves and be able develop strategies to address their barriers and improve their lives (Bucharski, Reutter, & Ogilvie, 2006). In a qualitative descriptive study by Bucharski et al. (2006) on culturally appropriate HIV counseling and testing, Aboriginal women asserted that the solutions come from within themselves and they have "the knowledge and the capability and the expertise" (p. 733). The Aboriginal women were referring to the importance of playing a primary role in being involved with policy and program development in HIV planning.

Research Design: Two-Eyed Seeing Approach

This research study has grown out of my Master of Nursing study(Whitty-Rogers (2006) and long standing relationships with First Nations communities as evidenced by Charlotte Jesty's (Aboriginal community health nurse) attendance and participation at my PhD oral candidacy exam. These relationships that I have built and continue to build in First Nations communities in Nova Scotia are essential to working collaboratively with First Nations communities. As Charlotte Jesty has pointed out to me on several instances during my previous research and as I embark on this study, First Nations people need to trust you before they consider engaging in research. I have learned this in my previous study as well as in clinical experiences with Mi'kmaq women in the health care setting. I value their respect and honesty as women share very private and in some instances intimate details about their personal life.

Two-Eyed Seeing (Marshall, 2007) is an umbrella approach that blends our knowledges together-Western and Indigenous. The use of both Indigenous approaches and Western methodologies were needed in this study in order to represent the multiple realities of Aboriginal women's experiences with GDM in Nova Scotia. I recognized the importance of avoiding positioning myself totally in the Western or Indigenous paradigm when doing Aboriginal research because it could limit my understanding of the women's experiences rather than valuing both entities for developing knowledge through a Two-Eyed Seeing perspective (Marshall, 2007). Two-Eyed Seeing (Sesatuk Etuaptmnkl) is an approach developed by Albert Marshall, a well-respected Mi'kmaq educator and Elder in Nova Scotia, for the Integrated Science Program at Cape Breton University, Nova Scotia. The purpose of this integration is to bring Indigenous and Western science together (A. Marshall, personal communication, June 28, 2009). According to Mendez (2007), "the value of ancestral knowledge of native sciences to Canadian society is immense. This knowledge encompasses the spectrum from medicinal properties of plants and herbs, and the holistic approach to health care to environmental issues" (p. 3). Two-Eyed Seeing is a metaphor for blending scientific and medical knowledge that takes into account the contributions of Aboriginal cultures, science, and experience. As Elder A. Marshall (personal communication, June 28, 2009) says it is not enough to go through life with one perspective; we must embrace all the tools. As discussed above, Two-Eyed Seeing includes Western and Indigenous approaches.

Participatory Action Research (PAR) is the philosophical western approach that forms the backbone of the study. Five specific principles of PAR (see below) are followed in this study. These principles guided, infused, and informed all the research activities and were integrated throughout my study.

Indigenous approaches[3] using the work of (a) Shawn Wilson, (b) Charlotte Loppie, and (c) Marie Battiste, all highly respected Aboriginal researchers in Canada, formed the Indigenous approach and the sacrum of the study. An historical etymology for the word "sacral" is that it is rooted to the earth and very scared (Skeat, 1958).

With PAR and Indigenous approaches blended together in two-eyed seeing, I conducted a situated study within Mi'kmaq communities. I learned a significant amount from my work in terms of these approaches. I kept track of the tensions and the things that worked well in my journal. I built times of reflection into the process-times to reflect with the women, with the communities, with my supervisory committee, Charlotte Jesty RN, Aboriginal community health nurse and other community advisors. I outlined the principles of these two approaches below and how they were used with the research methods.

I knew that there needed to be some way of understanding what I was discussing in conversational interviews and talking circles that had a specific and rigorous western methodology for data analysis to bring these two overarching approaches together. Pidgeon and Hardy Cox (2002) caution researchers to be sensitive in their western approach to research to avoid using assumptions and principles of research methodology

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[3] I will use the terms Indigenous 'approaches' instead of using the words Indigenous 'methodologies' because Indigenous methodologies are in the process of development, through the work of both indigenous and non-indigenous scholars. The etymology of the word methodology refers to "the abstract theoretical assumptions and principles that underpin a particular research approach, often developed within a specific scientific or social science disciplines" (Grant & Giddings, 2002, p. 12).

that may create a distancing of learning from Aboriginal people, thus compromising addressing important issues and concerns. This caution and others led me to think about data analysis of the transcript data from the interviews and the talking circles. While I did not want to undertake another western methodological approach, I also did not want to position any of the data without understanding how the women would interpret their experiences on the transcripts.

The principles of hermeneutic phenomenology for data analysis were appropriate to understand the experiences of GDM and the participants' lived interaction with health care and policies. This approach to data analysis breathed air into the study and in fact was the lungs of the research design. It allowed for a description of each woman's experiences as well as a reflective interpretive discussion with them that prevented me from jumping to conclusions based on my understandings alone. The Indigenous approaches guided and enabled me to blend the ontology they espoused with the epistemology of hermeneutic phenomenology. Therefore the study approaches ended up being Indigenous approaches (ontologically and culturally safe). Participatory Action Research (research design and research processes epistemology), and hermeneutic phenomenology was used for data analysis with the philosophy of critical hermeneutics assisting with the framework for the findings and discussion around the SDOH and inequities the women experienced. Together these created the critical ontology I was looking for (Kincheloe, 2006) and created the flow I needed between the two approaches for Two-Eyed Seeing. Each of these is discussed below.

In this process of breathing, I encouraged and tried to understand what was told to me (conversational interview and talking circles) but I also looked for deeper meanings from the descriptions that were hidden from view and overlooked in previous research because of the approach or design of the study. My goal was to bring new understanding to the question of what it was like for these women to live with GDM. In the discussion, I used the SDOH as my theoretical framework to understand the participants' experiences. For example, based on the findings, using a SDOH framework, what do the women's stories tell us about the determinants of health, the generation of inequities in GDM for Mi'kmaq women, and the possible solutions seen from both sides? How would we address these equities and inequities?

Outlining and presenting these findings in a talking circle brought me back to the action cycle of PAR. Based on these talking circles and individual conversations we came up with further actions needed to address these findings and decided on which actions we wanted to address within this doctoral study.

Research Methods

There are many understandings of the way to undertake participatory action research (PAR). For example it is a methodology to some, a philosophical approach to others. For the purposes of this study, I incorporated specific principles of PAR which include 1) collaboration; 2) democracy, which means that the participants can freely participate; 3) equity, which recognizes Mi'kmaq women's equality amongst themselves and with the researcher and; 4) improved social practice; and 5) reciprocity as will be described below. It is considered a philosophical and guiding approach in doing research with Aboriginal peoples as explicated in Canadian Institute of Health Research guidelines (CIHR, 2007) and according to the OCAP Principles (Ownership, Control, Access, and Possession) developed to monitor research with Aboriginal peoples and as a means to protect their culture and language (Schnarch, 2004). I used these PAR principles as a philosophy to follow and a way that I believe aligns with the Indigenous approaches previously mentioned and outlined in what follows.

The philosophical premise of PAR is that people are not objects or tools that researchers can manipulate (Obilade, 2005). Rather, they are people who are valued for their knowledge and their life experiences. The philosophical underpinnings of PAR are congruent with "postmodern tradition that embraces a dialectic of shifting understandings" whereby "objectivity is impossible" and "multiple or shared realities exist" (Kelly, 2005, p. 66). From this perspective, different forms of knowledge are valued and shared. Vollman, Anderson, and McFarlane (2004) state that PAR is "a philosophical approach to research that recognizes the need for persons being studied to participate in the design and conduct of all phases (e.g., design, execution, and dissemination) of any research that affects them" (p. 129). Adhering to these principles throughout the study and consistently checking with the participants concerning their experience of the research activities served as a way to maintain a culturally safe environment.

PAR resulted from the work of Kurt Lewin (1944) who many consider to be the founder of action research (Gillis & Jackson, 2002; Stringer, 1999; Young, 2006). Lewin introduced the term “action research” as a way of examining the social system and at the same time aiming to change it (Gillis & Jackson, 2002). Results of Lewin’s teamwork, using action research revealed that research could be an effective method of change. Streubert-Speziale and Carpenter (2003) add that action research assists with understanding human experience that goes beyond the “traditional researcher and participant dichotomy” (p. 253). Ontological threads that underpin action research encompass that action is value laden and morally committed. Action researchers view themselves in relation to another individual in their social contexts (McNiff & Whitehead, 2006). The epistemological foundations for action research aim to solve problems “in a given context through a democratic inquiry where professional researchers collaborate with participants in an effort to seek and enact solutions to problems of major importance to the local people” (Greenwood & Levin, 1998, p. 75). Action research fits in the realm of social science, where this research tends to focus on trying to solve complex issues of daily living (Greenwood & Levin, 1998). When using an action research process, participants can determine whether the proposed research design will be effective in solving their problem(s).

PAR Principles-My Backbone

Collaboration.

Collaboration refers to working together for a common goal (Koch & Kralik, 2006). Researchers and participants try to identify common ground for whom the research is important and who would benefit from it, such as stakeholders, participants in the study, community members, or health care providers. Collaboration does not equal harmony and therefore every effort must be made to develop a relationship with others and try to find a way to work effectively together. Collaboratively, through ongoing conversations and back and forth discussions, participants and researchers can discuss ways to improve current situations and build capacity (Koch & Kralik, 2006).

Respectful research with Aboriginal women is needed to address issues related to and arising from their experiences with GDM. Respectful research means to understand and respect Aboriginal worldviews and to ensure protection of their culture and knowledge (CIHR, 2007). In recent years, researchers have begun using (PAR), an approach that allows participants to have a voice and be engaged as co-participants in the research process (Gillis & Jackson, 2002; Streubert-Speziale & Carpenter, 2003). Like other researchers, I have chosen PAR because it provided an approach where Mi'kmaq women and their communities would be respected and valued for their Indigenous knowledge and would be active participants in the research. Koch and Kralik (2006) concur that PAR brings researchers and participants together in a way that creates and shares spaces for working in a collaborative and trusting environment that will create meaningful knowledge. Collaborative means developing a partnership within a framework that includes trust and cooperation between the researcher and the Aboriginal communities (CIHR, 2007).

A critical and foremost component of this research is to build a trusting relationship with the Aboriginal women and their communities using a collaborative and participatory approach to help them critically examine their experiences with GDM. This research was built on my Master of Nursing work where I engaged in a qualitative study using a feminist methodology and Indigenous framework to examine the childbirth experiences of 11 Mi'kmaq women living in a First Nations community in Nova Scotia. This previous research experience helped me examine and reflect upon my own personal beliefs, biases, and has opened my eyes to Aboriginal world views.

Democratic.

A second PAR principle that guided my research is democracy which means that individuals choose to freely participate (Koch & Kralik, 2006). This means that the participants were involved at all stages of the research process. The issue being studied needed to originate from the participants and the First Nations communities. Participants could be involved in developing the research design in collaboration with the researcher, data collection, and data analysis and be a participant in the dissemination of research findings. There is a partnership formed between the researcher and the research participants (Koch & Kralik, 2006).

Equitable.

The principle of equitable recognizes Mi'kmaq women's equality amongst themselves and with the researcher served as a third PAR principle that guided the study. PAR promotes participant control and learning takes place through mutual interaction between the researcher and participants (Gillis & Jackson, 2002). PAR provides an opportunity for participants and researchers to decide together on the outcome of the study and the dissemination process (Koch & Kralik, 2006). For instance, people who have an opportunity to participate in developing a policy or program are more likely to feel ownership and a willingness to use it (Patton, 2002). Knowledge generation is a critical component in PAR (Dickson & Green, 2001; Maguire, 1987). Hence, "People's experiences are valued in participatory research as theory is generated from the experiences, lives and understandings of all participants" (Koch & Kralik, 2006, p. 9).

Improved social practice.

Improved social practice was another key principle of PAR in this research. An important aim of PAR is to bring about social change, which can address the inequality of power distribution (Koch & Kralik, 2006; McTaggart, 1989). The intent was to affect the lives of the participants in the study in a manner that they perceived as beneficial. The social change in many instances raised consciousness or behavior changes of the participants in the study. Consciousness-raising is an important process in PAR because it enables people to view the world differently (Koch & Kralik, 2006). It is rooted in feminist and political movements (Henderson, 1995). Consciousness-raising is concerned with social, political, and economic limitations on freedom and provides the opportunity to engage in social action to effect changes (Henderson, 1995) and matches the critical ontology of Kinchole (2006). The dialogue that occurred with consciousness-raising helped Mi'kmaq women in my study gain insight into how they can take action to challenge some of the barriers to health care (Henderson, 1995). In some instances the Mi'kmaq women took action on their own such as changing their eating habits, increasing physical activity and worked on restoring their language as discussed throughout the study.

Reciprocity.

A fifth PAR principle that guided my study is reciprocity when entering into research with Aboriginal women. The nature of reciprocity is such that it helps to dispel the hierarchical state between the researcher and those being researched through a back and forth discussion (Koch & Kralik, 2006). Reciprocity may give researchers and individuals involved in the research a sense of their own identity (Bannister, 1999). From a philosophical perspective, Habermas (2002) helps us to understand reciprocity by saying that it is the "experience of a closeness across distance to another acknowledged in his or her difference" (p. 74). Habermas (2002) claims that reciprocity acknowledges the relationship without restriction, where the person is associated with another without being subjected to violence, which results in benefiting both. In this way, both persons feel valued in the relationship. Valuing the lived experience is an important characteristic of PAR (Fals Borda & Rahman 1991).

Genuine research collaboration develops when researchers and Aboriginal people enter into a partnership where there is mutual trust and respect (CIHR, 2007). Within a trusting and respectful relationship, PAR principles can ensure there is equity, respect, power sharing, and that everyone is involved in the decision-making process (CIHR, 2007).

PAR is becoming a common methodology and is widely accepted for increasing knowledge and empowering research participants (Dickson & Green, 2001; Park, Brydon-Miller, Hall, & Jackson, 1993). Since this research approach is effective for examining the daily lives of people, producing knowledge, and addressing inequities through action initiatives, it is an appropriate methodology for research with Aboriginal people.

Challenges of PAR

Wadsworth (1998) points out that a major challenge for individuals using PAR is designing a process, which can result in innovativeness and imagination. Some scholarly work has originated from researchers who found unique sources for ideas and then sought opinion from experienced researchers (Wadsworth). A large part of success in using PAR comes from individuals who know their research method and have the imagination to envision a situation and then encourage others to share the vision. These were reasons why I endeavored to collaborate with the Mi'kmaq women and community members on an ongoing basis throughout the study.

It is paramount to note that some individuals criticize PAR for being a "soft method" referring to methodologies (Young, 2006, p. 501). This idea originates from researchers who hold science in high esteem as the only truth (Fals Borda, 2001). Fals Borda (2001) maintains, "truth is revealed and established more through the testimony of actions than through logic or even observation" (p. 30), and like many PAR researchers he considers science as socially constructed, generating significant knowledge for important causes. However, neglecting to use a participatory approach for Aboriginal research violates the CIHR guidelines which advocate for this approach because it promotes a strong partnership, allowing for full participation, equal power relations between participants and researchers, and involvement in the decision making process (CIHR, 2007).

Another challenge when using PAR is to ensure community members are active participants in the research process (Gillis & Jackson, 2002). Ensuring that all community members are invited to participate takes considerable time, planning, and knowledge about the community. Decisions need to be made as to who will be involved in the research and who will be co-researchers, in addition to which members will provide data and validate results at different stages. In this research, it was important to include participants who wanted to participate as well as to include other community members in the discussions.

Issues concerning power imbalances and egalitarian relations require constant monitoring (Gillis & Jackson, 2002). Novice researchers need to be aware that there may be shifting of power during the research project because community members could change as a result of moving or electing not to participate. Being sensitive and responsive to all members of the community is critical (Gillis & Jackson, 2002). There were times when the community members took the lead, especially at the implementation stage, while at other times I took the lead at the information and talking circles.

Greenwood and Levin (1998) caution us that PAR and participatory research approaches are constructed on “political analysis of power relations” and the belief that change happens if people relinquish their power and address the oppression (p. 175). Therefore, getting along does not represent sustainable social change (Greenwood & Levin, 1998). In keeping with CIHR (2007) guidelines, I was vigilant in making certain that communication is continuous, accessible, transparent, and there was clear understanding with the community as part of the research process.

Analysis of transcript data was another challenge to PAR. While often a straightforward approach such as qualitative data analysis is used, here in being true to the Indigenous principles and the PAR research process, I needed to look at the deeper meaning of the experiences.

Indigenous Approaches (Sacral Part of Study)

Knowledge is considered relational in an Indigenous paradigm; it is shared and interpersonal relationships are integral to the research (Wilson, 2001). Relationships are not just with the participants but they encompass the cosmos, as knowledge is shared within the universe which makes up animals and plants (Wilson, 2001). When using an Indigenous approach, the researcher should ask how he/she is fulfilling his/her relationship within the world (Wilson, 2001). The morals also known as the axiology are concerned with how one is gaining knowledge and then using that knowledge to fulfill the obligation in the relationship between the researcher and those being researched. Understanding and respecting Aboriginal worldviews can help to establish effective relationships with participants and communities (Canadian Institute of Health Research, 2007). Thus, I would not have been able to fully explore Mi’kmaq women’s experiences with GDM if I was limited to only a western approach to research. My previous experiences working with Mi'kmaq women as a maternal-child nurse helped me to understand some of the complications around perinatal care and GDM. Building a trusting, respectful, and sensitive relationship was crucial to the Mi'kmaq women conveying their experiences to me. My previous Master's work has revealed the high incidence of GDM and some concerns that Mi'kmaq women have during pregnancy. My relationship with the women participants in my Master's study were trusting, respectful, and reciprocal; some of the women expressed interest in being involved in future research work with me in this area.

Battiste (2000) asserts that protection of Indigenous heritage and culture is paramount when conducting research with Aboriginal communities. Similar to Wilson's (2001) view, Indigenous knowledge "embodies a web of relationships within a specific ecological context," and therefore Indigenous people possess their own knowledge, traditions, and customs within their culture (Battiste, 2002, p. 14). Furthermore, Battiste (2002) claims that dissemination of their knowledge should be directed toward First Nations students and future generations to ensure Indigenous knowledge and skills are preserved. Aboriginal Peoples have the right to self-determination and human rights and they are considered a binding treaty which should never be broken (Henderson, 2000). Indigenous principles represent a holistic paradigm that includes the physical, emotional, spiritual, and mental domains of human life and the maintenance of quality life. In my research, I valued and honoured Battiste's beliefs about Indigenous heritage, dissemination of knowledge, and Indigenous principles and use this knowledge as a guide for my own research. According to Loppie (2007), participatory research is “intimately linked to many Indigenous philosophies through value of local participation, learning through action, collective decision making, and empowerment through group activity” (p. 278). Loppie (2007) in her work also includes the physical, emotional, psychological, spiritual, and social capacities of individuals. Using a PAR philosophy is beneficial because this approach views the research as a reciprocal process engaging the researcher and participants in decision-making and in non-hierarchical relationships. Community healing can occur through participatory research.

As Loppie (2007) notes, multiple constructions that described reality from Aboriginal women’s perspectives and that of the Western world were needed in her study on midlife health in First Nations people to help understand the women’s experiences. It was by engaging in dialogue with these women that Loppie (2007) was able to gain a more in-depth understanding beyond social construction and the need to accept pluralism. Likewise, I engaged in conversations with participants and elders and other community members to learn about their experience with GDM and how they are affected by various determinants of health and health policies. I also used a Western constructivist paradigm, similar to Loppie (2007), as this lens views not just one reality but rather multiple realities. Reality is thus transformative and transactional (Loppie, 2007). Using participatory principles, a deep sense of respect emerged for the participants’ intellectual ability and Aboriginal ways of knowing. I believed that these paradigms provided an understanding of the Mi’kmaq women’s experiences from a human and contextual perspective (Loppie, 2007).

Integrating Indigenous Knowledge and Indigenous Principles into the Research

Indigenous knowledge is protected by Indigenous principles (Battiste & Henderson, 2000). This knowledge teaches from creation, is considered sacred, and is a life-long journey. Indigenous knowledge teaches people about taking responsibility for their lives, helping them to develop relationships with others, and is used as a guide to learning and respectful behavior (Battiste, 2002). Indigenous principles identified by Battiste (2000) include but are not limited to the following: 1) protect the heritage of the Indigenous peoples; 2) heritage includes principles of self-determination, meaning that Indigenous people have the right to develop their own cultures; 3) Indigenous people are the primary guardians of their culture; 4) respect and recognition for Indigenous peoples culture; 5) ownership of their heritage; 6) control over their lands and resources so that they can discover, use, and teach Indigenous knowledge, art, and culture to their people (Battiste, 2000). These principles offer some protection against non-Indigenous scholars, policy makers, and other dominant groups who, although their actions may not be intentional, could fail to respect Indigenous culture and language. Hence, these Indigenous principles helped to guide my research.

Many Indigenous principles are rooted in inter-connectivess, a belief that is not always valued in Western science. For instance, in the Western world research is carried out using a linear process where people do not move forward until the previous step is completed. In contrast, Indigenous methods use an integrated process where various research goals are addressed simultaneously and the relationships between the research partners are connected (Henderson, 2000).

As mentioned above, “a relationship with all of creation” is of fundamental importance to meaningful Indigenous research (Wilson, 2001, p. 177). As Wilson (2001) points out, Western paradigms embrace the notion that the researcher is an individual in the research and his/her aim is to gather new knowledge, whereas in an Indigenous paradigm, knowledge is relational and therefore is shared not just with the participants but with everyone including the animals and plants. For me, a non-Indigenous researcher, this blend of epistemological and ontological approaches from these specific Indigenous writers enabled me to go forward with a degree of confidence. Yet my epistemological and ontological situation mandated that I continue to review and hold these principles and understandings central to each step of the study.

The Data Collection

The setting.

This research was conducted in two rural Mi’kmaq First Nations communities in Nova Scotia. Approximately 10–20 Mi’kmaq women from each of these communities receive prenatal care and give birth each year. The health center for each of the communities is located in the community and a major function of these facilities is to provide prenatal and postnatal care services to Mi’kmaq women. The participants chose different places to be interviewed such as one participant in a private office in my workplace during a time when no one was around, one participant was interviewed in her private office at work, one participant chose to be interviewed in a school during summer or after school hours, three were interviewed at the health center in their community in a private space, and three participants were interviewed in their homes.

The participants.

The participants were invited to participate through purposive and snowball sampling (Patton, 2002) on the basis of the following criteria: Mi'kmaq women, 18 years or older, living in one of the two Mi'kmaq communities I was in touch with, who have or had GDM. Purposive sampling refers to observing and interviewing people who have experienced the topic of interest (Gillis & Jackson, 2002). Snowball sampling is used when you ask if there is anyone else that may be interested in participating in the research (Gillis & Jackson). Nine Mi'kmaq women formed the core group of participants. The Mi'kmaq women's ages ranged from 28 to 48 years old. They each had between one and eight children.

Gaining Entrance to the First Nations Communities

It was important to build relationships with the two communities before beginning the research. I contacted the health director or executive director (depending upon their title) in the community and consulted with them about my research. I approached them again once I received ethical clearance through the University of Alberta University Ethics Board. At that time, I asked the health directors for the name of an individual to set up an initial information session. Once the person was named from each of the communities, I asked him/her to organize talking circle # 1. In one community, the community health nurse invited Mi’kmaq women who had GDM to attend the first talking circle/information gathering. In the second community, the community health nurse invited me to a prenatal class with several pregnant mothers and a maternal child health worker.

Although I initially led the talking circle in the first community, the community health nurse initiated the second talking circle until she finished her prenatal teaching on healthy nutrition and then invited me to explain my study. In both instances, I followed PAR principles whereby the Mi’kmaq women were given an opportunity to pose questions, provide comments, and have a back and forth conversation with me (Bergum 2002; Koch & Kralik, 2006). Meeting with the community was intended to begin a relational and respectful description of study design and to ask for input from the community concerning the topic of GDM, research questions, and a description of the SDOH. Although I anticipated that some potential participants, elders, community health nurses, dietitians and whomever else they would like to invite to explore health issues around prenatal care and GDM will be present at this first talking circle, only potential and actual participants, the health director, the community health nurse, and a maternal child worker attended. During the first talking circle, I explained my proposed research. I provided some background on the SDOH, and how it could impact people’s lives. The talking circle provided an opportunity for deciding together how to go forward and plan for conversations with Mi’kmaq women who had or have GDM. At this time, potential participants and other community members in attendance were given a letter of introduction explaining the study. I clarified that there was no obligation to participate in the study. I asked community members in attendance who they thought could inform potential participants about the study. Israel, Schulz, Parker, and Becker (1998) found that the presence of a community organizer is key to the success of community-based research. This person could bring people together in the community to participate in the research (Israel et al., 1998). The role of the community member was to work closely with the participants and organize the talking circles, assist with recruitment of participants, and act as a community liaison. The community member's role in each of the communities was crucial to the success of this study, so it was important that I developed a trusting relation with them. I did not anticipate any serious challenges but I was aware that this person may not be successful in recruiting participants and/or engaging others in talking circles. At that point, I discussed any concerns with the community advisors such as Charlotte Jesty, Jennifer MacDonald, Juliana Julian, and Dawn MacIntosh and asked for their guidance and support. In addition, I discussed any concerns of this nature with my supervisory committee. Fortunately, I did not have any concerns with regard to recruiting participants for this study.

The community member approached the Mi'kmaq women in person and/or contacted them by telephone. In either instance, she/he handed out or mailed potential participants a copy of a letter of introduction (Appendix A) for the study. The community member verbally clarified information in the letter to ensure that potential participants understood the purpose of the study and the nature of participation. The letter included a request for the potential participants to contact me if they would like more information or wanted to participate in the study (Appendix B). My phone number was provided and the women were encouraged to call collect, so that cost was not a barrier to their participation. Three of the women in one community agreed to participate in the study after I presented the information in the talking circle. The other 6 participants whom the community member informed about the study wanted me to phone them directly because they wanted to participate in the study.

Once the participants expressed interest in participating in the study, a time and place convenient for them was arranged. At that time, I discussed the purpose of the study in more detail and answered any questions or concerns. If a Mi’kmaq woman agreed to participate in a one-on-one conversational interview, a participation consent form (Appendix C) was signed. The purpose of the informed consent form was to ensure that the participants were fully informed about the study so they could decide whether they wanted to participate in the study or not. I explained the purpose of the study and asked if they had questions before they signed the consent form. Some of the participants had questions and once they were answered, they willingly signed this form. A second conversational interview with each participant was held to review the transcript and formed the beginnings of a collaborative data analysis. After the second conversational interview, I asked each woman if she would like to move to a talking circle to discuss the findings and focus on possible actions that may help to address GDM. An information letter asking the women to participate in a talking circle was provided to those participants who wanted to participate (Appendix D). I explained that I wanted to explore further with them in a group setting their experiences with GDM and that we could discuss the actions that they thought would be helpful to improve their health outcomes. They were informed that their names would be kept confidential. We know very little about how this form of diabetes affects women, families, and communities. I also hope that we can look at actions we can take to address some of the problems. Although all nine participants agreed to participate in the second talking circle, only five women participated. Also, one woman who decided not to participate in a conversational interview participated only in the talking circles. Participants signed a participant consent form for the talking circle (Appendix C). This consent form was used to ensure the women knew why they were participating in a talking circle and that the participants were informed that their anonymity and confidentiality would be protected to the best extent possible in the group discussion. The participants were given the choice of verbally consenting instead of giving a written consent (Appendix E). However, all participants signed the consent for the talking circle. In addition, in one First Nations community other women came to the talking circle: two Mi'kmaq women (one with Type II diabetes) and one woman who was non-Aboriginal. They also signed the participant consent form (Appendix C).

The interviews.

Focus groups, participant observation and field notes, interviews, diaries, and personal logs, journaling, questionnaires, and surveys are effective methods of data generation employed in PAR (McNiff & Whitehead, 2006; Stringer & Genat, 2004). For the purpose of this study, one-on-one interviews (conversations) and talking circles were used to provide an opportunity for participants to tell their story. These methods are well received by Aboriginal people (Dickson & Green, 2001; Loppie, 2007; Weber-Pillwax, 2001) and gave me an opportunity to explore the differences and similarities regarding the women's experiences. Narratives and storytelling are frequently used as teaching and learning practices in Indigenous communities (Weber-Pillwax). Talking circles present opportunities for participants to share information with each other and develop ideas collectively (Tompkins, 2002; Wilson & Wilson, 2000), while one-on-one interviews seek more in-depth information on a topic and provide circumstances for further elaboration and/or classification on a topic (Gillis & Jackson, 2002). The participants were informed that they would have a choice to participate in talking circles, interviews, or both. Although my hope was that an Elder may be a participant and open the talking circles with a prayer to safeguard the women, this did not occur. However, I did have an opportunity to speak with an Elder about GDM and diabetes in one of the communities. An honorarium of $50.00 was given to the Elder for her time and wisdom in guiding me during this research journey. Also, the participants were given $20.00 for each visit to cover incidental expenses such as babysitting or transportation.

Aboriginal women who were reluctant to participate in a talking circle and preferred to be interviewed one-on-one with the researcher were given this opportunity. However everyone who wished to participate in the talking circle attended. The preference for one-on-one interviews may be due to wanting private time or not wanting to share an intimate part of their life (Koch & Kralik, 2006). If one-on-one interviewing was preferred, participants would have been interviewed in an area mutually agreed upon by the participant and researcher. Participants were informed prior to the interview that they had the option of having a Mi'kmaq interpreter present to assist with interpretation if necessary (Appendix F).

Data was collected by means of one-on-one conversations and a follow-up discussion with each participant. As previously mentioned, the women were offered a choice to discuss the findings in a talking circle or in a private forum. These conversations served as an appropriate method for discussing sensitive topics with the women in order to gain an understanding of their experiences with GDM. As Koch and Kralik (2006) note initial questions are usually broad and conducted in a conversational tone. Respectful research with Aboriginal people should not begin with questionnaires and measurements. The interviews should be flexible to provide the participants with ample time to share their views and describe their experiences (Nilson, Bharadwaj, Knockwood, & Hill, 2008). A community approach invites all voices and concerns to be heard and helps to build capacity in First Nations communities.

The conversations with the participants were audio-taped and transcribed verbatim to ensure accuracy of the data. Confirmation of confidentiality was obtained from the transcriber prior to transcribing the data (Appendix G). I wrote field notes after the conversation(s) with the participants were completed. Field notes help provide a more accurate and comprehensive account of the interview (Streubert-Speziale & Carpenter, 2003). During an interview, Oakley (1981) stresses the importance of using "non-directive comments and probes to encourage a free association of ideas which reveals whatever truth the research has been set up to uncover" (p. 37).

Data Analysis Approach

Hermeneutic phenomenology as explicated by van Manen (1990) was chosen as the type of data analysis, so searching for essential and peripheral themes of the phenomena being studied are used as a way to structure the data. Most importantly here, life experiences were described, checked with the participant, and interpreted in terms of life existential, body, time, space, and relation, as a framework to present the findings.

Van Manen (1990) looks at the lifeworld through the life existentials of lived body, lived time, lived space, and lived relation that occur in a description of an experience. For our purposes here for example, this meant listening to the women as they described experiences of trying to change eating habits on a limited budget and poor access to close grocery stores. The transcribed experience was then examined while asking how are the life existentials present in this description, what one is foremost in it, and why. While these life existentials occur simultaneously in a situation, it is useful to look at each one of these as they show themselves in a particular description of an experience or a story. I also understood that this was not a reductive process, but rather a purposeful sorting through the data to come up with themes that speak to the essential structure of the phenomenon under study, experiences of living with GDM.

Van Manen’s (1997) approach to data analysis stays close to lived life and garners a way to preserve experiential data. Three overall approaches for the analysis of the transcripts was used: first, transcripts are read as a whole to understand the elements present in the text; second, transcripts are read to search for phrases that seem to be particularly revealing about the experience; and third, a detailed sentence-by-sentence reading of the text is undertaken to highlight statements that are particularly essential or revealing of the experience being described. As the analysis proceeded, certain experiential commonalities or themes emerged. As successive transcripts were reviewed, common themes among the various descriptions were noted. The themes and subthemes began to slowly appear. According to van Manen (1990), “Theme analysis refers to the process of recovering the theme or themes that are embodied and dramatized in the evolving meanings and imagery” (p. 78). Data analysis proceeded until in collaboration with the Mi’kmaq women I attained a thoughtful understanding of the elements.

Some background to hermeneutic phenomenology is necessary to show that it is a philosophical inquiry that is rooted in human experience. The term hermeneutics comes from the Greek word “Hermeneia” (Annells, 1996, p. 706) or as Thompson (1990) claims interpretation. A contemporary definition of hermeneutics refers to the theoretical and practical approaches that are associated with interpretation of an emphasis on the importance of language (Thompson). Gadamer (1976) claims that hermeneutics is applied to situations that are not easily understood and need interpretation. Over the past century, hermeneutic philosophy has changed from asking specific questions associated to interpretative methods to more existential-ontological questions.

Annells (1996) states that hermeneutic phenomenology is “an inquiry arm of philosophical hermeneutics” (p. 705). Philosophical hermeneutics is concerned with understanding a situation or phenomena (Annells). Van Manen (1990) describes hermeneutic phenomenology as “a human science which studies persons” (p. 6).

Traditional scientific research aims to hypothesize and is interested in generalizing, whereas phenomenology has a broad focus and is interested in things that are not replaceable, but rather unique (van Manen, 1990). Natural science requires quantitative measurements such as observation and experiments, while human science includes description and interpretation (van Manen, 1990). Hermeneutic phenomenology is concerned with both aspects of methodology which include descriptive referral to the phenomenological aspect and hermeneutic which refers to an interpretative component (van Manen, 1990). Descriptive methodology represents how things actually appear without interference. Hermeneutic phenomenology makes a claim that all data can be interpreted (van Manen, 1990). Thus, lived experiences are always meaningful. Hermeneutic phenomenology is a unique type of phenomenological interpretation that is aimed at revealing different meanings of the phenomena (Spiegelberg, 1975). This approach is philosophy aimed at understanding a specific phenomenon in either text or written word (Streubert-Speziale & Carpenter, 2003).

Gadamer (1976) claims that hermeneutics helps to integrate the known and unknown worlds. Critical to this research as in any research is that the philosophical stance needs to be congruent with the methodology (Streubert-Speziale & Carpenter, 2003). People cannot be separated from the text (Gadamer, 1975). Heidegger (1962) took a more radical approach to understanding. Rather than attempting to understand another person's experience, Heidegger's focus was on examining the possibilities of existing in the world in a particular way. Spiegelberg (1975) is convinced that hermeneutic phenomenology can change not only one's views on life but the way one lives OR how we act in certain situations; it can provide direction which description alone cannot attain.

Hermeneutic philosophy does not aspire to patriarchal systems so prominent in western philosophies (Thompson, 1990). It rejects any connection to Cartesian dualism. It demonstrates that understanding people is restricted by one's social interests, beliefs and values, language and present time. Hermeneutics is useful to nurse-researchers because it helps them understand their decisions, keeping in mind the importance of human values. A prime focus is on the social, political, and ethical considerations of each step of the research process giving more insight into the situation (Thompson, 1990) which fits well with the Indigenous principles stated above as well as critical ontology.

Thus, hermeneutic phenomenology can be used to describe and explain people's health and illness, and in this study the experiences of Mi'kmaq women with GDM. Using hermeneutical description and explanation can help us to understand the situation through interpretation (Allen & Jensen, 1990). The written account of the phenomena (text) is the ultimate goal of interpretation (Allen & Jensen, 1990).

I used hermeneutic phenomenology as part of the data analysis and data interpretation process. This means that I asked questions arising from the data to clarify i.e. areas that seemed vague. Critical hermeneutics is defined by Morrow and Torres (2002) as "attempts to ground social inquiry in the understandings of agents (hence its hermeneutic or interpretive dimension), as well as taking into account the social structural contexts of action" (p. 7). Critical hermeneutics is an end sphere of interpretative theory. An assumption of critical hermeneutics is that not all interpretations are true and that it is important that people can distinguish quality interpretation (Thompson, 1990). There is no single meaning in any interpretation and messages develop meaning each time they are interpreted. From this lens, the meaning of texts or messages develops over time and with each interpretation, meanings are created (Thompson, 1990). Furthermore, critical hermeneutics works on the premise that not all "social actors" are recognized and many traditions are socially accepted by a few people as gospel (Thompson, 1990, p. 258). Hence, it is important to expose their oppressive meanings that many may not even recognize.

Critical hermeneutic theory aims to demystify and dig deep into the meaning, often times not evident to people (Thompson, 1990). This theory is based on removing illusions about phenomena and therefore, meaning can be questioned. Moody (1990) helps us to understand that critical hermeneutics is focused on drawing attention to the systematic features of society that prevent dialogue from being embodied in everyday life.

Data analysis required that I become immersed in the data (Streubert-Speziale & Carpenter, 2003). This process required that I listen intently to the participants' descriptions followed by thoroughly reading the verbatim transcriptions or documented responses (Streubert-Speziale & Carpenter, 2003).

Phenomenological human experience looks at the construction of human experiences, i.e., their everyday lives (van Manen, 1990). Themes and how they are interpreted make up the complexity of people's lives. Human beings have different lives and realities. Being aware of people's different lifeworlds is an important component of nursing research as it helps researchers appreciate the past and present experiences of their participants in their daily lives. As Patton (2002) points out, “the themes, patterns, understandings, and insights that emerge from fieldwork and subsequent analysis are the fruit of qualitative inquiry” (p. 4).

Thematic analysis is defined as “the process of recovering the theme or themes that are embodied and dramatized in the evolving meanings and imaginary of the work” according to van Manen (1990, p. 78). Van Manen (1990) has identified four existentials to help guide thematic analysis which include lived body (corporeality), lived space (spatiality), lived time (temporality), and lived relations (relationality). Phenomenological research considers these four categories as fitting in the world structure. Van Manen (1990) considers these four fundamental existentials as important for raising questions, reflecting, and writing.

The first fundamental existential to be discussed is lived space. The lived space in this study will naturally refer to the participants’ home and community in the world in which they live. Van Manen (1990) helps us to understand this concept by saying that when we want to understand a person, we ask about his/her world which may include such things such as the person’s interests, background, or childhood. The lived space helps me to discover some fundamental meaningful facets of people’s lives. In this study, I explored the participants’ experiences with GDM. A second fundamental existential is lived body. The lived body refers to recognizing that when we meet individuals, we meet them through their body. Persons may disclose or possibly conceal something about themselves without any deliberate consideration. A third fundamental existential is lived time (temporality). Lived time is subjective as opposed to objective time. This time can be enjoyable or can be uninteresting. When researchers attempt to get to know people, they ask about their past and explore where they see their life unfolding. A fourth fundamental existential is the lived other (relationality) which refers to the interpersonal space that is shared with one another. This relationship can be an acquaintance such as a handshake or being present and/or learning about someone through the media, books, or other modes. It is at this point that one forms an impression of the other person. These four existentials of lived space, lived body, lived time, and lived relation each have their own uniqueness but cannot be separated. They form a life world. Hermeneutic phenomenology stays close to people's lived experiences. This approach to data analysis will help the participants as well as policy makers and health care providers understand how the SDOH cannot be separated from people's lives.

While reflecting on what I saw, I was reminded by van Manen's (1990) work, how "close observation involves an attitude of assuming a relation that is as close as possible while retaining a hermeneutic alertness to situations" (p. 69). This reminder made me cognizant of taking my time and interpreting the data slowly, reflecting, and looking for places where I did not understand and had questions. I read and reread the text several times over several months, living and sleeping with the data.

I found the meaning did not "jump out" at first. As time went by, I came to identify the themes as described in the successive chapters through focusing on the life existentials that occur in each and every human situation, space, time, body, and relation (van Manen, 1997). I would have missed the meaning generated through focusing on these existentials in each situation if I had not dug deeper and reread the transcripts and other phenomenological literature explicating a lived experience. According to van Manen (1990), "Theme analysis refers to the process of recovering the theme or themes that are embodied and dramatized in the evolving meanings and imagery" (p. 78).

Listening to the audiotapes while reading the text helped to situate me back in the communities when I was having the conversations. I needed to visualize my participants as well as review my field notes to see the bigger picture. While phenomenology creates a text through the various research methods, here I also was attentive to the spoken/orality of the women during the conversations. This was their main way of communicating experience and I wanted to stay close to them after the conversations through the audio-taped conversations.

Depth gives meaning to a lived experience (van Manen, 1990). Merleau-Ponty (1968) conveyed that "Depth is the means the things have to remain distinct, to remain things, while not being what I look at present" (p. 219). As I struggled at times to find meaning, I opened my mind to think much differently than I have in the past (van Manen, 1990). Instead of coming to conclusions quickly or determining the outcome before and if it happened, I listened openly and did not try to compare my previous study or experiences with this study. This allowed me to create a space to reflect and gain perspective, allowing the pedagogic voice of each mother to be heard which led to common themes becoming apparent (van Manen, 1990). Sometimes the interpretation of what the women were saying would strike me while I was listening to classical music or documentaries on the car radio. Looking at art work or going for a walk at night helped to give me space to think about the participants' stories. I found I had to live with the women's stories for months to gain an appreciation of their lived experiences. In coming to an understanding of the women's stories, I reached the point where it was not just about presenting their experiences but it was about presenting their stories in a manner that revealed a message, something that teaches us (van Manen, 1997). I met with the text daily over the course of several months which van Manen (1997) describes as "go through it, encounter it, suffer it, consume it, and, as well, be consumed by it" (p. 153). I was trying to invent a space to hear the pedagogic voice (van Manen, 1997) of the Mi'kmaq women so that I could better hear them speak their wisdom.

I had to clarify the meaning of words during the conversation with Veronica as well as other mothers because I knew their language could possibly be misunderstood. It was important to capture the participants' meaning to be sure I understood the meaning in terms of the context in which they lived. As Gadamer (1989) points out, words are "verbally constituted . . . Every such world is of itself always open to every possible insight and hence to every expansion of its own world picture" (p. 447). Therefore, words have different meanings for these Mi'kmaq women, and thus I found it was important to consider language when having these conversations with the women. According to Gadamer (1989) we need to be attentive to language because "language is the universal medium in which understanding occurs" and "understanding occurs in interpreting" (p. 389). In the midst of conversation there needs to be questions and answers with the goal being verbal and expression of oneself.

By listening to their verbal expressions such as sighs and pauses and observing and recalling their facial expressions, I began to capture the essence of their experiences more effectively. I found that when I heard the story for the first time I could not completely synthesize all of what the women were saying. However, having the audiotapes gave me an opportunity to play the tapes over and over, listening to their different voices until I better understood the conversations they were conveying. Rephrasing questions and asking for clarification also assisted with gaining insight into the women's lives. As Gadamer (1989) maintains "to keep oneself so free from what one encounters of the world that one can present it to oneself as it is" (p. 443). As I engaged in the conversations, I closed off my inner thoughts so I could just envision their lives as they presented them and through reflection, I could understand what the women were saying in a pure state without distraction.

Listening to the audio tapes over and over to begin searching for themes also helped me to recognize the sincerity of these women. I recall one of the participants, Barbara, saying my name ever so gently. I remember being touched by the genuineness in her voice. I could not put this well into the written text of transcripts yet it was very important to note as Barbara wanted so desperately for me to understand and I wondered if maybe, just maybe she knew I might understand something others had not. Her openness and frankness helped me to obtain a fuller understanding of her life and be able to see themes emerge (van Manen, 1990). I had my transcript data, my field note data, my research diary and while much of the study data was still in flux, I also knew that I would eventually see what the women were telling me.

Although I can never fully understand what the Mi'kmaq women were experiencing, I wanted to come as close as possible to their actual lives and wanted them to know that I was always open to correction should I be too far away from the way life unfolded. The space I was able to create was through the phenomenological approach (van Manen, 1997). The only experience I had was providing nursing care for women with GDM in the hospital and interviewing Mi'kmaq women in my previous study on children birth experiences; I did not care for women in their home communities. Conducting this study helped me realize that Aboriginal women were more relaxed in their own First Nations communities, receiving prenatal care and education from people of their own culture or from the community health nurse who knew them so well, than when they were receiving health care from non-Aboriginal people in acute care settings. I observed their comfort level during a prenatal class on healthy eating as they asked the community health nurse questions in an engaging manner. For example, I learned that Aboriginal women lacked knowledge on GDM but were motivated to learn about this condition. Although the community health nurse was non-Aboriginal, this difference in ethnicity did not interfere with their relationship to her. I also observed how the women talked to their children while they were engaged in conversations. The women discussed their children, other members of their family, events that were occurring in the community, and other daily issues. I discovered that these women learn better in informal settings where they know and trust the health care providers, where they feel safe to tell their experience and describe their treatments received without being judged. Because I have been engaged in previous research with Mi'kmaq women and have heard similar struggles around access to care I feel that I have a better understanding of what these mothers in my study are encountering from the socio-economic realm than in the past with my childbirth study. Hence, I am able to describe their story and begin to interpret.

The participants shared their feelings without seeming to worry that this information would be disclosed as public knowledge once the study was disseminated. The women did not seem to hold back on their personal stories. It was amazing how they opened up. They knew I believed what they were saying which is why I think I did not have to probe for more information. As I was writing this section of the dissertation, it came to mind that my sense of comfort and at-ease approach with mothers in obstetrics was never a problem for me; my conversations with my formers patients were meaningful because I stayed and talked to them as people. I can remember several women who I coached/supported in labor and I helped them relax and be as comfortable as possible. Sharing Aboriginal knowledge and valuing the importance of them as persons was important. It not only helped me in my relationships with Aboriginal mothers, but it helps me in the work I now do as an educator at the University. Being sensitive to people as persons is foundational to moving forward in enhancing my relationships with everyone I encounter as a nurse, a mother, and a person.

Van Manen (1997) describes the dialogue as “Talking together as friends” (p. 98). A conversation begins with getting to know the person through a casual chat and when the conversation becomes of interest to both persons, a deeper and mutually interested conversation usually ensues (van Manen, 1997). Not only are we as nurses/nurse researchers setting up collaborative hermeneutic conversations (van Manen, 1997) but the research participants were encouraged to reflect on the GDM experience in a way they have likely never thought of before. Collaboration, one of the PAR principles that I used in the study, was important because it provided an opportunity for the women to think about and suggest ways to improve their health during pregnancy with GDM.

My Intentions Throughout the Study

Although I planned to explore Mi'kmaq women's experiences about GDM, I was aware that I could not discuss their health concerns without considering their living conditions and the social circumstances such as income, food, housing, employment, and issues around social exclusion that directly and/or indirectly affect their health. Too often health care providers such as nurses and doctors only consider health from a biomedical model where the focus is on primarily treating the illness; they fail to see the connection between people's lives and health. If people's basic physical and emotional needs are not met, they are more likely to have poorer health outcomes. For instance, when Mi'kmaq women do not have the financial resources, they cannot purchase healthy foods, they may not have the education to know what foods are healthy or that they require closer medical follow-up when they have GDM during pregnancy. Not having these resources available creates barriers for women staying healthy during pregnancy and there is a higher likelihood of them having poor pregnancy health outcomes. OR when formal prenatal care programs are not available to Aboriginal women, limited prenatal care education may mean more severe complications with health conditions such as GDM during pregnancy and birth.

The SDOH are at the heart of equity in health (McGibbon, McPherson, & Etowa, 2007). Equity implies that all individuals, families, communities, and groups have access to health care regardless of their race, gender, ethnicity, income, or social status. As highlighted in my literature review, Aboriginal women do not experience the same equity in health as non-Aboriginal women (NWAC, 2007b). Aboriginal peoples have poorer health than the general population (Assembly of First Nations, 2007; Health Canada, 1999; Bourassa et al., 2004). Much of their poor health is a result of colonial practices and the implementation of assimilation practices that was/is thought by many to solve Aboriginal issues. Colonial practices still exist and are widely evident in health care settings in Canada today. Health care providers have a responsibility to address these long overdue colonial issues rampant in health policies and practices. As Stout (2005) points outs, "A healthy living strategy must consider the effects of colonialization and discrimination" (p. 20). Since we know the negative effects of SDOH, and we recognize that health is a human right, we, as health care providers, have a serious obligation to be advocates for Aboriginal women and their families to make changes in collaboration with the women to achieve better health outcomes. As a researcher engaged in Aboriginal health research, I have a responsibility to use the PAR process to work in sincere collaboration with the participants and their communities to impart social change and/or raise awareness about situations that affect their health with GDM.

Choosing a critical hermeneutic approach to understand and portray the Mi’kmaq women’s experiences with GDM enabled me to get at the historical roots of dominant ideologies that are so intricately embedded in their everyday lives (Smith, 1987). The researcher needs to be able to highlight how dominant practices tend to trivialize the actual realities of Mi’kmaq women’s lives which, in turn, labels, stigmatizes, marginalizes, and leads to further oppression of them (Lopez & Willis, 2004).

What May Be Potential Actions/Outcomes

In this study, the Mi’kmaq women and other members of the First Nations communities and I worked in collaboration to develop potential action(s) to address GDM. The frequent conversational interviews and talking circles during this research may lead to the Mi’kmaq women forming a support group to help them address health issues such as regulating their blood sugar, self-administration of insulin, healthy eating, increasing physical activity, and other concerns related to GDM during pregnancy. The women discussed having a support group as well as attending more workshops on diabetes and other health conditions. Support in itself is an important component of PAR. Two participants got together at their school to discuss ways to increase physical activity among the students in their school. The women may choose to get together on a regular or impromptu basis to discuss issues about their health and or other topics that they feel need to be addressed in the future as they began to develop a closer relationship with each other. During the talking circle sessions, the women discussed their current health practices such as eating and activity as they engaged in conversation about their pregnancies. Indigenous people prefer research methods such as storytelling and talking circles because they fit with their paradigm (Wilson, 2001). I observed how they engaged in laughing and talking harmoniously together while discussing their experiences with GDM and ways to prevent diabetes in the future.

Some of my participants described strategies they developed to increase physical activity during pregnancy or attend educational sessions to learn more about maintaining glucose control through dietary control during pregnancy. The women did not invite an Elder in the community to have a dialogue with them regarding how they were going to address their nutritional practices during this study. In one community, an Elder was not invited because I was told by the community health nurse that most of all the Elders had died and the ones who were living were not well enough to attend. In the second community an Elder was not invited to the informational session or the talking circle but I do not know the reason for this decision. However, I met with an Elder who did not want to be named from the second community whom I knew from the past and she suggested that community members should get together to talk about a community garden and the food they are eating (personal communication, September 1, 2012). She expressed interest in being a part of helping her community prevent GDM and diabetes. This Elder shed some light on previous eating practices during pregnancy during the time when diabetes was a considered a rare problem (Young, Reading, Elias, & O'Neil, 2000). She informed me that she ate potatoes, fish, and meat growing up. She learned how to cook and prepare foods at an early age. She said you learn to be a little adult when you are 5 years old (person communication, September 1, 2012). Having the input from this

Elder and possibly other Elders may help other Mi’kmaq women develop more insight into their own knowledge and health practices around eating and other aspects of healthy lifestyles. It might help them look further into their social circumstances such as unemployment and financial security that could be some of the root causes of GDM during pregnancy.

When the participants engage in specific activities, they may then report back to the group about the outcome of their actions in the form of a talking circle (Koch & Kralik, 2006). In my study, the Mi’kmaq women themselves incorporated new strategies and planned to make further changes and address issues such as a need for more educational workshops, better transportation, a women’s gymnasium, developing a community garden, and other initiatives in their lives that are discussed in successive chapters in this study. In some instances, PAR can result in action from the entire group as they decide that a particular change is beneficial to their lives. It may also be that the action is talking about it; in other words consciousness-raising (Henderson, 1995). Another example of action was that the Mi’kmaq women want to approach the Chief and Band Council to request assistance in developing appropriate and reliable transportation for them to attend their health-related appointments during pregnancy and to address resources for mental health in their community. Taking the initiative to improve access to health care demonstrated how the Mi’kmaq women took ownership for their health as well as an example of self-determination in that they are making decisions and choices about the quality of their health.

Credibility and Trustworthiness of the Study

The Four R's described by Kirkness and Barnhardt (1991) (respect, relevance, reciprocity, and responsibility), in addition to relationships and collaboration and partnerships (core principles of PAR), were the guiding elements to enhance the trustworthiness and credibility of this research.

According to Dillon (1992), respect means to care for something, to value and appreciate and regard it as being important, something to safeguard. Conversely, to ignore, neglect, and reject something fails to respect something (Dillon, 1992). Respect in this research means to accept traditional knowledge, values, and beliefs of the First Nations communities and work with them in a collaborative role. Being sensitive to the importance of respect during interactions with First Nations people was considered highly important. The participants informed me on several occasions how important it was to be respectful to them. One mother told me that she would not have participated in the study if she sensed I judged her as a mother during our initial conversations. This mother was concerned that I may not approve of what she was going to give her children when they arrived with fast food [hamburgers and pop]. She told me she was relieved when she saw that I was respectful and non-judgmental toward her.

Relevance serves as another component that needs consideration when conducting research in First Nations communities (Kirkness & Barnhardt, 1991). Researchers must respect the cultural integrity of First Nations people and recognize what they value as Indigenous knowledge (Kirkness & Barnhardt, 1991). Universities have a responsibility to assist First Nations peoples to understand and build upon their "forms of consciousness" as they expand their knowledge about their worldviews. Research in the past has not always been relevant to Aboriginal peoples' health needs (Young, 2003). The health directors, community health nurses, and participants remarked that addressing GDM was very important and timely in their community. Reciprocity is another guiding value for this research.

Reciprocity occurs through a two-way process of learning and exchanging ideas (Kirkness & Barnhardt, 1991). Furthermore, reciprocity "entails honoring each other's roles, which is important for the success of the project" (Pidgeon & Hardy Cox, 2002). This process requires a balance of sharing and acquiring knowledge (Pidgeon & Hardy Cox, 2002). The participants and I shared knowledge which helped them gain insight into the causes of GDM and ways to try to improve their health such as eating more fruits and vegetables and minimizing/avoiding high fat foods, learning how to regulate their insulin, increasing physical activity, and other strategies for improving their health. In return they shared their issues around access to health care, food security, low income, and other SDOH related to their experiences with GDM. There was frequent back and forth dialogue about the causes of complications related to diseases and explanation on why medical procedures were likely carried out, demonstrating I understood and validated their concerns. This study gave me a deeper insight into how my nursing practice impacts patient care. I also gained insight into the importance of culturally competent and culturally safe care, as well as the importance of creating relational and ethical space for patients and families.

Responsibility refers to empowering Aboriginal people through inviting them to be active participants in the research (Kirkness & Barnhardt, 1991). Researchers have a responsibility to create a welcoming and nonthreatening environment to make Aboriginal people feel comfortable and safe (Kirkness & Barnhardt, 1991). Similarly, researchers are accountable and need to understand they have a responsibility to ensure sacred spaces and traditional knowledge are respected and valued throughout the research. My responsibility in this research is to ensure the research is carried out in a safe, respectful, and honest manner following the Standards of Nursing Practice (College of Registered Nurses of Nova Scotia [CRNNS], 2012), Entry Level Competencies for Registered Nurses of Nova Scotia (CRNNS, 2009), and Code of Ethics (CNA, 2008) in nursing. As mentioned above, I was very cognizant that I was respectful in carrying out the conversations and talking circles. The women were receptive to participating in the study and engaged willingly in conversations with me.

Ethical Consideration

Approval to conduct this study was obtained by the Health Research Ethics Board, Panel B (HREB) Review Committee, University of Alberta. Also, additional approval was obtained from the Mi’kmaw Ethics Watch in Nova Scotia comprised of Mi’kmaq leaders, Elders, educators, and other professionals in Nova Scotia prior to commencing the study.

The research was guided by the Canadian Institute of Health Research CIHR (2007) guidelines for health research involving Aboriginal people. I adhered to the

OCAP principles (ownership, control, access, and possession) for conducting research with Aboriginal people (CIHR, 2007). OCAP principles were developed as a political response to colonialism to manage and protect Aboriginal culture.

The participant consent forms were signed by all participants. A group consent form for the talking circles was also signed by the participants who attended them. I informed the participants that they could withdraw from the study at any time without compromising the health care they receive. The participants were assured that confidentiality would be maintained throughout the research process in the research interviews and follow-up, and in the dissemination of information. However, in the talking circle, I could not guarantee anonymity and use of confidential information for what was discussed there. To guarantee anonymity further, a pseudonym was used during transcription, publishing, and will also be used for the presentation of research results. To protect the identities of participants, information about each participant was purposefully kept vague to avoid reader recognition.

Over many years I have gradually developed relationships with Mi’kmaq people. Therefore, I endeavored to address GDM in a way that would assist them, not establish another barrier in addition to what they have already encountered.

Chapter IV

Entering Two First Nations Communities

Relational Ethics—Guiding the Journey

As I prepared to introduce my study to the Mi’kmaq women, relational ethics helped guide my journey. Relational ethics literature opened my eyes to the importance of developing a trusting, genuine, and respectful relationship with patients and families, and in particular with Aboriginal women. Although I knew that building a relationship was important and something I always considered as a priority with my patients, I developed a deeper appreciation for caring for people in health care when I immersed myself in relational literature. This, in turn, also helped me to understand how Aboriginal people value relationships. The focus of the study became discussing together with the Mi’kmaq women what is best or may work for them to achieve health and reduce heath disparities. Through sharing their experiences we generated thoughts and actions to assist the women and their families in their experience of GDM and to find ways to respond to these encounters.

According to Bergum (2004) relational ethics is “an action ethic” (p. 486). Rather than judging people, actions are done out of goodness and genuine concern for people without knowing for sure in the long run if the actions were right or wrong. It requires an inner sense though that it is the right thing to do (Bergum, 2004); a deeply embedded sense that this is right in the context and within the relationship.

Austin, Bergum, and Dossetor (2003) assert that relational ethics provides a means for assisting nurses in understanding how ethical practice is situated in relationships between nurses and patients. Austin (2008) asks nurses to reflect on how they interact with one another from the perspective of the patient and the professional. Relational ethics replaces objectivity with conversation and respect, and focuses on the relationship. Respecting other people is foundational to relational ethics. When people are isolated from each other, taking a relational approach helps to bring understanding and gather people together. Bringing people together helps to facilitate a conversation, a chance to exchange words so everyone has an opportunity to discuss, ask questions, and have a back and forth conversation (Bergum, 2002). Bergum (2002) refers to this relationship as one of mutual respect because in this moment or space each person's needs and desires are considered important in the relationship. Austin (2008) notes "an individual or group may be severely disadvantaged when decisions are made: their voice may not be heard, their needs not given priority. Relational ethics points to such vulnerability" (p. 19). Nurses need to keep the ethics of relationship at the forefront of the care they provide. They are responsible for caring for and educating patients and families with whom they develop partnerships (Bergum, 2004).

Nurses often work in hierarchical institutions where there is little autonomy, where control is common practice and where minority populations often feel marginalized and discriminated against (Browne & Fiske, 2001; Browne, Smye, & Varcoe, 2005). However the current structure is the best guide we have at the moment to measure our effectiveness as ethical practicing nurses. Ethical in this situation means to do good and to value what is important to people (Potter et al., 2010). To assist us, nurses need to gain a deeper understanding of the meaning of relational ethics in planning and providing nursing care to patients and families. Relational or ethical space refers to the mutual respect and freedom of choice (Bergum & Dossetor, 2003). It also depends on the negotiated understanding of respect. “Mutual respect” is a fundamental component of relational ethics (Austin, 2008, p. 19). Mutual respect can only take place in a space where both parties receive the same attention (Bergum, 2002). Being open to others with consideration given to the power dynamics in relationships is paramount (Austin, 2008). Nurses are moving away from old practices of controlling patients to more of a patient-centered relationship (Hawthorne & Yorkovich, 1995; Wright & Brajtman, 2011). Respectful communication is needed to guide nursing practice. By this I mean that nurses need to interact with patients and families in a genuine and compassionate manner through verbal and non-verbal ways. According to Bergum (2002), “nurturing the space” between patients and families and nurses is the “ethical focus” (p. 10). It is the “you and I” where the relation is held (Bergum, 2002).

I knew it was important to nurture relational spaces as I entered into this research with Mi’kmaq women. Preparing for entering the First Nations Communities I engaged with nursing, philosophical and Indigenous literature, and critically reflected on the views of a number of Aboriginal scholars and the health and lifeways of Aboriginal people, and Mi’kmaq people in particular.

In my Master’s research on childbirth experiences of Mi’kmaq women, I grew to understand some of the challenges of being a Mi’kmaq woman. The hospital experiences of Mi’kmaq women during childbirth varied, however a number of common observations were identified. Misunderstanding, lack of respect, lack of autonomy, lack of choice, unprofessional care, devaluation, discrimination, and insensitive care frequently characterized their birth experiences. Some women were vocal about their feelings and concerns while others were reserved and quiet. These findings are congruent with Baker and Daigle (2000) and Enang (1999) who reported that misunderstood minority women, specifically from a First Nation's community in New Brunswick as well as African Nova Scotia women, experienced discrimination which created feelings of isolation and devaluation. The historical trauma from colonialization and residential schools that Aboriginal people have endured, and in some cases still experience, has had a profound effect on many First Nations communities (Browne, 2005; Knockwood, 2001; Smith, Varcoe, & Edwards, 2005). I believe having this knowledge and experience helped me understand some of the difficulties Aboriginal women have in the health care system.

My Entrance to the First Nations Communities

As a non-Aboriginal Registered Nurse I could not help but wonder what to anticipate entering First Nations Communities to engage in my study on GDM as a researcher. Porr (2005) describes this wonder as trying to understand the "other" as a researcher through exploring the lives of women one is researching. Building a trusting relationship is highly valued in the Aboriginal culture in order to engage with participants and in meaningful research (Browne, 1995; Canadian Institute of Health Research, 2007; Whitty-Rogers, 2006; Woods, 2010). I did not want to be regarded as a "foreign researcher" who entered a community for the sole purpose of retrieving information for one's academic gains (Elias, O'Neil, & Sanderson 2004; Ishtar, 2004). According to the

NWAC (2007a) and from my nursing experience, I value the importance of gaining women's confidence and respect. I am genuinely concerned about Aboriginal women and their families' overall health and wellbeing.

Although I was a little apprehensive in preparing for my initial presentations at the health centers, I felt confident knowing that I had extensive knowledge and clinical experience in maternal/child nursing. I had a beginning understanding of culturally competent and culturally safe care which is essential to having a dialogue with Aboriginal women.

As I embarked upon this research, I knew I had to learn more about Indigenous knowledge and pedagogy. According to Battiste (2002), Indigenous knowledge includes "a web of relationships within a specific ecological context; contains linguistic categories, rules, and relationships unique to each knowledge system; has localized content and meaning; has established customs with respect to acquiring and sharing knowledge" (p. 14). Battiste's (2000; 2002) work, along with my own nursing experience and extensive literature review, has helped to situate me and increase my awareness around the importance of family and community relationships in Aboriginal communities. It has also helped me to reflect on culturally appropriate ways to work alongside the Mi'kmaq women with GDM to conduct this research. Battiste (2000) asserts that indigenous knowledge, including oral modes of transmission, is an essential and significant process for Indigenous educators and scholars. Dobbelsteyn (2006) claims that Aboriginal people embrace the values of family and community in addition to the contributions they make. They maintain a balanced approach to health, to their culture, to their past history, and are connected to their Creator and to all living things around them which is critical to understanding Aboriginal ways of knowing (Dobbelsteyn, 2006). Families must be considered an extension of the patients and not separate from their loved ones. This means that researchers need to position their work in a relational context. Writing must be done in the first person. Battiste (2000) asserts that the medicine wheel depicts "symbolically that all things are interconnected and related, spiritual, complex, and powerful" (p. xxii). Hence, similar to a Cree Scholar, Wilson (2007), people are not separate from their environment or families. Likewise, Loppie (2007) maintains that "Western constructivist and Indigenous paradigms generally agree that reality is a product of multiple human constructions, woven from the fibers of individual and collective context, perception, and action" (p. 277). Interaction with people creates the context and the human understanding (Battiste, 2002; Loppie, 2004).

Introducing the Study

I began contacting the First Nations communities after I received ethical approval from the Human Ethics Research Board at the University of Alberta and the Mi'kmaw Ethics Watch in Nova Scotia. Initially, I met with the health director and the community health nurse in both communities to become acquainted and to introduce the study. Prior to a face-to-face meeting, I contacted them by phone. I explained who I was and briefly described my past and current experience/affiliations with working with First Nations communities. They asked me several questions about the study, such as how many women I would be meeting with, what type of questions I would be asking, and other matters of concern. I knew gaining entrance to the community depended on establishing a working relationship and how I communicated with the health directors. I admired their thoroughness and due diligence in this regard. I was cognizant that the health directors and community health nurses needed to have a good understanding of the research methodology as the community relied on them to advocate and protect Aboriginal people.

When I met with the health directors and the community health nurses to further discuss the study, I gave them a copy of the proposal and discussed the study in more detail. These face-to-face meetings in the communities gave me an opportunity to get to know them and for them to know that I was sincerely interested in making a difference in their communities. I explained that I was not conducting research solely to fulfill my academic endeavors, but rather I was interested in the overall health and well-being of their communities. I also explained that the women would be active participants in this study. Observing their facial expressions and listening to the dialogue between patients and families coming to the health centers helped me gain a better understanding of the role of the Health Center and the value of having this facility readily accessible to community members. In one of the communities the health director informed me that many Elders had died. She said that there was possibly only one Elder living who could attend the talking circle to discuss GDM. Initially, I was surprised at the number of Elders who had passed on as this is not the norm in my own culture. In addition to conducting the study, I maintained frequent contact with the First Nations communities because I was involved in other projects alongside the communities related to increasing the number of Aboriginal students entering the nursing program and developing cultural competencies in the nursing curriculum in the School of Nursing at St. Francis Xavier University.

During this study, I was challenged to present multiple realities and to reflect upon the women's lived experiences. Being a non-Aboriginal researcher means that I attend to the space created by working across cultures (Smith, 1999). It also heightened my awareness around how nurses and other health care professionals need to be aware of the importance of close relationships that Aboriginal women have with their families and their communities.

Working with First Nations communities and faculty and staff at St. Francis Xavier University on other health-related projects helped to raise awareness of Aboriginal issues in education, politics, and the legal system. These connections gave me a broader perspective in which to start the conversations. Having a broader view helped me to realize the importance of listening carefully to the stories of my participants. Instead of thinking about what I might ask next during the conversation, I tended to let the women talk. In this way I was able to gain more context of their lived situation and this approach helped to convey that I valued their knowledge. Their concerns around the SDOH such as poverty, housing, and social exclusion prior to beginning the study, confirmed the need for this study on GDM. As Ishtar (2004) contends "the time and the need has come for all of us who are concerned with social justice to sit down and talk to each other" (p. 72). Although the women did not refer to the terms SDOH, they referred to their lack of funding, access to care, and availability of food as well as housing concerns that Raphael (2006) describes as the specific mechanisms that different societal groups experience which ultimately affects their health and well-being.

During the meetings with the health directors and community health nurses in each of the communities, we discussed the methods for conducting the study and the types of questions that might be asked. They were happy to know that it was a qualitative study and that although I already had some questions developed to begin the conversation, the Mi'kmaq women would guide the conversations and suggest actions. The conversations were meant to give the women an opportunity to explain their lived experiences with GDM. Each experience is unique and special, and therefore I wanted to assure them that our dialogue was important. I was thinking at the time that the conversations and talking circle sessions may lead to the women organizing a support group in the near future. There was some indication this was happening when I met with the women from both First Nations communities during a talking circle and following the individual conversations. The women began discussing ways to become more physically active themselves and also suggested ways to encourage their children to do the same. As mentioned in the previous chapter, support is also an important element of PAR. The women discussed ways that they could provide support through education and reaching out to other community members. In one First Nations Community I was invited by the community health nurse to attend a prenatal class as a way to become acquainted with some community members and to introduce my study. Three pregnant women and their children attended this prenatal class. Another First Nations woman who was not pregnant but who worked with prenatal women as a maternal child health worker also attended.

When I arrived at the health center the Mi’kmaq women were fully engaged in a conversation with the community health nurse on healthy eating. The Mi’kmaq women and the community health nurse welcomed me to the gathering. I joined the conversation whenever it was appropriate but I was cognizant of not interfering with the flow of the conversation or dominating the conversation with my nursing knowledge. However, whenever the opportunity arose I gently introduced some information around GDM. At one point, I identified some foods that were high in sugar and discussed the importance of controlling blood sugar during pregnancy. I listened as the community health nurse explained what foods were high in fat and sodium and what foods were good sources of protein and vitamins. The women were deeply engaged in the conversation. Sometimes I would nod to acknowledge that I agreed with what was being said and found this nonverbal approach helped to demonstrate I was listening to them. As I observed the dialogue between the nurse and the women, I sensed by the happy expressions on their faces, the nods, and/or the verbal responses that they had complete trust and valued her knowledge. Also, the women appeared physically comfortable and engaged in the conversation as their bodies were slightly bent over looking at the educational material on the table related to healthy eating as they asked relevant questions to clarify information where necessary. The community health nurse used an array of Health Canada resources to explain Canada’s Food Guide and to emphasize why the women needed to eat healthy foods during pregnancy and postpartum.

During the discussion, the nurse explained that sweet potatoes had more food value than white potatoes because the former has fewer carbohydrates. She discussed other points such as choosing fruit with little or no sugar. The Mi'kmaq women asked questions without hesitation. For example, they smiled and conversed with her on such things as drinking 1 or 2% milk instead of whole milk because of the higher fat content in whole milk. It was evident by their questions and back and forth discussions that the women wanted to take good care of their health and their unborn children. They wanted to learn as much as possible about healthy eating.

The non-hierarchical environment provided an opportunity to ask the women about their pregnancy experiences. I found myself discussing GDM in an informal manner. The women were comfortable to discuss their health all the while playing and interacting with their young children. The children ranged in age from two to three years.

During the prenatal class, the women gradually disclosed their concerns around eating healthy during pregnancy. The women seemed to enjoy having this time to discuss their pregnancy concerns. A major concern for the women was if they would develop diabetes later in life. It was sort of a fait de complet. They were all aware that GDM can lead to diabetes which may be why they were anxious to engage in the discussion. Although none of these women had GDM, they were keenly interested in the topic and offered to spread the word about my study. They knew some women who had GDM as well as some women and men with diabetes. All the while we engaged in conversation, their children played together. Sometimes we just stopped in the middle of a conversation so that the mothers could attend to their children. I observed the women's loving and patient manner. There was no sense of hurry or annoyance from the interruptions. The mothers remained calm and interested in what their children were doing all the while they listened to the community health nurse. Children are considered a gift from the creator (Baker, 1998). Children are an integral part of their life. One participant in my previous Master's work shared her perception of the difference between Aboriginal and non-Aboriginal women during childbirth. One Mi'kmaq mother recalled when "a native child is born the first thing the mother does she'll smell the baby, and then she'll kiss it's heart (the child) and the nurses even said a non-native mom will just take the baby and kiss the baby" (Whitty-Rogers, 2006, p. 115). It was evident that the Mi'kmaq mothers saw their children as a source of pride and joy.

Although I felt welcome, I was cognizant that they were watching me. My previous experience working with Mi'kmaq women in maternity nursing and in earlier research helped to increase my sensitivity to the situation. Ishtar (2004) points out that as a "white researcher" I need "to reassess our enculturated attitudes and behaviours" (p. 73). I wondered if they viewed me as a White middleclass woman/nurse who has a privileged life working in a university. However, I did not sense that I was a threat in terms of judging them. I realized that it was too soon to build a trusting relationship but I sensed I was being accepted by the mothers present at the prenatal class. Although they would not be the participants in my study because they did not have GDM, it was still important that they trusted me. The women offered to tell other women about the study.

My experience in the second First Nations community was equally positive. The community health nurse in her role as facilitator invited three mothers who had GDM to attend an information session at the Health Center in their community. The health director and the dietitian also joined the discussion. They listened while I explained how

I became involved with this research. I remained sensitive to the women's questions and listened carefully to their stories about GDM. I was encouraged that their immediate response was to participate in the study. The women were happy to know that everyone was an equal partner in the study as part of the participatory research approach. One of the mothers stated that she was ignored/not given a voice when she was in labor at the hospital. She emphasized that nurses and doctors need to "listen to patients." For example, she said that nurses and doctors did not believe her when she said she had to "push in labor." During the conversation, we discussed possible actions such as building community gardens, health programs in schools, and raising funds for housing. The women indicated they were looking forward to having further conversations.

I vividly recall my first meeting with a participant named Annette, a 30-year-old Mi'kmaq mother and her three children. Annette was the first Mi'kmaq participant who I interviewed in the spring of 2010 for this study. I was looking forward to this meeting. I phoned Annette one morning to tell her that I had been given her name from a First Nations health worker at the health center in her community and wondered if she would like to have a conversation on her experiences with GDM. I felt strange making the call to someone I did not know. I explained to Annette that the health worker had offered to be the facilitator in the community and her role would be to invite women with GDM to participate in my study. Furthermore, the facilitator suggested that I contact Annette directly. Annette asked if I could interview her at my workplace. She was taking her children to Kids First Family Resource Program the day I phoned but planned to come to my office around noon time. Annette arrived with her three children around lunch time as planned. She said her son did not have school that day so she brought him along with her two younger children. During the conversation, there was a lot of movement in the room. I felt as though they were “jumping around.” It was a form of dancing; my body attuned to Annette and her children’s body as we engaged in this conversation on GDM. Annette referred to the activity as a dance when she stated “no you’re not getting mine (meaning her two year old could not have her mother’s food), go dance over there.” There was a rhythm in the space that we occupied. This activity created a feeling of life and excitement.

As I greeted her children, I wondered what was going through their minds. It may have been a new adventure or perhaps it was being confined to one space. In any case, it did not seem to matter as they were not shy and began interacting with me almost immediately as I arranged the table so they could eat their lunch while their mother and I began to discuss her experiences with GDM. As I began to get to know Annette and her children, recollection of my own children and experiences began to emerge as we sat together at the table.

Van Manen (1990) helped me realize that the starting point for phenomenological analysis can be my own personal experiences of the phenomenon such as becoming a mother. Van Manen (1990) states “My own experiences are immediately accessible to me that no one else’s are” (p. 54). I reflect on my own experiences as a mother, having so much to do, and trying to entertain the children when I took them to visit people. Although my experience of being a mother is just one possible experience, Kirova-Petrova (1996) points out “It became feasible for me to grasp how this particular experience transformed my entire lifeworld" (p. 30). In what sense is my experience as a mother similar to Annette's life? Is it different than mine? Although I did not have GDM, I did raise children and learned how to parent without attending parenting classes. In my opinion, there is no "recipe" or right way. There is an abundance of literature on the subject but it comes down to the fact that the experience of motherhood is unique. But I do remember being concerned and fearful at times of my children's growth and development. For Aboriginal women, the transition to motherhood is complex in particular as they birth their babies in a culture vastly different from one they grew up in and this exposure, with dissimilar values, beliefs, and attitudes, may result in enhanced vulnerability in their transition to motherhood (Meleis, Sawyer, Im, Messias, & Schumacher, 2000). Aboriginal people living in the North of Canada believe that individual and community values are directly related to people's health and recovery from illness, and if not acknowledged, recovery may be affected (Moffitt & Wuest, 2002). Moffitt and Wuest (2002) recommend that health care providers include traditional healing practices and the use of interpreters to be active participants in the care process as a way to diminish enhanced vulnerability encountered in the health care system.

Individuals are situated in relationships and we need to value the uniqueness of people and see them for who they are (Gadow, 1999). Dillon (1992) asserts that respect is an attitude, a way of valuing something. The word "respect" originates from a Latin word which means "to look back at, regard, consider" or "treat with deferential regard or esteem" (Oxford Dictionaries, 2001). Respect is a powerful word and one that carries a responsibility, an honor, and a high regard for the person. My understanding of respect from the perspective of this study deepened with meeting my first participant, Annette. This mother had all she could do to attend to her children and talk to me at the same time about GDM. I wanted to help but I really did not know how I could assist her until we became more acquainted.

I observed this mother and her children. I was touched by this beautiful example of parenting love and devotion to her children. During the conversation the children were talking, moving, and walking around exploring my office, asking questions, and at one point wanting to be taped. Her baby daughter was asleep in the stroller for most of the time but her other daughter and son were moving from chair to chair and walking around. Sometimes the older daughter climbed on her mother's lap to be comforted. The continuous movement in the room made me realize how active young mothers have to be to take care of their families.

Because Annette did not hesitate to participate and was willing to meet about her experiences with GDM as soon as we connected, this readiness conveyed a beginning sense of trust and respect between us. It was hard to describe in words how uninhibited Annette was in telling her story even though I was a stranger to her. The moment was right and she wanted to reveal her experiences with GDM and she knew I was truly interested in hearing them. This space between us and her children set up the space of the conversation.

During our first conversation, she disclosed some very personal details of her health condition as follows:

> My uterus lining was dangerously thin, and since I'd already discussed wanting to have my tubes tied and 'cause my partner wants a bazillion kids and that's fine for him, but my body can't handle it and I have a duty to the three of them to be here as long as I can. And I'm in therapy [referring to mental health] as a part of that too, like I know I need to get fit and I know I need to get better. (Annette)

This was a beginning point as she graciously began to open up and share her thoughts and concerns around her experiences with GDM.

The literature review, my previous research study with Mi'kmaq women, and discussions with colleagues at the university where I work all point to the need to address access to care and the poor political and socio-economic conditions that Aboriginal women endure. I am more cognizant of why Aboriginal women and families face the barriers to good health, something that is still misunderstood by mainstream society. As mentioned in Chapter II Aboriginal people continue to experience victim blaming and stereotyping. According to Mikkonen and Raphael (2010), it is not medical care nor lifestyle choices "that shape the health of Canadians" but instead it is the living conditions they experience" (p. 7). Many Canadians are misinformed about how low income, social services, access to care, education, and housing can gravely affect people's health outcomes. And this shows itself as well in the western institutional care model where no accommodation is made for those living with the highest health disparities in the country. Rather there is a general assumption that people have control over their living situations, but with the Mi'kmaq in this study as is for other Aboriginal people, this is not the case. The CNA (2005) claim the problems for Aboriginal people around “poverty, equity and social justice” is primarily structural in nature (p. 6). To change policies and health care practices, Aboriginal people need help to build capacity to take action in order to address the health inequities they encounter.

During the data collection stage I attended a ceremony known as a Mawio’mi at the university where I work. Everyone at the university was invited to attend. This ceremony is a celebration of the Mi’kmaq people’s lives where they share stories, dance with each other, give thanks to their ancestors, and value the teachings of their elders. There is also a feast where Mi’kmaq people bring traditional foods such as eel, bannock, stew meat and others along with some western food such as chicken and hamburger. Dancing and eating occur simultaneously as everyone intermingles. During a conversation with some First Nations people at Mawio’mi, I heard similar comments from some of the nearby community members that the Elders are dying. They showed a video depicting a large number of Elders who had died from diabetes and heart disease. As I was watching the video, I reflected on the young people that would miss out on Elders passing on their traditional knowledge. Also, I reflected on Elders sharing their knowledge, I thought about how Annette and other mothers wanted to pass on their knowledge so that it would benefit their own children and community members, including the future generations. It was evident from my conversations with this mother and the presence of her children that she was very close to them. Her children went everywhere with her; this was an incredible and lasting bond.

Conclusion

As I reflected on my beginning thoughts, I was guided by the critical need to ensure that patients feel safe in the environment where nurses provide care. Developing a respectful relationship early on, starting with the health directors and community health nurses, was key to being invited to conduct my study. The health directors and community health nurses needed to know that no harm would come to the Mi'kmaq women in their community. My role as the researcher was to recognize and respect the rights of the participants and their families (Canadian Institute of Health Research, 2007). Listening carefully to what the participants were saying by giving them a voice and being non-judgmental was critical. I had an ethical responsibility to conduct the conversations in a professional, caring, and respectful manner. Not being Mi'kmaq was something I always kept in mind as I entered their communities and during every event and conversation that I was a part of. Evoking Bergum's (2002) views on relationships, I was guided by the sensitivity and genuine love she portrayed in her work on relational ethics with her own obstetrical patients.

Chapter V

Theme I

Uncovering the Experiences of Gestational Diabetes Mellitus

> The world is our home, our habitat, the materialization of our subjectivity. Whoever wants to become acquainted with the world of teachers, mothers, fathers, and children should listen to the language spoken by the things in their lifeworlds, to what things mean in this world. (van Manen, 1997, p. 117)

In collaboration with the Mi'kmaq women, four major themes emerged from the conversations with them. They were: Uncovering the Experiences of Gestational Diabetes Mellitus, Barriers Limiting Access to Equitable Health Care, Social Support During Pregnancy, and Feeling Compelled to Take Action. The focus of this chapter will be on Uncovering the Experiences of GDM.

A Beginning Understanding

Being diagnosed with GDM came as a surprise to most of the Mi'kmaq women in this study. Although the women were aware of the high incidence of diabetes in their communities and the increased risk of developing this condition, they did not expect it to happen to them. Once they were diagnosed with GDM, there was no turning back.

This condition creates an entire life change both to their body and their mind and in some instances, it defines who they are. The diagnosis takes up a big part in their lives as it evokes fears for self and baby and community people as well as their existing children. Once diagnosed with GDM the women felt there was little or no chance of themselves and their children avoiding diabetes later in life.

During pregnancy, women are most concerned about the safety of their baby and their own health outcomes (Lothian, 2008; Mercer, 1995; Rubin, 1984). Stainton et al. (1995) found that fear is generated from uncertainty as women in high-risk situations wait during pregnancy, hoping that they have healthy babies. In a study on health behaviors of postpartum women who experience GDM, Evans, Patrick, and Wellington (2010) report feelings of uncertainty in women who are informed that the risks for developing diabetes is higher later in life. Similar to these studies, Whitty-Rogers (2006) found that Aboriginal women experience anxiety and uncertainty about their health when diagnosed with GDM. Neufeld and Marchessault (2006) conducted a qualitative study on two generations of women in an Aboriginal community. Their subsequent report stated that during a discussion on having GDM the mothers indicated they experienced apprehension and anxiety of being diagnosed with diabetes later in life. They were also concerned about how it may affect their baby in utero. Like other women, Aboriginal women love their children and their deep concern and genuine love as a parent is evident through the stories of my participants and in the ways they interacted with their children during our conversations.

Aboriginal women’s lives are complex because they have many factors that negatively affect their lives, such as the SDOH and health inequities. Storytelling about their experiences with GDM in relation to topics such as diet, exercise, stress, and engaging with health care providers is a good way to learn and to begin looking for ways to prevent diabetes (Neufeld & Marchessault, 2006). According to van Manen (1997), "we gather other people's experiences because they allow us to become more experienced ourselves" (p. 62). Moreover, van Manen (1997) explains that from a phenomenological perspective it is not so much about the subjective experiences but rather the focus is on what is the nature of the experiences and in this instance, what is the nature of GDM. I began to understand the women's experiences through using critical thinking and reflection based on the work of van Manen (1997). I framed my thoughts around a) What is it like to have GDM and b) What does this mean to the Aboriginal mothers? Avoiding preconceived notions about what it may be like for women helped to minimize my bias as I guided the discussion, asking for clarification, and minimizing questions. I remained silent at times and did not feel the need to clarify some information. I gradually became immersed in this rich text gaining meaning from the Aboriginal women's experiences during pregnancy and after birth. Van Manen (2005) describes the researcher's feeling as entering the "space of the text" to appreciate the experience of another person through the text (p. 3). This space refers to the place where the writer becomes inspired by the words being expressed by another. It means going to another place; a private place away from everyday reality (van Manen, 2005). This is a place where the researcher/writer gains insights which may move the person in a deeper dimension to better understand the language. It can also be difficult because writing cannot always convey what the writer wants to show. Here the writer may be halted or may need to enter the text with an awareness of the vagueness of language.

New insights into the experiences of these women arose every time I entered into their world through reading and during the conversations with them (van Manen, 2005).

For instance, one participant described her experience as, “feeling sick, miserable, and I don’t know how, how we [mother and her child] did it but we did” (Jane). She was able to keep strong not knowing that she had GDM at the time which demonstrates her incredible strength and determination. She explained that she did not feel physically well during her fifth pregnancy, later to find out she had GDM. Jane was frustrated because the doctors and nurses did not take her seriously when she described her symptoms. The work of van Manen (1990, 1997, 2005) assisted me in understanding the meaning of lived space in the women’s lives. Jane’s lived space was negatively affected (van Manen, 1997) when the health care providers did not acknowledge her symptoms of feeling cold and not feeling well during her pregnancy when she went to the hospital. Jane did not feel comfortable in this space (van Manen, 1997). She felt alone and vulnerable because the health care providers claimed they did not think there was anything wrong with her. She had no one to advocate for her. The hospital space did not bring back fond memories when she was pregnant. Other mothers were feeling the experience of space being taken up in their womb; of the baby growing larger; of GDM taking up space in daily life through the regime of diet, exercise, and insulin if necessary; parenting, and others. Annette remembered daily space through her trips to the park.

> I don’t feel like I’ve been the most patient mom in the world but I, I know that about myself too though, I’m a better parent in public when we’re doing something structured as a group. Like we go to the public library, we go to the

> park. My daughters love the library too, I miss the playground, when I wasn't workin' we went to Kids First. Or we did, we went to the park and that's why we go for walks and we do stuff like that because I, that, that's my strength as a parent, my honeys, would rather stay home and um 'cause you're kind of sc, the little one's really scary now, she's terrible 2s just. (Annette)

Veronica's lived space (van Manen, 1997) was consumed with trying to become physically comfortable as her baby grew in utero. She felt restricted in being able to move around. She tried to control her cravings because she knew the additional calories were responsible for her gaining a lot of weight. Veronica recalled, "I started gettin' bigger and then my appetite started, I wanted, like cravings." It was hard to control those feelings for food as she had her favourites that were hard to pass up. The additional body weight made her feel uncomfortable. Veronica stated [baby] "was so big and he was always on my bladder and it hurt all the time." I asked her if her insulin needed to be increased near the end of pregnancy and she stated "Yeah. I think it was after a while it was like 12 units" (Veronica). When her baby was born he weighed "Ten pounds and half an ounce" (Veronica).

When Kate was seven months pregnant, she was uncomfortable living in her own home so she moved into her parents' house. She was physically exhausted. The only comfort she had was staying with her parents. She also felt a sense of closeness and security with them, especially in her condition. The lived space as described by van Manen (1990) is illustrated in the following excerpt

> I couldn’t, I had to s, I had to stay at my parents’ house the last month, or the last 2 months really. I had to stay at my parents’ house, I had to sleep in my father’s recliner because I couldn’t lay down, I couldn’t breathe if I laid on my back, if I laid on my stomach it hurt my hips too much uh and obviously I couldn’t lay on my stomach so I had to lay in a recliner, I had to sleep in a recliner. (Kate)

Another mother [Annette] described how she struggled with lack of physical space living in a small trailer with her husband and three children while she was waiting for her home to be built. She compared the trailer to the size of my office at the work; the size of two average-sized offices with two large windows. Annette described her home in the following manner

> And my house is like this, this is my living room, kitchen area. They [her children] don’t have a room so their toys are at all times in the livin’ room. All of their furniture, so swing, she’s got a chair, her sister’s got a chair, she’s got an Exercsaucer, and they have other ones that are just outside like lawn furniture. I had to do stuff in the shed and she played in it but like there’s so much stuff. She doesn’t have a dresser because we couldn’t afford the space, she doesn’t have a crib because we couldn’t afford the space, you know, four of us share a room, and that was my reality when I was pregnant too, it was so hard dealing with [baby daughter], she was so ill, she had eczema so, so bad on her face, and I’m tired and diabetic and try not to like cry like my kid or screaming or, ’cause really like sometimes I feel like ‘cause of my high and lows that I was just as whatever as

> her because I, I just, there was no filter, there was no, it's hard to think right when you, when you're diabetic or and you're having a moment. (Annette)

Annette did not have enough living space for her and her children to sleep, nowhere to play and store the children's toys, and limited spaces for furniture. It was a confining space and difficult to keep tidy. The space in which Annette lived affected how she felt (van Manen, 1997). The small space made her feel restricted and not able to move around. It was not a good feeling and sometimes got the best of her. She longed for a wide-open space where everyone in her family had their own space to think and play. Space would give her freedom.

Carol felt space being taken up by adjusting to having to check her own blood sugar levels and take insulin according to a schedule. She stated: "And I felt even twice as better because they got me to do your cue sticks, they got me to do my schedule and they got me to do my insulin, how to write it down" (Carol).

The lived spaces that were experienced by each of the participants reflected how they each felt about the spaces they lived in during their pregnancy while having GDM. Inquiring into lived space experience gives people an understanding of the quality of the experience (van Manen, 1990, 1997). Exploring the lived space with the women living with GDM revealed a sense of physical burden, restriction, and anxiety.

The Mi'kmaq Women's Experiences

The meaning of the women's stories often came from a single word or phrase such as "having no energy" or "life is hard," as well as from their laughter and their sighs. Their stories led me to reflect more on language and the power and meaning of words than in the past. Simple phrases or words as mentioned above are common language. Gadamer (1989) reminds us “the object of understanding is not the verbal means of understanding but rather the world that presents itself to us in common life” (p. 446). Furthermore, the verbal world in which we live does not prevent us from understanding, even if the language is from a different culture or way of expressing oneself (Gadamer, 1989). Whatever language is used, “we never succeed in seeing anything but an ever more extended aspect” of the world in which one lives (Gadamer, 1989, p. 447). The stories and feelings the women conveyed (being surprised, the experience being life altering, feeling they had no way out) provided a broad view of the Mi’kmaq women’s lives.

Taken by surprise.

Similar to the findings of a recent study on experiences with GDM (Persson, Winkvist, & Mogren, 2010), most of the Mi’kmaq women were surprised by their diagnosis of GDM later in their pregnancy or when they found out after giving birth that they had experienced the symptoms of GDM. Likewise, in Evan’s (2003) study on GDM, participants revealed that they were caught off guard.

The majority of the mothers attended prenatal classes at the health center in their First Nations communities. According to the Community Health Nurse in one community (personal communication, January 18, 2012), prenatal classes were taught every two weeks on various topics such as nutrition, activity and rest, gestational diabetes, partner violence, what to watch for in pregnancy, signs and symptoms of labor, the labor process, and breast and bottle feeding. Women also received education on GDM including how to maintain normal blood sugar levels and counseling on healthy eating when they went to the hospital to meet with the dietitian after they were diagnosed with GDM. As an incentive to attend, the women were given an infant car seat free of charge if they were present at a minimum of 6 classes. They also received prenatal education from the doctors and nurses in the office and perinatal unit on topics related to maternal changes in the body, fetal growth and development, and overall assessment regarding the progress of their pregnancy.

There was a distinct difference between their experiences in their community and in the acute care setting. The prenatal classes in their First Nations communities served not only as an opportunity to learn about pregnancy and birth but it was also a time to discuss everyday life concerns such as relationship issues with their partners and/or other members of their family. The setting was informal, surrounded by people from their own culture and people they knew well. There was no sense of rush or urgency; the atmosphere was a slow and relaxing pace.

During one of the talking circles, other Mi’kmaq women in the community, in addition to the participants, gathered to discuss their concerns about GDM. One participant shared her personal situation as follows

> First time I had gestational diabetes was in 1989. Yeah, I had it with my last three children. 1989, 1992, and 1994 and I’m Type II diabetes now. I um, after I had my last one, I was kinda heavy and the doctors told me you know to, if you don’t

> start takin' care of yourself losing weight, well you're probably gonna have Type II diabetes and then probably within the year, I um. . . . So anyway, so I've had Type II diabetes probably since '96. (Participant 2, talking circle)

When I asked her if she changed anything, she responded by saying

> No. Like I know there's things, I know there's things I shouldn't eat or whatever, whatever, whatever, you know I go to diabetic clinics and that and just, with me it just seems, kinda seems to go in one ear and out the other. And that's just, it seems to be worse when you're pregnant. (Participant 2, talking circle)

This participant acknowledged that she needed to makes changes in her lifestyle since becoming diabetic. She managed to make one change which was eliminating sweets in her diet to keep her weight in an appropriate range. However, when she was having her children and when she was diagnosed with Type II Diabetes, she explained "I don't know it's just, I don't know it's hard to explain how I felt like they coulda told me 'til I was black and blue and I woulda still done what I wanted to do" (Participant 2, talking circle). The women discussed how difficult it is to makes changes to their lifestyle. One participant believed that diabetes occurs because "I think we talked about it before and it's like we don't make our health a priority" (Participant 3, talking circle).

The conversations with the participants were reflective of a holistic approach to health which included physical, psychological, emotional, and spiritual elements of health (Loppie Reading, & Wein, 2009). Healing occurs when Aboriginal people maintain a balance and connectedness to one's life and when they envision where they are going (Regnier, 1995). When they come together to share their visions and discuss their concerns such as these talking circles, it helps to restore their rituals (Ermine, 1995). Similarly, the Mi’kmaq women view their health as holistic and unite “the ideology of balance and the interconnectedness of the natural world” (Baker, 1998, p. 323). Healing is connected to restoring harmony and balance (Baker, 1998). When the participants in my study felt out of balance, they did not feel healthy.

In contrast to the health centers in their communities, the atmosphere outside their community was not informal and Aboriginal people do not have the same sense of comfort dropping in. They cannot just drop into a clinic; they have to have an appointment. In this western setting the emphasis is primarily on disease prevention and medical treatment. It is not designed for patients to be seen in a reasonable length of time as one participant responded to another participant during a talking circle session. They discuss “Do you think that when you were, you were diabetic, do you think it would have helped if a nutritionist met with you on a regular basis?” (Participant 3, talking circle). “Wouldn’t have made any, well it probably would’ve helped a little bit, know what I mean? But I go see a nutritionist now at the diabetic clinic” (Participant 2, talking circle). “Do you think the diabetic clinic is doing you any good or do you think you could pass on that message” (Participant 3, talking circle)? “I told [Doctor] the other day I don’t know why I even have to go. I said you can give me the information here. What pisses me off is going to the diabetic clinic is they take so damn long, it’s a turn off” (Participant 2, talking circle). The participants discussed what would work better for them. They thought it would be better to have nutritionists present in their community on a regular basis to help guide them and be available to answer questions instead of just being told what they should eat when they went for appointments outside their own community.

Kate was frustrated because GDM was never mentioned as a possible health condition during her first pregnancy. She was admitted to the hospital once during her pregnancy and described her entire pregnancy/hospitalization as a "strict" experience. When she gained 20 pounds during the Christmas holiday, she required hospitalization. She recalled that they [lab technicians] "wake me up and, and take blood. Um nobody was allowed to bring me food, you know, it was really, she was really, really strict about" (Kate). At the end of a rigid week in hospital the doctor gave her pamphlets on how to control her sugar but did never mentioned anything about suspecting GDM. She explained:

> She [doctor] never really mentioned it [GDM] . . ., or I never took any medication or anything like that. She [the doctor] was just very adamant about me controlling it through my diet, which when you're, I was 18 years old, I'm a kid, I'm gonna eat junk food or, you know, I'm pregnant. (Kate)

This particular scenario depicted how misled Kate was in understanding the health consequences of this condition as she stated:

> You know my doctor [general practitioner with first baby] never really explained to me, like I told you before I didn't really understand it was affecting the baby more than it was affecting me, I thought it was just going to, you know, frig up my weight and, you know, not you know, I really didn't think it was gonna have any big effect on me 'cause I kept oh it goes away after I have the baby. (Kate)

Looking back, Kate wished that they [doctors and nurses] would have taken the time to explain why the blood work was done and that because GDM was suspected, she required more frequent follow-up.

Some women knew they are at increased risk of developing diabetes later in life because it is familial, however it did not occur to them that they could develop GDM at a young age. The participants described finding it difficult to understand what was happening to their bodies, leaving them feeling overwhelmed and afraid at times before the diagnosis was confirmed. Sometimes this fear continued throughout their entire pregnancy. For example, Jane knew that she did not feel like her normal self during one of her pregnancies yet she did not know why she felt discomfort. She described her symptoms as follows

> Yeah they [doctor and nurse] just sent you home, and I was sick, I was like I didn't know that if I didn't eat my sugar would drop and it used to drop lots, like and I'd get sick, and I'd be tired, and I'd be weak, and I'd be cold in the middle of July, like freezing cold. (Jane)

By her fifth pregnancy she was well aware of even the most subtle changes in her body. Yet she wondered why the health care professionals did not understand what she was experiencing. How is it that the health care professionals do not listen to patients when they have ailments? Do health care professionals understand that embodied approaches help them understand human beings (Wilde, 1999)? According to Wilde (1999), "meanings of health and illness can be understood through embodied approaches, such as phenomenology" (p. 27). Jane and other mothers' practical knowledge could be realized through this way of knowing their body. Jane sensed there was something wrong with her body; it was out of balance and she wanted something done to bring her back to the way she was feeling before she became pregnant. She described feeling sick because her body was out of balance physically and emotionally, mentally, and spiritually—all components of her well-being.

In life we live in our lived bodies (Merleau-Ponty, 1962/1992) and if we become too focused on our object bodies, we cannot really carry on with feeling well. Yet as Gadow shows in her 1980 article, people do learn to get on with life. People try to learn about their health problem(s) so that they can develop strategies to cope with the condition. However the Mi’kmaq women here did not have time on their side . . . they had to learn quickly and shift quickly from managing their object body to staying in their lived body to take care of their children. It was as though their object body was trying to take over and pull them from their lived body where they knew they needed to attend to the children and other members of the family. For example, Annette struggled with trying to quit smoking when she discovered she was pregnant because she knew it was an unhealthy practice. Yet she knew if she quit she was going to gain more weight which naturally affected regulating her insulin and keeping her blood sugar normal, and affected her unborn baby. She tried to manage the objective body so she could attend to the lived body:

> But there’s uh, oh it was just so hard so ’cause what do ya do, even if you want to quit during your pregnancy this is, and this is just a thought out there, what do you do if you quit, you know you’re gonna gain more weight, you know you’re gonna

> eat more ’cause that’s what people do, and so what do I do, up my insulin or gain, me and my baby gain a bunch of weight or, and those are real questions for me and, and I just wasn’t strong enough to quit yet, we’re workin’ on it again. (Annette)

Annette found a way to balance eating healthy and taking insulin but smoking was so much a part of her life that she could not see herself quitting at this time. Finding ways to unify the body and self and bring them into harmony to minimize the conflict (Gadow, 1980), as in the case of women with GDM or other illness would be most welcome.

Many participants commented that they could have been placed on the appropriate medical treatment [insulin and/or diabetic diet] if they had been diagnosed earlier in their pregnancy. They were puzzled as to why they were not diagnosed sooner in pregnancy. The mothers were dismayed at the entire situation because they placed their health in the hands of competent health care professionals. For example Annette explained that the doctors did not diagnose her with GDM until shortly before she delivered with her first pregnancy. She was required to wait for a referral to a diabetic clinic, a formal process which delays starting on insulin.

> They were very much more proactive in my last two pregnancies than my first. I was only on needles with him the last 2 weeks, by the time they caught it and whatever and done anything about it. They gave me a, like it was so formal when they waited for my referral here and it was valuable weeks I coulda been on insulin. With my girls, I was on it almost as soon as I could be. (Annette)

As I reflect on Annette’s situation I think it is serious neglect and lack of competent health care that there are no check-ups and follow-ups. If GDM or diabetes is suspected, laboratory testing is readily accessible which can then be followed by appropriate interventions. Because GDM and diabetes are so prevalent in Aboriginal communities, prompt diagnostic testing is needed. It really is a serious access issue. I too wonder why the referrals take long and why it appears that no follow-up care is provided. Receiving the diagnosis of GDM late in pregnancy was upsetting for Annette because she had no time to prepare for GDM, physically or mentally. There was no chance to come to terms with the condition quickly.

Another participant was not diagnosed with GDM until her sixth pregnancy. Although Jane did not feel well, she did not suspect GDM until the diagnosis was made. During her fifth pregnancy though, she noticed that she was not feeling well but the health care providers did not suspect GDM and as a result no diagnostic testing was carried out. Looking back she recalls

> I was really sick, I know now what it was, you know, and every time I went to the hospital it was like oh well we can’t find anything wrong with you so it’s just normal pregnancy aches and pains, and I’m like this isn’t normal, you know, I’ve had like five kids and I’ve never went through anything like this. I’d go home and, and it was, it was just terrible, I, they knew nothin’ then, you know, then it, it seemed like they didn’t even take the extra step to see what they could find out. (Jane)

Although this pregnancy occurred 22 years ago she still questions why the doctors or other health care providers did not detect that her blood sugar levels were abnormally high. At that time, I recall the prenatal protocol was to do glucose screening with the initial prenatal blood work and a glucose tolerance test was done at 28 weeks gestation. Therefore, I wonder what the laboratory results revealed at that time or were they even done. This is something we will never know.

During our discussion of ways to stay healthy Jane revealed that she now has Type II diabetes. She was diagnosed at 40 years of age. She explained:

> Because I had my last baby at 35, by the time I was 40 I had diabetes, to get the energy to get up and do something about it is just, 'cause you're just so tired, like today I, I ate and all of a sudden I'm feeling like . . . like what I'm trying to say is to get the energy to, to get well enough to plant a garden or walk. (Jane)

During the first meeting with Jane, just shortly into the conversation, I observed how her face grew gradually pale and she leaned back in her office chair as though she was becoming weak. I ask her if she was feeling OK and she responded "yeah." I then asked her if she was getting tired and she responded "Yeah, yeah" (Jane). I offered to stop the conversation any time because the discussion was extending over lunch hour. She smiled and responded that she wanted to continue the conversation. Although Jane did not exhibit much vitality, I could see in her eyes and sincere smile that she genuinely wanted to carry on the dialogue. She was eager to share her life experiences. By choosing to continue the conversation when she did not feel well sent a strong message that she saw this opportunity as a necessary step to share an important part of her life in the hope of helping other women and gaining insight into her own personal life. This action speaks to an obligation and a genuine concern to use this opportunity as a way to share her knowledge and hopefully educate others.

Similar to Jane’s experience, Kate was not diagnosed with GDM during her first pregnancy 15 years ago. Although her blood sugar level was borderline high during her first pregnancy, her doctor did not label it as such. There was no plan to put her on insulin. Instead, Kate’s doctor gave her educational pamphlets on eating healthy because her mother and other members of her family had diabetes and the need to monitor her blood sugar levels was stressed. Being a teenager complicated matters because being young she did not want to be restricted from eating “junk food.” If she had only known her life may have been different as she stated “I would have searched for more information on preventing GDM” (Kate). She considers herself a responsible person and mother. Veronica was sad when she learned that she had GDM. She stated “I don’t know, like I kinda got upset that I got it. Got gestational diabetes ‘cause I didn’t want it but I kinda knew I would, ‘cause my mother had it and my sister had it” (Veronica). Veronica knew what lay ahead of her which is why she reacted so emotionally when she received the diagnosis.

Laura became upset when she first discovered that she had GDM. Getting the diagnosis one minute and then being expected to follow a treatment plan immediately was overwhelming as she described

> I went to go see this doctor and I was pretty upset about it because uh, well really I wasn’t payin’ attention to him, right, you know, like, I was like kind of in shock

> that he was puttin' me on insulin 'cause um my sugars were OK in the morning time, they were OK in the afternoon, but in the evenin' time they were high, so he told me that he's gonna put me on insulin and that I was to take it at like supper time. (Laura)

There was no time for her to conceptualize what was happening. Moreover, there was little time to learn how she was going to administer insulin, a skill that requires practice and observation by someone knowledgeable in the health field. As a result, she had very little time to prepare mentally and to be instructed on administering insulin. I wonder if the doctor considered the impact that this life change would have on Laura. She was devastated by the unexpected news. Instead of giving Laura an opportunity to ask questions and discuss how long it may take to learn the procedure for self-administering this medication, she had to adjust immediately. She stated "I said OK then, then he [doctor] writes up this paper, then he sends me upstairs to a diabetic clinic to um, to go see the nurse" (Laura). As I reflect on the situation I begin to be more drawn into it. It is not appropriate for patients to be taught a procedure for the first time and then be expected to be able to carry out the task on their own without guidance and reinforcement. Learning a procedure for the first times generally requires reinforcement from nurses and other health care providers (Hall & Edgecombe, 2010). In my own experience with patients, mothers required frequent demonstrations by nurses before they had the knowledge, self-confidence, and psychomotor skills to self-administer their insulin.

Aboriginal women's health and health interventions are part of who the women are as persons as well as their relationships with each other. It is well known that Aboriginal people believe that their lives are directly affected by physical, emotional, mental, and spiritual well-being as they view their health from a holistic perspective (Bartlett, 2009; Health Council of Canada, 2011; Iwama, Marshall, Marshall & Bartlett, 2009). According to Browne and Fiske (2001), in a study on cultural encounters of Aboriginal women in a northern region of western Canada, Aboriginal participants expressed gratitude for being able to share knowledge and have a voice involving health care decisions. Yet western medicine (where many Aboriginal people receive health care) takes an opposing approach and views health in isolation without considering the family, their cultural views, and their community milieu (Health Council of Canada, 2011). Aboriginal people rely on their family for knowledge and support about many topics such as health care. Including patients and their families as part of health teaching is critical.

The conversations with the women led me to wonder how Laura and other mothers coped with having to take insulin when there were other physical and emotional changes occurring in their body. For example, Laura did not receive the correct information on administering insulin. Instead, she was sent to a non-Aboriginal nurse who gave her a brief explanation on how to administer insulin and was then instructed to go home and take her insulin as though it would be no problem. There was no opportunity to practice drawing up the correct dosage, to self-administer the insulin, and to ask questions. There seems to have been professional and structural factors that may not have been in place to ensure Laura had the proper assessment and support to be knowledgeable and comfortable to administer her own insulin. In my conversations with the Aboriginal women, a number of them learned a lot about health from their families. Part of learning therefore requires families to be involved (Hall & Edgecombe, 2010). One participant stated: “But like I was just, but yeah I went to a couple of prenatal classes um and like I said just talking with family members really um, kinda made me feel a little more at ease” (Kate).

I wonder if health care providers take into account appropriate care; cultural difference; structural, economic, and political factors to question how Laura or other mothers would get along taking this medication on their own. In looking back to my own practice and observing how I and other nurses taught patients about self-administration of insulin, caring for an abdominal incision, breast feeding, and other obstetrical care, I do not think I considered the multitude of factors as mentioned above that affect whether a patient is able to carry out health care interventions. Wondering about and questioning this care practice seems absent. So we might ask what is really going on in the logic of care? Mol (2008), a professor of political philosophy in the Netherlands, argues that giving patients choices does not improve health care outcomes. Patients are already considered active participants in their care. In Mol’s (2008) work in diabetic clinics, patients learn ways of taking care of themselves, such as administering insulin. Mol (2008) reminds us that treatments on patients are not always easy on them. Mol (2008) suggests that patients need to know what they should and should not do related to their health. They need guidance as part of good care. Sometimes what health care providers are thinking is happening or what patients understand are not really what is going on at all. Often we think that if patients are instructed on ways to take care of their health, they understand what they have to do to get well. If they do not carry out these instructions, health care providers should respect their decision. Good care arises out of collaborative relationships between health care providers and patients where knowledge and technical aspects of care are adapted to the patient's health condition(s) (Mol, 2008). I wonder if the health care professionals were thinking that their job was complete when they instructed the Mi'kmaq women on procedures such as insulin administration. Or is this a situation where health care professionals are driven by knowing the doom that is upon the Mi'kmaq women and they cannot do anything about it? Or were they operating from something more sinister like fast-held stereotypical stigmas around the women?

Unlike the other women, Veronica was not surprised when she was diagnosed with GDM because diabetes was common in her family. She recalled:

> I was always tired. Like I kinda figured it was the way I was eating, because like I'll have a good munch out and I'll be like ugh all drowsy . . . I'll be like no; I gotta go for a walk. I'll get up, go for a walk and I'm like just wobbling. It was, I don't know, like I kinda got upset that I got it. Got gestational diabetes 'cause I didn't want it but I kinda knew I would, 'cause my mother had it and my sister had it. (Veronica)

Veronica knew her general eating practices contributed to developing GDM. Her body did not function like it used to before pregnancy. Merleau-Ponty (1962/1992) states that the body learns how to perform an action; in essence it responds to the call. Veronica was surprised by her body's lack of response. Her body let her down; it became foreign to her. She was confused by its lack of being there for her. These feelings of weakness and drowsiness were strange and she did not like the feeling it left within her body. During our conversation I sensed a profound love for her son and the baby she lost as a result of a miscarriage. All the while we talked, her son played close to her side. Every now and then he came over to me to show his toys. I observed how his mother smiled at him while we talked. One time he brought over his bus for me to look at. I responded "This is your bus? I like your bus" (researcher, field notes). The little boy smiled back at me (researcher, field notes).

Loretta lived in fear that her children were going to develop diabetes based on what other community members told her.

> But most likely that'll be, that's what will happen, she'll have diabetes when she like, usually like if the mother has diabetes they have a baby, if they're gestational, then their kids will have diabetes, and so far like, I know of one friend of mine who had gestational diabetes and now her two boys are diabetic. (Loretta)

It is like a dark cloud hanging over Loretta. There is no way to run and escape from it.

From the participants' points of view, diabetes will find you wherever you are. The threat of developing diabetes is real for these women leaving them feeling they have no control over the future regardless of how they eat or their general lifestyle. As Neufeld and Marchessault (2006) found in their study with 28 Aboriginal women living in Manitoba, causative factors such as diet, inactivity, and weight gain similar to the women in my study increased their risk of developing diabetes. Although there is a sense of not being able to avoid diabetes regardless of what the women do, I wonder if the perceived inevitability gives these women insight, experience of knowing what to expect, and perhaps helps them discover ways to minimize their symptoms and learn ways to prevent GDM. Experience can bring knowledge but it can sometimes be painful (Gadamer, 1989). Gadamer (1989) uses the example of how parents try to prevent their children from gaining experience through common situations that will bring about an unpleasant feeling. But Gadamer (1989) points outs that people should not be spared experience. Negative experiences can bring about new experiences from which individuals can learn. In this instance, I wonder if the participant’s experiences can bring forth positive knowledge and allow them and others in their community to gain more insight into their health to reduce the incidence of GDM. Based on my conversations with the women in the study, I think they would agree that although this has been a difficult time for them, they are learning about themselves and their health through this journey. To illustrate an example, I have used an excerpt from Annette’s story.

> Well even, even, even it goes back a little further just ‘cause I was overweight by the time I got to [third child] all my life we live and ate a certain way. And it’s hard to un-live those ways. Like ya know how you teach your children like eat everything on your plate. Don’t tell me, eat somethin’ on your damn plate or you’re not getting a treat. But I don’t tell, I try not to tell my children, [son’s] a little more on it and I try to explain it to him you make your kid eat even if they take seconds. Well if they don’t eat it all K so their eyes were bigger than their

> mouth. It doesn't mean you make them, 'cause then you, it's almost like uh part of their life philosophy or whatever, you take it and you, and you shouldn't and you learn, you learn those habits. And so anyway I over ate and I was pretty big and then I had [son] and I got bigger and I stayed that way. And I still had that mentality. And I still do and I gotta stop and go OK you're full, I need to, and I know it's a, I overeat at supper almost every night but I'm trying not to. (Annette)

Annette developed her eating habits at a young age and continued to do the same in her adult years. Being diagnosed with GDM helped Annette gain insight into making changes in her eating practices. Annette found attending workshops and having mental health therapy beneficial in helping her cope with GDM and other life issues. As a result she is using this new information to educate her children about healthy eating.

In understanding the bodily experience in living with GDM, I use the work of Gadamer (1996), who asserts that we need to learn how to recognize our needs and be able to work through our difficulties. But in order to do this we must be conscious of what is happening to our bodies. Furthermore, "The life of the body always seems to me to be something which is experienced as a constant movement between the loss of equilibrium and the search for a new point of stability" (Gadamer, 1976, p. 78). When the body experiences GDM, it needs medical science, insulin, and nutritious foods to help restore its balance. When the body is out of balance, it feels vulnerable (i.e., at risk to ill health). Understanding the body's physiological and psychological functioning can help people seek and learn strategies to cope with and improve their health and thereby gain the strength and confidence to function in life.

Life altering experience.

Gestational diabetes quietly entered some Mi'kmaq women's bodies without warning, while other women experienced the disease like a thunderstorm. In both instances, it altered the way they would live their lives during pregnancy and in the future. This condition was similar to a flu-like virus where it took over their bodies for a period of time and did not leave until pregnancy ended. The participants reported that once they were diagnosed with GDM, the condition was on their minds all the time. There was a sense of personal blame as the women talked about the inevitability of developing diabetes later in life. Although they tried to eat healthier and exercise, they knew these strategies would not be enough to prevent GDM.

Carol described her concerns about developing diabetes later even though she did everything she could during pregnancy. She stated:

> Just because I am big I am going to get GDM. Felt good when the pregnancy was over, always in my head what a good job I was doing taking insulin. Amazed after the baby was born, it [diabetes] is a warning . . . I am trying my best not to get diabetes. (Carol)

Annette's life was altered when she experienced fluctuations in her blood sugar levels causing her much discomfort and worry. For instance, when her blood sugar was low, known as hypoglycemia, she said she could not think straight, a symptom of hypoglycemia (Black, Hawks, & Keene, 2001). Annette found it challenging to cope with the physical symptoms of fatigue and lack of concentration while trying to get her blood sugar back to normal. She explained her concerns in the following manner:

> Sometimes I feel like 'cause of my high and lows [blood sugar] that I was just as whatever as her [mother] because I, I just, there was no filter [no way to vent], there was no, it's hard to think right when you, when you're diabetic or and you're having a moment. I've seen my mom say some pretty ignorant stuff to me that my mother would never in her wild, she doesn't even remember it to this day. (Annette)

Some participants tried to rationalize why they developed GDM. Some attributed the condition to consuming high amounts of sugar and/or alcohol, being overweight from not exercising regularly or by inheriting this trait. Neufeld and Marchessault (2006) report similar findings in a qualitative study of why Aboriginal people develop diabetes during pregnancy in their study of 14 mothers and 14 grandmothers, all of whom were Aboriginal. Although only one grandmother and two mothers had GDM, while 2 mothers discussed having high blood sugar during pregnancy, they said that eating junk food, smoking, drinking alcohol, and hereditary factors were among the common reasons for developing diabetes in pregnancy (Neufeld & Marchessault, 2006). Regardless of the causes or risk factors associated with GDM, the Mi'kmaq women knew their lives had changed and they had to face reality. Evoking the thoughts of van Manen (1998) as he states "a reassuring explanation is required to appease us and to help us to resume or rebuild an unbroken relation with the body and thus with the world" (p. 6). More explanation on GDM would have helped put the women's minds at ease about why they developed GDM.

Being diagnosed with GDM meant the women's daily schedules took a sudden and irreversible change. They were required to follow a regimented schedule, something most of them never anticipated would happen. Efforts to succeed in managing diabetes invaded their lives and their families' lives, forcing them to alter the ways they were living (Beverly, Penrod, & Wray, 2007). One of the greatest changes the participants had to make was to adhere to time. In the Mi'kmaq culture, time is considered a cultural symbol as life is viewed as cyclic (Baker, 1998). Time passes as a rhythm as opposed to being linear (Baker, 1998). This is in contrast to western thinking where time governs everything we do as most people wear watches and live their lives based on time and schedules, Aboriginal people place less emphasis on time and events begin when they arrive (Baker, 1998). Having to adhere to specific schedules to eat and manage their GDM altered the women's ways of living. Although the women did not communicate any problems with adhering to a schedule when taking insulin, they mentioned that they had to check their blood sugar and administer their insulin at prescribed times. Veronica described having to check her blood sugar a "couple of times a day" and took insulin "three times a day." I was going every week . . . for the stress test" (Veronica). Having to monitor their blood sugar and administer insulin was foreign to them.

Laura found it difficult telling her children that they could not have cookies any more. "Even like with the food I made my children suffer with me, you know, I didn't buy cookies. It was a sacrifice to avoid cookies" (Laura).

Likewise, Veronica had to change the way she was living because she was not following a healthy lifestyle. She knew her drinking habits and poor eating practices would compromise her baby's and her own health.

> Before I got pregnant I wasn't very healthy at all, I was always like drinkin' alcohol and eatin' greasy foods and just anything. When I got pregnant I stopped it all and then I started prenatal class, after that I had, that's when they started tellin' me about brain food and how to eat better, healthier, and things like that so I started doin'good because I was losin' weight while I was um pregnant because I was eatin' better and healthier. (Veronica)

Becoming pregnant resulted in Veronica eating healthier for a short period of time. However, being restricted to healthy foods and avoiding fast foods frustrated her and she began having "cravings for Tim Horton's cappuccinos" (Veronica). Although she knew high fat food and high sugar intake were contraindicated with GDM, she found it difficult to control her cravings for these foods. We know from recent literature that changing to healthy lifestyles requires social support. Social support provides a means of decreasing and/or preventing the crippling effects of unhealthy social environments (House, 1981). Social support leads to a healthier lifestyle by reducing stress, helping individuals feel included, and providing emotional resources (CNA, 2005).

Some women experienced fear and uncertainty when diagnosed with GDM. For example, Loretta described her experience as "awful."

> That’s the reason why I don’t have, I don’t want to have another baby. ’Cause I know next time I get pregnant I’ll be gestational again. Um, just taking insulin and just having a low sugar . . . that, that’s the most scary part. (Loretta)

Fear continued to plague her to the point that she did not want to have any more children.

Anne was worried about the health of her unborn twins. By 32 weeks gestation, her life substantially began to change. She described her experience in the following manner:

> Feeling nauseous and I was getting sick, got light-headed so the [community health] nurse told me go get it checked out. Once I started bleeding they got me prepped. They shipped me to the hospital [tertiary care] and I was in hospital for about 4 days and then I got let out of the hospital and then I was put on bed rest and for the remaining of my weeks I got, I was just going in and out of hospital. (Anne)

Following discharge from the tertiary care hospital, she was readmitted back to the regional hospital near her community on a nursing unit where there were a variety of medical, antepartum, and post-partum patients. She remembered hearing other babies cry and desperately wanting to hear her own baby cry. Anne experienced feelings of uncertainty not knowing when she was going to deliver her babies. She agonized every night over whether this would be the night that she would go into labor. Anne still to this day recalls “every night there was new baby and I just wanted to hear my babies cry.”

Carol described how GDM changed how she felt during pregnancy in the following manner: “it [blood sugar] was high and uh I found I slept a lot. I drank a lot of water, there's a lot of things to know that I was gestation diabetes" (Carol). Carol was amazed about how much there was to learn when she was diagnosed with GDM.

Kate's life changed when she became pregnant at 18 years of age and found out she had to eat nutritious food because the doctor was following her blood sugar. Kate was not experienced in cooking healthy meals as she stated:

> When I would go see her [doctor] if I, if she felt I had gained too much weight, it was just stop eating so much. Eat more fruits and vegetables. Um don't eat any sugary foods. Don't have any snacks, don't go to fast food places, but not giving me options for other things, and you know I wasn't much of a cook, I was 18 years old. So my partner and I, we ate out a lot. (Kate)

Since cooking was not something that Kate could master at a young age and she knew she had to eat healthy, she and her partner decided to eat out in restaurants frequently.

Some women's faith in the health care system was shaken when they discovered that the health care providers did not provide the safe care they anticipated. For instance Laura experienced a life altering experience when she discovered she was prescribed the wrong insulin dosage and almost died as a result. She described the situation with great emotion and fear in the following excerpt:

> I was listenin' to her [nurse] because she was giving me the instructions and then she told me OK you take 44 units of um insulin at supper time, so I was take, takin' 44 units of insulin which was only supposed to be 4 units of insulin. And when I had that feelin' of bein' like um shaky and, you know, sick . . . I would eat chocolate bars and it would be two of them. I could have um killed myself or

> somethin' 'cause when I looked at my sugars some of them were like 2 and 3. I could've went into a diabetic coma or somethin' like. She initially considered suing the doctor and nurses but after discussing the incident with her mother, she changed her mind. (Laura)

Her mother thought there was no point to seek legal action because both Laura and her baby are healthy now. However, this incident changed the way she thinks about the health care system as she no longer trusts health care providers. She is afraid that the same thing could happen again.

Financial concerns weighed heavily on a number of the Mi'kmaq participants. Some women lived on welfare which meant they only received a small income every 2 weeks. Because nutritious food cost more than unhealthy food, the women vocalized that their monthly income was much too low for them to eat healthy. One participant explained:

> Our, the social budget isn't uh, I don't think it's changed in years, you know, a single person's welfare is $185 every 2 weeks. You know, you pay 20 bucks to go in town. It just covers uh your personal stuff, your gas to go in town, and your food. (Jane, conversation)

Carol found that buying healthy foods was a financial challenge because of their higher cost. Her frustration was captured in the following phrase "it's [healthy food] just too much money and like it's not too much money, it's cheaper stuff, it's bad for you" (Carol).

Another participant shared her frustration with having to live on a low income as follows:

> I like to gamble, but I know people that are never gonna make it off that friggin' reserve with their $184 ration check, or however much, and what do you do when you can't bring home food. . . . And but Chief and Counsellors say we're not gonna help and you can't dig yourself this hole 'cause this little girl asked the Chief all these questions, what are you gonna do when somebody blows their ration or he's got no food, a purchase order, so what happens the next ration 'cause when you get a purchase order for food it comes off your next welfares, well what do you do. (Annette)

It was a vicious circle and a struggle for these women when they were diagnosed with GDM because they found it difficult to fulfill this important role of being a mother. Van Manen (1997) states that parents "bear, give bearing to children, make available space and ground for being" (p. 60). From this perspective, Mi'kmaq mothers give place and space for their children to live, with the focus on keeping them safe. GDM altered the way they live their lives; now they have to be much more vigilant about taking care of their health. As Mikkonen and Raphael (2010) point out: "income determines the quality of other SDOH such as food security, housing, and other basic prerequisites of health" (p. 12). The women know what they have to do to stay healthy and that their children need to be healthy. Their greatest barrier is low income, similar to the findings of Barnett, White, and Horne (2002), Loppie, Redding and Wein (2009), and Raphael (2006).

Lack of energy.

Lack of energy became a prominent thread during the conversations. The women explained that they were accustomed to taking care of themselves and their families prior to being diagnosed with GDM. Once they developed GDM, they experienced feeling a lack of energy before starting on insulin.

Annette described finding it hard to cope as she explained: “I had no energy and it was harder the second time around, the third time around” [successive pregnancies]. Although she had been proactive in learning about GDM, she described her personal situation as “being hard. You know, sometimes it’s hard . . ., I really try and take all the courses I can, I really try and educate myself, and I go to the Kids First, I sign up for a lot of the programs”(Annette). Regardless of what she did to try to feel better, it was a struggle. Loretta described feeling “shakiness” while Carol states “I had no energy. I didn’t want to get off the chair, I didn’t want to move. I felt too tired. My mouth was so dry that I chewed on ice cubes and it was never cold enough.” During Veronica’s pregnancy she found that when her blood sugar levels were under control she felt fine but when her levels dropped “I got lazy” [meaning tired and no energy]. Kate found that she had more energy and lost weight during her second pregnancy when GDM was diagnosed earlier than with her first pregnancy. “I had a lot more energy when I was pregnant with my daughter than with my son, um and I actually technically lost weight the whole time” (Kate). Jane went from having GDM to developing Type II diabetes in later years. She experiences ongoing fatigue now that she has diabetes. Feeling no energy added to their exhaustion during pregnancy.

Loretta needed to gain back her physical energy to care for her 2-year-old daughter. Without insulin, her body felt limp and drained. Loretta described the feeling as “It was just . . . you “don’t want to do nothing.” Before being diagnosed with GDM, she could barely care for her daughter, a toddler at the time who was very active. She recalled: “and chasing after her [daughter], oh you just have no energy” (Loretta). Evoking the views of van Manen (1997), Loretta views her child as an extension of her body and what affects her affects the relationship with her child. As a parent, Loretta wanted to ensure her daughter was properly taken care of at all times. She embodied her motherhood role such that she looks at her daughter as one who needed to be protected when Loretta was unable to do care for her. Insulin was like a “generator pump” as it kept her body functioning so she could keep her baby and her own body healthy. She recalled the initial insulin administration: “I remember the first shot of insulin I had, oh my god, I felt good after that. Yeah, I felt like normal” (Loretta). As I looked into her eyes I can see that gentle sparkle and excitement that she likely felt after starting on insulin therapy. Insulin helped her maintain her bodily strength to get through her pregnancy with GDM.

Without having the energy to care for their children the women were unable to embody their role as a mother to take care of their children (van Manen, 1997). Since their bodies changed and they were losing control there were times when they could not take care of themselves or their families. One participant described how lack of energy affected her: “I kept falling asleep in our daytime, I didn’t have the energy, I found like it was such a big thing for you to do a task that was such an easy thing to do before you were pregnant"(Carol). However, insulin became a "saving grace" for some participants because as soon as they started on this medication, they began feeling better. When Annette started taking insulin she found "I just felt, my body just felt better, I don't know how else to explain it cause I felt so draggy and just not well" before treatment. The women explained that they were used to taking care of their families but with this condition they were not able to do the things that embodied the meaning of their lives as mothers/caretakers until they began taking insulin.

Taking insulin created an emotional "roller coaster" feeling for some. Annette described feeling emotional when she had to begin taking insulin. "I couldn't do anything, I was emotional, one minute I'm yelling at someone, the next minute I'm crying . . . I had no energy and it was harder the second time around, the third time around" (Annette). Jane recalled her experiences with GDM as "it was miserable, it was from July, and she [daughter]was born in December so it was like that whole time I was just like sick, miserable, and I don't know how, how we [she and her family]did it." Carol explained "that it really bothered me just to know that I took the needles but uh it, like I said it helped me." Although some mothers did not want to have to take insulin during pregnancy, they knew they had to take it for their health and their babies' health.

After the shock of being diagnosed with GDM, acceptance is a natural progression. The Mi'kmaq women were grateful knowing that they only had to take insulin during pregnancy; there was an end in sight. However, the women were guarded because they knew the odds were against them for developing diabetes later in life.

Aboriginal women are recognized for their strength and commitment to their family (Kenny, 2006). They consider this as an important responsibility. A woman’s ability to give birth and raise her child/children is considered a highly regarded position among Elders, Chiefs, and others in Aboriginal communities (NAHO, 2004). Lacking energy to care for themselves and their families may be perceived as a weakness by some members of their communities; a situation that makes women vulnerable. Thus, lack of energy to carry out their motherhood roles becomes a stressor for the Mi’kmaq women. For instance Jane is melancholy when she describes her partner’s reaction during her experience with GDM. She recalled:

> My family or my partner he didn’t realize like what this does. To him I was lazy, you know, “why don’t you get your ass out of bed and get the house clean, you know, or cook supper. Do something productive other than lay there and do nothin’, sleep all day.” So that, that, and, and even today that, uh that is a big challenge for me in, in, in my relationship, right? Um it’s easy for him to say yeah, well get up and go for a walk or do this. (Jane)

This notion of fatigue feeds into stereotypes whereby the Aboriginal women are not considered useful but rather sluggish or idle and was evident in my discussions with Jane.

> Just need help to get through to the, get to that point where you can start feeling better, right, like I say. So I think that our, our uh families or partners need to be more educated also . . . because it doesn’t only affect you, it affects everybody. (Jane)

Jane wished that her partner understood what it meant to have GDM. She attributed his disrespect for her condition as being due to lack of knowledge about how diabetes affects her body. Having diabetes caused family dynamics that created a lot of strain on her relationship with her partner. It also affected her relationship with others. If only she could find a way to help them understand. Van Manen (1998) refers to the state of illness as “a person’s well-being is being disturbed” (p. 6). Illness affects everything the person does including time, priorities, and relations with people. I wondered how Jane could help her partner to understand this condition. During our conversation I sensed that her partner disregarded her health condition, thus labeling her as lazy, which has deepened the hurt she was feeling.

No way out; Feelings of hopelessness.

It became evident that there was a sense of no way out and feelings of hopelessness at times as the Mi’kmaq women described their experiences with GDM. The disease seemed to linger in their minds and they were never sure if it was really going to leave their body. There was a sense of hopelessness clouding their lives and the future of their children. How are the women going to stop diabetes from spreading? How do the women find a way to live with their body to find comfort and contentment? van Manen (1998) maintains that nursing has a responsibility in assisting patients who need nursing care “to recover a livable relation with his or her psychological being” (p. 1). One mother had inspiring words “Imagine that world -community will be diabetic free" (Carol). Sadly enough she knows this is not possible because so many people in her community have diabetes and the incidence is growing.

Marsiglia, Kulis, Perez, and Bermudrez-Parsai (2011) assert that hopelessness exists in situations where people expect negative outcomes. The characteristics are exhibited by negative feelings, cynicism, and lack of meaning in one's life. Others believe that there is nothing that can be done to change a situation (Abela, Gagnon, & Auerbach, 2007). During the conversations with the Mi'kmaq women some of them felt there was no way of escaping this condition; it was inevitable. They had to be realistic, otherwise they were denying reality. It is as though the disease took hold of their bodies without much warning. Regardless of what they did, GDM was going to be with them throughout their pregnancy and possibly successive pregnancies. No longer could they be carefree about what they ate. Changing their eating habits to incorporate more nutritious food during pregnancy required a lot of planning and will power.

Annette described her experiences with GDM as suffering. During pregnancy things just "got harder" (Annette). This difficulty meant that she did not have a lot of time to herself. She described pregnancy as "suffering." Part of the suffering she claimed was attributed to fatigue. Annette stated "I didn't have the luxury of being able to just go take a nap. I had to suffer through [pregnancy]." This condition affected her health in various ways such as low self-esteem, needing more emotional support, low energy, and anxiety around how to prevent developing diabetes in later life. She was afraid that her children were going to develop diabetes. She felt she was "between a rock and a hard place"; it reminded me of someone being given a life-sentence. She was concerned about her own health and the health of her children. She wanted to be proactive to prevent diabetes but was not sure if the path she was on was going to help her and her family to avoid diabetes. Listening and reflecting on Annette's story as well as other participants has revealed the complexity of their lives in becoming mothers (Bergum, 1989).

The women do not see a way to break the cycle; to them GDM is unavoidable. Some women thought it was foreseeable that they would develop diabetes later in life because other members in their family had this condition.

> That's what will happen, she'll [referring to her daughter] have diabetes when she gets older. It's like if the mother has diabetes they have a baby, if they're gestational, then their kids will have diabetes, and so far like, I know of one friend of mine who had gestational diabetes and now her two boys are diabetic. (Loretta)

In a sad tone of voice, Carol stated "my grammy and granddad were diabetic, uh my sister's diabetic, her family, children are diabetic, her and her children are diabetic and the only thing it bothers me, . . . like I said it, uh they just let it go." She explained that when her parents were growing up, they could not afford to buy junk food so they ate healthy foods. However, times have changed and it became necessary to purchase foods which are unhealthy but cheaper and affordable. "I think a lot of us did end up with diabetes, you know it just came a habit of buying those things that you used to buy" (Carol). Furthermore she stated "you wanna keep on buying them things. And a lot of people now keep the same list [grocery list], I know there's a lot of people that write the same things down over and over again" (Carol). Thus, purchasing unhealthy foods became a habit; a way of life. Because Carol was aware of the dangers of buying unhealthy foods, she was making a conscientious effort to purchase nutritious foods.

The Mi'kmaq women are deeply concerned about their health and the health of their babies. Although they worry about their babies during pregnancy, it is evident that the women are concerned after delivery that their babies will develop GDM or Type II diabetes later in life. They know they have to take ownership of their health and the health of their children. Although the women do not have all the answers to their questions and concerns, they are wise about their health and know they have to find ways to provide a healthy future for their children.

From the participants' perspectives, the term "healthy" refers to some of these major areas: not having chronic disease such as diabetes, being in a normal body weight range for height and stature, being mentally stable without feelings of suicide or depression, and not suffering from substance abuse. The women want their children to grow up healthy. Having these research conversations provided an opportunity for the women to voice their concerns. Education does not seem to be the only solution. In other words education is not just one SDOH but there are many factors that have already been identified such as income, food security, and other things that help prevent diabetes.

Family and community relations.

Carol is shouldering the responsibility of diabetes; carrying the worry of her family and other community members. She is particularly concerned about her sister

Mary’s husband who recently suffered a stroke and had his foot amputated as a result of diabetes. Carol described her sister’s personality as a very “tough person [meaning resilient].” She stated: “my sister goes through so much, the emotions of it [diabetes] . . . like you know everything was taken away from him [husband]. He was no more independent in the house . . . but they all worked on it and Mary’s a tough woman” (Carol). Carol was concerned about the emotional and physical stress on her sister. Therefore “tough” meant that her sister was acting very strong and able to cope with her husband’s sickness. Despite the challenges that Carol’s sister faced with her husband having had a stroke, she was able to care for him and her children. Mary has been married for over 25 years. She further explains that her sister “Stuck with him through everything. And she’s the main supporter and she’s just a fantastic woman” (Carol). During our conversation Carol wanted me to understand how hard it was for her sister to be the main health provider for her husband. She considered her sister as having a strong character and being able to deal with difficult situations that a lot of other people would not be able to handle. She is very proud of her sister’s ways of coping with the situation. Often she thought, if only she could relieve the pressure for her sister and family. Mary’s actions and Carol’s own demonstration of caring and reaching out to their family signifies a strong bond that exists in Aboriginal communities. Carol, Mary, and other Aboriginal women are working hard to prevent further damage from the effects of diabetes. I could sense that Carol offered as much support and kindness as possible during this difficult time (field notes, researcher).

Some women found it challenging keeping their weight under control during pregnancy. Veronica had difficulty maintaining a normal weight gain because she craved foods during pregnancy. Veronica explains “When I got pregnant I stopped it all and started prenatal class, . . . they started tellin’ me about brain food and how to eat better... I started doin’ good . . . I’m losin’ weight and they’re like that’s good.” The women in her prenatal class remarked that “you’re heavy and we don’t want you to get diabetes, gestational diabetes . . . my boyfriend, he started worrying about me, he’s like I don’t want you to get diabetes babe” (Veronica). Similar to Carol’s family, Veronica’s family and friends also expressed concern for her and her baby’s health.

Likewise, Annette thought that there was a high probability that other Aboriginal women in her community were going to develop gestational diabetes and eventually diabetes when they got older. She stated “during pregnancy and how that affects their children and that’s what their children see and that’s what they want and it’s scary, those kids are probably gonna have, you know . . . I’m not tryin’ to be judgmental or whatever” (Annette). She realized that eating unhealthy food is a major cause of diabetes but also acknowledged that it was difficult for her and other members of her community to refrain from eating high fat food.

When we think of food, we think of feeding the body. People enjoy comfort food and sometimes that food is not always healthy for a person. Eating some particular high fat foods such as hamburgers tastes good and sometimes we eat foods out of habit. To gain more insight on habit, I turned to Merleau-Ponty (1962/1992) who describes habit as “knowledge in the hands, which is forthcoming only when bodily effort is made, and cannot be formulated in detachment from that effort" (p. 144) (an example would be getting accustomed to wearing a hat or driving a car where either of them becomes a part of the person) (Merleau-Ponty, 1962/1992). Individuals do not have to think about how to use either; they do not stand out as being objective, they are naturally a part of what we use. Food is another example where if we find something we enjoy, it just becomes second nature to buy it such as coffee or hamburgers. How is it that we change habit and still be in harmony with our bodies? How can our families and communities help us gain this harmony?

Life goes on through love and play.

Love and play are notable findings in my conversations with the women. The children are either with the participants at the health center or in their homes and the women's relationships with their children are molded by love and play. Children learn about the world through play (Perry, Hockenberry, Lowdermilk, & Wilson, 2010). They learn how they relate to the environment in a way that cannot be taught. Play provides a vehicle for children to learn how to live, communicate, and develop healthy relationships with people (Perry et al., 2010). The mother's ability to be able to provide a healthy environment for play is linked to her state of health (Ellis, 2004). For instance, maternal depression can affect the way women relate to their children as they may not respond in a healthy manner. Therefore it is important that women have the capacity to provide love and security for their children. Women's capacity to provide love is connected to their own well-being (Ellis, 2004). Location is important to consider because "good places are a source of belonging, identity, and security" as well as providing a place to be self-creative (Ellis, 2004, p. 33).

The Mi'kmaq women in this study engaged in playful activities with their children. Their warmth and attention exhibit how much they love their children. As previously mentioned, one mother came to my workplace with her three children to have a conversation about her experiences with GDM. Annette conversed with me and then quickly turned her attention to her children. It was striking how fluid it all seemed as the mother was at ease with multitasking. She was attending to her children simultaneously while engaging in a conversation with me. It quickly brought back memories for me. When I took my children to visit friends, I would try to talk to the children at the same time I was conversing with friends.

At one point when her baby woke, she breastfed her and placed her back in the stroller. At times Annette held her baby and her 2-year-old close to her chest, at the same time pouring their juice and talking. It did not seem to be an effort for her. It was amazing to see her care for her children calmly and yet be comfortably engaged in a conversation. I cannot help but think how busy this mother was and yet she freely gave of her time to participate in this study. It is evident that her children are very much a part of her life and she loves them dearly.

During my first visit with Mi'kmaq women during their prenatal classes and on subsequent visits to both communities I observed children playing while the women listened to the community health nurse. On one occasion while I was visiting the health center, the community health nurse cooked a nutritious meal for the women during their prenatal class as mentioned earlier. Meanwhile, the children continued to play in the room near their mothers and with each other. When it was time to eat, the mothers picked up the food for their children and helped them eat while they also ate their food. As the women ate, they continued to engage in dialogue on healthy nutrition and other topics related to pregnancy and concerns or questions about their child's health and eating habits. There was a sense of cohesiveness, tranquility, and genuineness among them as they shared their personal stories with each other (researcher, field notes).

As I listened to the women's stories, I realize that Aboriginal women normalize their lives through children's play and dance. Seven out of nine women talked about their children playing during the course of our conversations. Gadamer (1975) refers to play as "the movement to-and-fro obviously belongs so essentially to the game that there is an ultimate sense in which you cannot have a game by yourself" (p. 95). Therefore, another person (or persons) is needed to play the game. Gadamer (1975) refers to playing as a normal process which likely explains why these mothers see playful activity as something innate; something they naturally do as mothers. Gadamer (1975) uses play as a metaphor for understanding; we understand from going back and forth from the particular to the universal . . . perhaps this is a part of Aboriginal traditional knowledge. I observed the women had a sense of comfort having their children playing around them. The women were not annoyed by their children crying, talking, or seeking attention. While the mothers were telling their stories about GDM, they naturally exchanged conversation with their children without hesitation as though their children were participating in adult conversation. It was striking how in midsentence they responded or gently disciplined their children all the while they carried on their conversations with me. As Baker (1998) points out, in the Aboriginal culture, parents do not interfere with their children's lives. Likewise, parents do not interfere or discourage children engaging in a conversation or asking questions while they are talking to other people. It is considered the norm to stop and speak with the children and then continue on with the conversation.

Anne's 5-month-old twins were sitting in their walkers in the living room in front of a large screen television during our conversations. Animated cartoons were playing all the while we are chatting. Periodically the babies would glance across the room at their mother making sure she was still present. It was evident from their eye contact with their mother that they were very attached to their mother (researcher, field notes). Attachment is referred to as the reciprocal love and bond of the child for the parent (Perry et al., 2010). Bonding begins at birth and continues to grow over time. I observed the smiles on their faces and the excitement of the babies as they raised their arms and shook their baby seats when Anne spoke to them. At times they sought their mother's attention so they gently wailed and waved their arms. She responded to them immediately and smiled all the while we were talking. Sometimes I shut off the audio recorder during the conversation and just talked to the babies. They smiled back and looked up into my face as if to say I do not know you but I am happy you are talking to me (researcher, field notes).

Before I began the conversations, I reflected on how I was going to begin the conversation with each participant. Van Manen (1990) suggests that "The best way to enter a person's lifeworld is to participate in it" (p. 69). As I began the first interview with Annette, I recall wondering how I was going to stay focused with such activity in the room. Annette introduced her three young children: a baby girl, age 8 months; another girl, age 2 years; and her 7-year-old son. They appeared to be “happy go lucky children” looking around, exploring the space they were entering, being inquisitive like any children would be. The movement in the room was distracting at times but typical of children playing. It brought back memories of my two boys when they were young. They played around me all the time when I studied and read. As mothers we often become oblivious to the sounds and activity of children in the room which was what happened when Annette and I engaged in a conversation. Kirova-Petrova (1996) claims that play is fundamental to a young child’s world. I am comfortable with the children as I have lots of experience raising my own children as well as working in maternal child nursing during most of my nursing career. I felt at ease chatting with the children, especially the older boy because he wanted to engage in conversation, whereas his 2-year-old sister was more interested in drawing with a marker and just exploring the office. The older boy was eager to join in the conversation when he was not drawing. He asked questioned about how the digital audio recorder worked, etc. I was actually getting a glimpse of their lives.

During the conversation, Annette’s children remind me of how much space children in general need to play. The table in the room was an average size so I removed the paper to give them more room to color. This room was large and bright providing a friendly, welcoming space to play. I thought if only I had cardboard boxes for the children to play in. It reminded me of the times when I visited with my mother-in-law and she had cardboard boxes for my own children to play in. Ellis (2002), among others who have done research on place and space, believes that space can be considered an opportunity for “growth and creativity” for children and youth (p. 69) while place can provide a sense of security and belonging to a group or a community. As I read Ellis’s (2002) work and immersed myself in this fascinating thought, I could not help but wish that I had this knowledge about play when my children were young. However I realize the importance of these concepts and the need to convey this message to others. I wonder if Annette’s children felt a sense of belonging and security in my office. Based on Ellis’s (2002) and others’ work , valuing space to play and work are critical in children’s experiences at home, school, health care settings, and other places. It opens my eyes to the importance of play in children’s lives.

GDM affected the women’s ability to participate in the normal daily play activities that they enjoyed with their children. Their ability to participate and/or attempt to foster their energy was temporarily gone. GDM essentially removed every amount of vigor from their body. It struck me that Carol was describing something that was difficult to convey the meaning of because she knew I had not experienced GDM. Energy is one of those words that are used as everyday language when we describe how tired we are from perhaps strenuous activity or working hard. However, it is not a term that health care people take that seriously during pregnancy because mothers tend to be fatigued and have low energy during their third trimester. How is it that Carol can truly convey to me the meaning of low energy she experienced when she was pregnant? It was not something I could see but Carol tried hard to make sure I understood what she was saying and how it affected her world with her children. The children had to adjust to their mother's changed behavior, something they were not accustomed to. Lack of energy meant not being able to do the things Carol did as a mother such as playing with her children. She stated:

> I didn't sleep, before when I first didn't know I had gestational diabetes I could be sitting watching TV or playing with the kids and all of a sudden I fell asleep on a chair, I would just doze off and/or get tired. (Carol)

Laura shared that her son was playing sports at the school near their home when I arrived at her home to meet them for the first time. When he came home, Laura proudly introduced him to me. I acknowledged his activity playing sports and he smiled. Barbara, an elementary school teacher, talked about children playing activities in the gym at school. According to her, it was a good way to keep the children's weight under control. Barbara did not have to persuade her son to participate in physical activity after school. Since he was 13 years old, he took the initiative to do this on his own. "He just goes to the gym after school when he was in school, goes with the gym teacher, . . . he was on volleyball, he started going on volleyball, he started playing ball, and he's on a hockey at winter" (Barbara). As a result of this activity she was proud to tell me that he lost 15 pounds.

On one occasion Annette was discussing her concern about trying to educate teenagers. In the middle of the conversation, she said to her 2-year-old daughter "Come here, get down, you wanna go play, go play" (Annette). During all three interviews her children played with either their toys and/or objects that I had in the office while Annette and I discussed her experiences with GDM. Likewise, Carol brought her children with her to the interview. The children played outside the office window. I was touched by the loving expression on Carol's face when she saw her children peering through the window and calling her "Mom." I could sense deep admiration for her children. Veronica's son played with his toys in the kitchen near his mother during our conversation. The children exhibited a sense of being happy and full of life.

Similar to Kirova-Petrova (1996) and Ellis's (2002) study, play is not only important for development, but it provides a sense of closeness to both mothers and their children. Play is a valuable way to communicate with others. Gadamer (1989) refers to playing as a special relation to what is serious; we play for leisurely activity. Adults know "that play is only play and it exists in a world determined by the seriousness of purposes" (Gadamer, 1989, p. 102). Playing, in the eyes of children, is a form of amusement however children take it seriously (Gadamer, 1989).

Lack of knowledge.

Information on women's experiences with GDM is sparse, even though screening for GDM has improved over the past several years (Persson, Winkvist, & Mogren, 2010). During my conversations with the women they all conveyed that they needed more knowledge about GDM and Type II diabetes. Some participants became more knowledgeable about GDM during their prenatal classes while some learned from other women in their communities or during various educational sessions they attended.

However, they all agreed that everyone in their community needed more knowledge in order to appropriately manage their health and improve their health outcomes.

The women viewed education as a means of decreasing the incidence of GDM. Adult health is based on what people learn early in life (CNA, 2005). One way of learning about ways to decrease the chances of developing GDM and diabetes is by addressing the SDOH by a different way of thinking about health. People need to address the social structures such as poverty, social justice, and education as the real issues rather than blaming individuals (CNA, 2005).

Annette stated that she was fortunate to have knowledge on GDM, particularly during her last two pregnancies. “And my education too at the beginning of my pregnancies could, because we knew more about First Nations getting gestational diabetes, like I was already kinda educated, oh and the dietician, I see the dietician” (Annette). She attended various educational forums in her community such as workshops and educational sessions to become more knowledgeable on diabetes.

Having no one to talk to about her concerns during pregnancy and after her son’s birth prevented Carol from knowing if GDM negatively affected her son’s speech. She stated:

> Like I didn’t have any, anybody to talk to when, when I had [son] and I thought it affected uh, like it was good for me to kept my sugars in place and it was good for me, that’s what I was always told. I just didn’t really have anywhere’s to go with it, there was no other person I could talk to that had gestational diabetes or the

> only time we did talk about it is during the pregnancy when we had the little meetin's for uh prenatal. (Carol)

She eagerly wanted to gain more insight into whether this condition was responsible for affecting her son's speech and overall health.

Jane remarked that she did not have much education on diabetes. Furthermore, she explained that the educators in her community also needed more education on this subject. She stated "I think we need more in our community, even the health care providers did not have the education. Yeah back then they should have known, but they didn't so what can you do, you can't go back, right" (Jane). Barbara did not have a good understanding about the physiology behind GDM when she was pregnant. Although she did not have to follow her blood sugar levels during pregnancy as closely as other women who were taking insulin, she wanted to be more knowledgeable on what to expect. She explained "I didn't really understand um when I was told that I have a diabetic pregnancy, still to this day it's kind of like little confusing" (Barbara). Laura was diagnosed with GDM during her third pregnancy. After being diagnosed she explained "just went to a health center and then I went to see [diabetic educator at the hospital] and she gave me that uh package, like that um strips [chem strips] and stuff like that" (Laura).

Anne could have benefitted from more education on breastfeeding. She discontinued breastfeeding and switched her son to formula because she found "at first it was hard to come by milk because I didn't like them [twins] drinking Similac [infant formula] 'cause it looked too thick and to me it was always gross" (Anne). However, she recalled her son had a "hard time burping. Freaked me out and my mom was like OK give me him . . . I knew I was gonna have a hard time breastfeeding him, so I breastfed him for 3 weeks" (Anne). Anne knew that she needed more education and strategies to be successful in breastfeeding. Since bottle feeding seemed to be the safest solution for her baby at the time, she opted for it.

Fear of developing diabetes later in life coupled with lack of knowledge around GDM contributes to their feelings of lack of energy, hopelessness, and uncertainty during their pregnancy. Being overwhelmed and surprised with being diagnosed with GDM led the women to seek support and assistance from the professionals at the health center in their community. However, the women learned quickly that this was not enough. It was a life altering experience that left them searching for answers.

Conclusion

As I became immersed in the women's stories, I grew closer to the women. While I listen to their voices on the audio recorder, I can visualize the expressions on their faces when we met. I can sense the heightened uncertainty in their daily lives and recognize they sometimes felt they did not know who to turn to for help. The majority of the women were surprised by their diagnosis with GDM; they had to quickly transform their lives in order to change eating habits and lifestyle. They described feeling: like they were suffering, like life was hard, like there was no way out, a lack of energy, lazy, they had no choice, etc. but they still remained strong and willing to do whatever was necessary to have healthy birth outcomes.

Not only were their bodies carrying their baby but they were also carrying a huge burden in their communities. They were genuinely concerned for their communities. As Iwama et al. (2009) point out the Mi'kmaq people work to try and address the issues in their community that have negatively affected their health and in turn almost destroyed their language and connection to one another. Some participants saw it as their responsibility to protect not only their children but their relatives from developing GDM and diabetes in the future.

Despite their challenges with GDM, the women carried out their responsibilities as best as possible. After the initial diagnosis, the Mi'kmaq women knew they had to accept what happened and carry out their daily activities with their children. Similar to the findings of Evan (2003), the women have been changed by this experience.

Chapter VI

Theme II

Barriers Limiting Access to Health Care

Background

Lack of access to health care often negatively affects Aboriginal women health outcomes (Loppie, Reading, & Wein, 2009; NAHO, 2006; Palacios &nd Portillo, 2009). The widespread pattern of a disproportionate lack of access for Aboriginal people is directly related to factors such as poverty, racism, discrimination, lack of education, and social exclusion, factors known as the SDOH (Guruge & Humphreys, 2009; Loppie Reading & Wein, 2009; Raphael, 2006). It is evident from this study that these factors all have an impact on the Mi'kmaq women's lives. These factors prevent them from engaging in health care that others take for granted. The Mi'kmaq women lacked the opportunities and resources readily available to others during pregnancy such as transportation for appointments, health care from providers of the same culture, sufficient income to maintain a good standard of living, more readily accessible grocery stores, and postsecondary education to name a few. Statistics Canada (2012) reports that according to the 2006 Census, 13.5% of Aboriginal women were unemployed versus 6.4% in the non-Aboriginal population. The rate of unemployment for First Nations people living on the reserve was 20.6% as compared to 13.8% for First Nations women living off reserves. Aboriginal women aged 15 and over who hold a university certificate, diploma, or degree at a bachelor's level or above is 7.1% whereas a similar group of non-Aboriginal women with similar education is 18.5 % (Statistics Canada, 2012). The women are aware of the disparities and know that strategies need to be developed to improve their access to care. They agree that changes need to be made and the first step is identifying their concerns and recommendations. For example, Anne shared that "food is expensive; it is a struggle—one way of thinking is to eat healthy is expensive. All the education in the world won't help if you don't have the money." Likewise, Jane explained: "there is nothing left once they give you a budget and your rent comes out of there, your lights comes out of there, your oil, and then whatevers." As we discussed their limited income, it became apparent that poverty was the result of public policies where individuals and communities had little input and control over decisions (Loppie Reading & Wein, 2009; Raphael, 2007).

My knowledge and experience working with Aboriginal mothers and my conversations during the study helped shape my dialogue with the women. Because I have cared for many Mi'kmaq patients and worked with others as colleagues, they have told me of a number of their challenges around socio-economic issues and discrimination. I know that when they describe particularly difficult situations, they find them very painful. I give them plenty of time to talk without moving on in the conversation. I feel as though they want me to know about their experiences in detail and want to be assured that their concerns will be brought forward during the dissemination process. Therefore, the dialogue often went from discussing GDM to looking at other factors that affect their lives. Turning to Gadamer (1988), he uses the term *dialectic* to explain that we learn from "the art of conducting a real conversation" (p. 330). Thus, "language, in the process of question and answer, giving and taking, talking at cross purposes and seeing each other's point, performs that communication of meaning . . . , to describe the work of hermeneutics as a conversation with the text" (Gadamer, 1988, p. 331). By listening to their stories and through this dialectic process, I was able to better understand their lives. As Gadamer (1988) asserts, I could "see things in the unity of an aspect" (p. 331) which helped me to write about the women's experiences and concerns.

For example Annette explained that she was troubled by the number of suicides in her community and another nearby First Nations community.

> We talked different times in our community about having an emergency uh, or crisis support team or whatever, something . . . community has never picked up but the idea is there, especially around suicide prevention 'cause that's such a high rate too. That was horrific, I think I was pregnant or just had a kid, I don't know, maybe I was both. It just goes against everything in our culture. I was just so deeply shocked and disturbed by that because you're carrying another life in your . . . Like I know suicides that are clustered in a family that are generational and how do you break that, and there's so much pain there because my dad, my uncle, my cousin, my best friend killed themselves. (Annette)

Annette appreciated that I was trying to understand what she was feeling as she described this horrendous experience. I responded "You feel the pain for each other" (researcher, field notes). Giving Annette time to express her feelings meant a lot to her. She lost close family members to suicide. She does not see any major changes occurring in her community to address suicide prevention. Although a mental health program recently started in her community, she knew that it was going to take a long time to see significant changes in addressing mental health issues.

Inadequate access to care is an important finding in this chapter. Here I further explore the meaning of access to health care and then move into barriers to health care which include geographical location of the health services, transportation, financial concerns, and impact of residential schools, communication/language barriers, and/or cultural competence and cultural safety issues.

Cultural competence means that health care providers provide care that is based on knowledge and competence in ways that are culturally sensitive and respectful (ANAC, 2007). Cultural competence also requires that health care providers consider their own cultural values and the health care system in which they work in order to eliminate inequities and improve health care for Aboriginal people (ANAC, 2007). Lack of cultural competence occurs because health care providers portray discriminatory attitudes toward the other person (McGibbon & Etowa, 2009). Cultural safety is a term that first originated from the Maori in New Zealand and addresses unequal power relations and inequitable distribution of resources in society for health and well-being (Ramsden, 2002). Nurses are concerned with improving health care access, recognizing that we individually are carriers of culture, and social, political and historical context of health care and addressing unequal power relations (Ramsden, 2002; ANAC, 2007). Building a trustful relationship where patients feel at ease and comfortable to disclose their health problems and/or questions helps them to feel accepted and provides an opportunity to share their values and beliefs. Becoming culturally competent where cultural sensitivity and understanding is acknowledged helps health care providers move toward cultural safety[4]. Cultural safety and cultural security (which both incorporate respectful recognition and integration of cultural beliefs, values, and practices) are important in enabling Aboriginal people to benefit from the care they receive (Reibel & Walker, 2010).

Access to Health Care

As I listen to the audiotapes of my conversations with the women and read the transcripts I began to realize that the word “access” has different meanings for each of the women. Lack of access caused considerable concern, frustration, hardship, and pain. I sensed that it was something that some women described as a “cross to bear” as there was no point in complaining about it; it was beyond their control. I felt there were times when they experienced their situations as hopeless. I found myself feeling melancholy at times thinking of what they had to endure. Perhaps it was their traditional knowledge, philosophy, and medicines that were passed down through generations to Aboriginal societies (Battiste, 2000; Smith, 2000) that gave them strength, determination, and commitment to take care of their families. Although this section describes a number of difficulties in accessing care or respect for their knowledge, I was captivated by their enthusiasm to meet and to explain their personal challenges even though they were realistic that not a lot was going to change in their community in the short term.

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[4] Cultural safety is concerned with inadequate distribution of health care. It aims to address unsafe situations that results from people being demeaned and to try to address power issues (Woods, 2010).

As we entered a room in the health center to begin a conversation, one participant informed me that “this meeting meant a lot” to her (Carol). She said she felt “goose bumps” to think that someone cared enough to try to help First Nations people (Carol). I was so touched by this comment that it made me stop in the hallway and look at her expression on her face. I saw a gentle woman who showed a genuine concern for the welfare of her people.

The Mi’kmaq women provided several examples of how they had limited resources such as low income, no transportation, lack of choice to where they wanted to receive prenatal care, communication barriers, to name a few. These limitations left them feeling frustrated, powerless, and discriminated against. As I reflected back on the moment in the corridor of the health center where I met Carol, I could hear those words again and again about having “goose bumps” when she knew I was coming to discuss GDM. To Carol, it was a moment of hope and possible change, something she had never anticipated would happen. Carol was amazed and appreciated that I took the time and interest to talk with her. Her sincerity moved me; I did not know her, yet those words made me feel instantly connected and accepted. Heidegger (1962) states that if we are open to hearing the words of another person, “we proximally understand what is said . . . we are already with him in advance alongside the entity” (p. 207). I could sense that because I was open to hearing about her challenges, Carol saw that I had already begun working alongside the Mi’kmaq women.

As I reflected on the women’s stories, I began to search deeper within myself so I could further understand what lack of access means. Before I could begin to understand the women’s situations, I had to explore my own experiences. I experienced access challenges when I was a child. Frequent throat and ear infections meant antibiotics and cough medicine were common remedies in our home. At that time, my parents did not own a car and had to wait for the driver from the drug store to deliver the medicine. I recall lying on the couch, so sick, listening for the sound of the truck to drive down our long driveway and waiting for my mother to go to the door to receive the medicine. Sometimes, I had to wait a couple of days because she could not reach the doctor or did not have the money to pay for the prescription. I remember being so sick at home for days on one occasion waiting for someone to take me to the hospital, only to be diagnosed with pneumonia. I was eight years old at the time. My mother said the doctor told her I would have died if I had not been treated at the time. When I entered my teen years, a very generous man my father worked for recognized the struggles that our family was experiencing and gave us a car. My family was in tears when dad came home with this car. Our socioeconomic status as a family was a barrier for us to access care readily and with ease. Although access to health care improved once we owned a car, looking back over my own life has helped me now to gain more insight into the Mi’kmaq women’s struggles of living in poverty. Reflecting on my childhood has also helped to put the women’s situations in context. The conversations with the women helped me to grasp some of the potential impacts of the lack of basic life necessities such as adequate income, housing, food, and access to health care-things that many take for granted and how essentials of life have affected their daily lives.

I began to think about how racial identity is frequently visible, taken for granted, and originates in social and economic freedom (McDermott & Samson, 2005). Whiteness is considered the norm in the western world, while those from minority groups and Aboriginal people often face racial issues (McDermott & Samson, 2005). The women described their struggle for sufficient income, nutritious food, health services, and many other services, and it was apparent that they were seriously affected by social policies that can be considered racist.

Aboriginal women's experiences differ depending on whether they receive health care in their own First Nations communities or outside their communities. In their own communities they are surrounded by people who care about them. In hospitals they receive care from health care providers who often do not know them or understand their culture and who are generally non-Aboriginal people. Aboriginal women relate more to their own familiar surroundings (Health Council of Canada, 2011; Kornelsen, Kotaska, Waterfall, Willie, & Wilson, 2010; Whitty-Rogers, 2006) and the people they respect and trust, than people in non-Aboriginal settings (ANAC, 2007; Browne, 1995; Brown & Fiske, 2001; Smye, Rameka, & Willis, 2006). Aboriginal women experience less anxiety and are more content delivering their babies in their own communities surrounded by their families (Kornelsen et al., 2010; Moffitt, 2004). They are strongly connected to their land and this land helps them maintain good health (Kornelsen et al., 2010). Knowing the value they place on their land helped me to realize just how important it is for Mi'kmaq women to receive as much health care as possible in their own communities close to their family as opposed to traveling to centers outside their communities. Being close to the land meant they could have access to their cultural traditions and the Elders would be there to pass on their traditional knowledge about birthing and motherhood roles. When they travel away from their communities, access to care becomes a challenge as transportation along with their physical, psychological, emotional, and spiritual wellbeing is not always met. I gleaned how their GDM experience was part of their life journey. Our conversations opened the way to seeing how they live their life amidst the socioeconomic struggles.

In both First Nations communities where the study was conducted, the women received prenatal education from non-Aboriginal nurses in their own communities. In one community, the community health nurse prepared a nutritious lunch for the women and their children during the class on prenatal nutrition. Conversations were held over lunch, giving them a chance to enjoy a meal all the while discussing nutritional foods, tips on grocery shopping such as reading labels and best foods to buy, budget shopping, and methods of preparing healthy meals. During my visit at one of the health centers, the women remarked on how much they enjoyed receiving a home cooked meal. It meant a lot to them to have someone cook for them, to be a part of a group, and to enjoy each other’s company. Being engaged in prenatal nutrition classes gave the women an opportunity to relax during a busy day with their children. This environment provided a safe forum to ask questions and discuss their concerns about pregnancy. During this time with the women I sensed the importance of community; a sense of togetherness. For example I could hear the enthusiasm in their voices when they talked about increasing their physical exercise. They all agreed that being more active would help control their weight and would assist them in feeling better. In one of the communities the women and I enjoyed an interesting discussion around increasing exercise programs for children in their school. Their welcoming response in the conversation made me feel a part of being involved in improving health in their community. Barbara explained that she was involved in promoting physical activity and implementing food choices to increase the availability of healthier food selection in the school cafeteria. She explained that she was determined to continue working hard to improve children's health in her community (researcher, field notes). The mothers were at ease talking to each other. They engaged in a conversation that they all had a passion for–improving their health and their families' health to prevent diabetes. There was a sense of security and a relaxing ambiance in this place. They shared their knowledge in an environment where they were not concerned about being judged. The women were eager to ask questions and provide comments, often laughing together. It was as though they were sitting in their home and having this private space to talk and enjoy each other's company all the while they were learning about prenatal nutrition. There were teachable moments for me as a nurse and occasionally I shared information back and forth with the mothers. Access to culturally sensitive information and being surrounded by other mothers from the same culture helped the women feel at ease. Since the health center is situated in the middle of their communities, they did not have to travel far for prenatal education. When the women have to travel outside their communities, the environment changed and so did their challenges.

Geographical location/transportation to health care services.

Because of the potential health complications associated with GDM as described earlier in this study, the participants required close prenatal monitoring and/or hospitalization in the event of impending complications. This meant that they had to travel frequently for some of their prenatal care outside their First Nations community for appointments with doctors and nurses specializing in perinatal care. The mothers described various challenges associated with access to health care during their pregnancy.

Transportation was a major concern and a barrier for some women because they had to travel frequently for doctors' appointments, laboratory work, fetal monitoring, diabetic counseling, and other follow-up. Safe, reliable transportation was a concern, especially when they had to travel outside their communities during stormy and treacherous driving conditions. Because they had GDM, closer follow-up to see specialists was required. Some women had a 20-minute drive while others had a 1½ to 2-hour drive, depending upon where they lived. Without a car of their own and/or icy road conditions during the winter season, transportation to appointments became a major obstacle for some women. For example, during Laura's third pregnancy she wanted to receive her prenatal care from a doctor in an urban center near where her boyfriend lived, which was a 2½ hour drive from her home in another First Nations community. However, this meant she would have to take a taxi because she did not own a car.

> So um I went to see her [endocrinologist] once and she's the one that called me up and told me that I had gestational diabetes, so then I get a call from the taxi driver 'cause I don't have a car saying um your ride wasn't covered to go to [an urban

> center], it has to be an um, you know, a specialist that, you know, an obstetrician. (Laura)

Because Laura’s referral from a doctor had to be from an obstetrician and not an endocrinologist to qualify for a paid taxi trip to the urban center approximately 200 kilometers away, she was unable to receive medical care in that center. Laura was frustrated over being ineligible for the First Nations’ taxi service that she thought should be available in her community regardless of who the doctor was or medical reason. Reluctantly, she resorted to receiving care by another doctor closer to her own community but unfortunately this meant being away from her boyfriend’s community. She was disappointed with this situation because it meant she could not be close to her boyfriend. He was a major support to her during pregnancy and he was the father of their baby. The rules are incongruent with the needs of her community and she hoped one day they would change, an action that will be brought forward from this study. Women need the support from their partner and other family members during pregnancy (Iwasaki, Bartlett, & O’Neil, 2005; Wong et al., 2006). Laura was disappointed but decided to forgo taking this issue to someone in authority because it would not change her current situation. This response brought me back to the work of bell hooks, a well-known African American feminist author, educator, and scholar who has devoted much of her time to educating people about racism, sexism, and classism. An indication that people are victimized is that they accept the status quo without questioning or being angry (hooks, 1984). Laura, like many Aboriginal women, felt vulnerable and afraid to speak up for fear that it would compromise her health care. However, in these circumstances women are likely to accept what they are told, thereby keeping them in the “dark” to finding alternate ways to live their life.

Although transportation was provided in most instances in First Nations communities for medical reasons, the schedule and possible personal conflicts with medical drivers sometimes limited the women’s use of this service. For example, women were hesitant to use the taxi service when there was a personal conflict between them and the medical drivers. Jane cautioned that “if you don’t get along [with the drivers] then you might wanna go in your own car.” Many women did not own a car and had to depend on relatives or friends to drive them to their appointments. For example, Annette preferred not to use the medical drivers because they were her “ex-in laws.” Because of family tension, she thought it was better to avoid those situations. In my previous study on childbirth experiences, a number of Mi’kmaq women would not use the medical drivers in their communities because of similar concerns (Whitty-Rogers, 2006). Not feeling at ease with asking someone to drive them to appointments created undue stress for some women. Despite this, most women still found a way to travel to all their medical appointments, demonstrating the value and commitment they placed on prenatal care and health outcomes for their babies and themselves.

Some Mi’kmaq women worried about arriving at the hospital safely when they were in labor. Similar to the findings of Van Herk, Smith, and Andrew (2011) access to healthcare contributed to the Mi’kmaq women’s fear of not having healthy birth outcomes. Feelings of anxiety and fear filled Barbara’s mind and body on the night she went into labor with her second child as she was an uncomfortable distance from the hospital.

Barbara prepared by purchasing groceries and picking up last minute items in the event she went into early labor. Women view their families as an extension of their bodies (van Manen, 1990, 1997). From her description of the experience I could sense how in tune she was to her body—every movement, every ache, and every pain. Barbara described how she was feeling before she unexpectedly went into labor.

> I was shopping so I stopped at the [garage] there, just before heading home and uh, geez I didn’t feel good, so I went in to go use the washroom ’cause I felt a little pressure right? I told the lady that was working there, . . . I really don’t feel good but I don’t feel labour or anything right. (Barbara)

Although Barbara was not expecting to go into labor, she was keenly aware of any sudden changes in her body as described above. She reacted quickly when her overall health condition changed. As Merleau-Ponty (1962/1992) asserts people live in their bodies and develop their experiences through their bodies such as through their feelings, language, space, and time. The objective body is always with the person and therefore does not move nor has to be directed (Merleau-Ponty,1962/1992). Embodiment is a way of thinking about individuals as a whole person where the body and mind are united as one (Wilde, 1999). Although Merleau-Ponty (1962/1992) does not refer to the body as embodiment, he views the body and mind as entwined (Wilde, 1999). Therefore in Barbara’s situation, embodiment refers to knowing and understanding her unborn baby as one through her experiences of becoming a mother. She wanted to safeguard her baby during the ambulance trip so that no harm would come to it (van Manen, 1990). She nurtured and loved her baby as the baby was part of her body (van Manen, 1997).

I may have glossed over Barbara's words of "feeling sick" if I had not been doing this research. In the Aboriginal culture, the words "feeling sick" refer to going into labor or if on a period [menstruation] (Charlotte Jesty RN, Aboriginal Community Health Nurse (personal communication, July 10, 2012). Many people interpret feeling sick as something transient where the person has physical or mental impairment but it gradually goes away. However, Barbara's description of feeling sick was much deeper. Although it meant going into labor which would involve pain and physical endurance, it also meant fear of having the baby before she arrived at the hospital. Barbara had a strong inner connection with her baby and she knew she was going to deliver soon. She was all alone, no family to call, away from her community. The safety of her baby and herself were her immediate concern. It is well known that women are primarily concerned about the safety of their baby and their own health outcomes during childbirth (Lothian, 2008; Mercer, 1995; Rubin, 1984). Living in a rural area complicated the situation because patients have to wait longer or travel further for care than those living in urban centers. As Wathan and Harris (2007) point out women living in rural communities may not have a constant connection to physicians or the assurance that they have the right provider at the time to meet their needs, creating further apprehension. This was the case in Barbara's situation. When the ambulance brought Barbara to the closest hospital, the nurses and doctor determined that she was fully dilated but not having regular labor contractions. Since this community hospital was not equipped to deliver babies, Barbara was quickly transferred to the Regional Hospital approximately 45 minutes away. She described her feelings of fear and desperation traveling in the ambulance as follows:

> I was kind of like getting freaked out and uh, they said um, we're going to put the doctor in the ambulance and a nurse just in case you deliver and uh, my sister just walked in just take my shoes I said, I'm fully dilated so she was starting to panic too, they're going to put me in the ambulance so all through I didn't get any pains until the . . . started wanting to push so they said just hold on, try to hold on. (Barbara)

As she described her feelings during the ambulance ride to the Regional Hospital, I witnessed the terror in her eyes. Her pupils became larger as she described those horrifying moments. It was the first time I realized the degree of terror that these women experienced. Barbara was relieved when she arrived at the hospital and moments later delivered a healthy baby.

No one to mind the children.

Having a number of medical appointments on one day required careful coordination, especially when the women had to take their children with them. Women had to plan their day knowing that they may have to wait a while for the taxi to drive them from one appointment to another. To illustrate the impact of this situation Annette stated:

> They really tried to accommodate me on the 1 day thing, and make sure I mean they're for 1 day 'cause I just wanted to get home to my kids . . . it's a long time

> for that age to wait, she's only young, and she wants to play and everything. (Annette)

Often Annette took her 2-year-old daughter along with her for appointments because she did not have a babysitter. In Anne's situation, she could not attend the talking circle as part of participation in the study because she did not have anyone to care for her children. Although she knew her children were welcome, she would have preferred to go by herself. The mothers pointed out that there were no affordable daycare centers in their community. According to Anne, the women found daycare centres expensive because the majority of the women did not have employment and thus were limited from using the daycare. In one community, the daycare charged $10.00 a day for one child and $15.00 for two children. Traditionally, the women had always depended on their families to care for their children when they require medical care but sometimes this was a problem when the women's parents were working or are away from the community. Having affordable daycare centres would be helpful.

Anne knew it was best for her to be in the hospital to be monitored during pregnancy but unfortunately, she had to wait until her mother came home.

> I felt uh nauseous. I was getting sick, got light-headed so the nurse [Community Health Nurse] told me go get it checked out, I said I'll be all right. Couldn't leave anyway 'cause I had, my mom was away and my stepdad and I had my daughters and I couldn't go anywhere so the next day when um I had my doctor's appointment I said it's OK I'll wait till tomorrow. (Anne)

Carol brought her three children to the health center when we met because she did not have a babysitter. I explained to Carol that I was happy to have her children join us. Annette found that not having a babysitter and having to take her children to workshops proved beneficial because they had an opportunity to learn about healthy eating. She was happy that all of them could benefit from the experience.

Although some mothers felt affordable daycare services would be helpful, they were unable to find other alternatives to enable them to attend appointments and events. Because the women could not afford to pay high rates due to their low income, they took their children with them wherever they went.

From the lived body perspective, the mothers considered their children physically separate from them, yet a natural extension of them (van Manen, 1990). The baby was separate from the mother who worked hard to develop a maternal-newborn attachment with her baby. Van Manen (1990) found that many people consider that “there is a deep significance in the knowledge that parents and children are of one flesh” (p. 105). They know their children from the perspective of being a parent and they treasure this relationship. I observed this attachment in the Mi’kmaq women interacting with their children. They enjoyed having their children around them. The majority of the mothers brought their children to our conversations at the health center or wherever we met. When meeting in their homes, I frequently observed them patiently settling their children before continuing on with our conversation. It was as though time stood still and the mothers were oblivious to what was happening around them as they attended to their children. Occasionally they would raise their voices but never in an angry tone, either responding or instructing their children to do something to amuse themselves. For instance, Anne picked up her twin boys from the daycare and brought them home to be with her during one of our conversations. Being the typical 2-year olds, they were walking around the kitchen exploring the cupboards while looking me over. I could see that they were curious as to why I was in their home. They peered in the lower kitchen cupboards all the while looking back at me. They knew I was a stranger.

Some of the barriers previously described by the participants around transportation and child care issues as well as other concerns in this study are indirectly related to Residential Schools. The following section will discuss some of the effects of Residential Schools.

Impact of Residential Schools

Residential schools were thought by some Mi'kmaq women in this study to have had a major influence on their financial stability, prosperity, and access to a healthy lifestyle. These women felt Residential Schools contributed to a life of financial reliance on welfare services. Some of the participants' parents and/or relatives spent a significant part of their youth in residential schools.

These schools were considered compulsory following the Indian Act Legislation enforced in 1920 (Smylie et al., 2000). Aboriginal children between the ages of 7 and 15 years were required to attend. During their time living in these schools, some children's hair was cut short, they were lonely, developed diseases, and died. They were forbidden to speak their language or follow traditions. Some were physically and sexually assaulted

(Knockwood, 2001; Smylie et al., 2000). Knockwood recalls "On September first, 1936, my whole family walked the five miles from the reserve to Shubencadie . . . My mother pointed to it and told us that we were going to the Indian College" (p. 26). The intergenerational effects of trauma in Residential Schools have resulted in numerous issues including parenting problems, the loss of their language, and low self-esteem (Warry, 2007). The movement to assimilate created a direct attack on Aboriginal culture.

Welfare Policies

Many participants were single and/or married but separated which meant they did not have a spouse or partner to provide financial support and in some instances family support. Diabetes brings on burden of care in addition to financial burdens. Women such as Jane attributed much of the financial strain in her community around welfare to Treaty rights. When I asked her to elaborate, she described her dissatisfaction with the Canadian government in the following way:

> What really gets me is like with our Treaties right, we were supposed to be uh given money like I don't know what Treaty money for, and now it's turned into welfare. So if you work and you get a job then you're not entitled to your money right. So the whole thing over the years has changed. And really I think we should be fighting it but it's, nobody's really uh challenged it yet. (Jane)

When I asked Jane if she thought women have enough resources to purchase food and clothing for their families, she responded, "I would probably say no to that." Jane provided a brief snapshot of what life was like for her and her family in what she referred to as her “social budget.” “Our, the social budget isn’t uh, I don’t think it’s changed in years, you know, a single working a person’s welfare is $185 every two weeks” (Jane). When she was receiving welfare before beginning to work she recalled “I think it’s 200 a week that I got. And . . . the reason that I get that much was because they add $30.00 for my diabetes” (Jane). Furthermore she stated:

> I have uh two other kids and myself that are lactose intolerant and I didn’t know this until just recently that if you’re lactose intolerant you can get [additional subsidy], uh if you get diagnosed then it can be put it on your budget. (Jane)

Jane was concerned that many community members were unaware of additional funding they were entitled to during pregnancy. She stressed that they needed to know what they are entitled to. Jane knew her rights as an Aboriginal woman and believed that she had a responsibility to spread the word. During our conversation, she briefly discussed the effect that colonialism has had on her people with the existence of residential schools and the failed promises of honoring treaties. Her views were similar to Warry (2007) who explains that there are instances when the Crown fails to honor treaties. The unfortunate part of this arrangement is that Aboriginal people are owed money. The government may disperse the money in the form of welfare according to Jane. Unfortunately, mainstream society believes that the government should not have any obligations to honor treaties (Warry, 2007). The lack of responsibility on the government’s part runs contrary to the rights of Aboriginal people.

As a result, many Aboriginal people are living on welfare which has created a poverty state (Warry, 2007). Raphael (2007) refers to the welfare state as being health care, social services, and other services that are used to help people in need to have guaranteed income to live during times when they are unemployed or ill and need financial assistance. The Canadian government has a responsibility to provide equitable services to everyone in need in Canada as outlined by the administrative policies in the country (Raphael, 2007). The welfare system has become a trap making it difficult for groups such as Natives and Blacks to escape (Hingley, 2000). Unfortunately, as a result they are sometimes branded as being lazy. Aboriginal people's health problems have been linked to their lifestyles rather than to socioeconomic and political conditions in which they are forced to live (Browne & Smye, 2002). Non-Aboriginal people have a tendency to blame Aboriginal people for living in poverty and being unemployed (Warry, 2007). They fail to see the barriers and understand the history behind colonialism that creates barriers for Aboriginal people (Smylie et al., 2000; Warry, 2007).

Gaining an Understanding

As I listened to the women's stories, I reflected on the writings by Isabelle Knockwood, a Mi'kmaq woman and Residential School Survivor. The Truth and Reconciliation meetings were happening in Nova Scotia in November 2012 the same time that I was writing this chapter. I had the privilege of meeting Isabelle at a formal presentation at St. Francis Xavier University, Antigonish, Nova Scotia where I work. I participated in the talking circle which was a moving and powerful experience. Knockwood (2001) briefly depicted her experiences living in the Residential School in Shubenacadie, Nova Scotia from 1936–1947. One example she gave was "they cut her sister's hair and she did not recognize her.' She had several black and white photographs displayed in the room of her time spent in the Residential School. I recall one picture of a dark stairwell which seemed to beckon one's imagination to consider what might have happened there. I could only glace at the pictures because they made me feel uneasy. All I could think of was the abuse and injustice that occurred in this school. I read her book *Out of the Depths: The Experiences of Mi'kmaw Children at the Indian Residential School at Shubenacadie, Nova Scotia (2001)*. I was familiar with some of her experiences from excerpts in her book and had an understanding of some of the painful experiences that she and other Aboriginal people endured. At one point during her presentation, she said that "Indian residential schools' intent was to kill the women and children" (Knockwood, personal communication, 2012). At that moment, I could feel shivers go up my spine and the palms of my hands began to sweat. As we sat quietly and listened intently, I found it painful to listen to Isabelle. She said "the church benefited- the souls". She was "trying to find out" what happened; "doesn't fit in" [meaning she does not fit in with others in life]. After she spoke, the facilitator who was a Mi'kmaq woman and the Aboriginal student advisor at St. Francis Xavier University encouraged us to engage in a talking circle. This gave everyone an invitation to speak. I felt heart sick as I listened to other Aboriginal people speak about their frustration at the loss of their Mi'kmaq language and their families having been punished in a cruel manner. However, there was a positive moment when we engaged in a discussion around hope for change. My colleagues and I shared how sad we were that our ancestors were the perpetrators and were responsible for colonial ways such as discrimination, social exclusion, welfare policies, inadequate access to health care, and attempts to intimate Mi’kmaq people.

I reflected on how lonely and disconnected Isabelle and others were while living away from their families in these deplorable conditions. As I continued to listen to everyone’s comments in the circle, I was touched by their sincerity as the dialogue created a united feeling among us. Similar to the talking circle with Isabelle, the more conversations I have with the Mi’kmaq women, the more understanding occurs between us (Gadamer, 1989).

Although the stories I heard during the above presentation were sad and painful, it allowed me to gain a deeper understanding of the women’s and their families’ lives, thus providing a richer context from which to understand their experiences. They provided concrete examples that helped me further comprehend what the women meant by the words ‘suffer ‘and ‘life is hard’, for example. Some women described life as hard to mean having one baby after another without much social support and having their babies close together.

> It was really hard, like that for (daughter) like she had eczema really bad on her feet so we ended up putting her in the sling to sleep . . . Yes they’re 14 months apart, it was really hard on my body, I had to have um, I didn’t have to but I elected to have my tubes tied when [daughter] was born, I thought about it before, because I know my increased risk of diabetes and all of this the more kids I have the harder it is on my body . . . I had a c-section for all of them. (Annette)

Jane stated "I don't think, I, I think that they feel that uh no matter how much money they get paid it's not, it, they'll uh be able to, that'll never go away [memories]". Hence, the effects of residential schools, a direct result of colonialism is evident in the women's descriptions of their social and economic disparities and health problems. For instance, in addition to the physical and sexual abuse of some of the participants' parents and grandparents in Residential Schools, there was also a loss of identity, pride, respect, language, etc. in Aboriginal communities.

I found their personal stories touched me more deeply than reading about the hardships of Aboriginal people in a book. It was the personal connection that I was developing with them that gave me a more in-depth perspective. In trying to explain my personal yet professional connection to the women, I recall their faces as they looked to me for assistance and support. This understanding of face is described by Levinas (1969) as "The face is a living presence: it is expression" (pp. 50–51). "Face and discourse are tied. The face speaks. It speaks, it is in this that it renders possible and begins all discourse" (Levinas, 1985, p. 87). Lavoie, Koninck, and Blondeau (2006) claim that "A person's face calls for care and respect for him or her" (p. 226). The expressions on their faces helped me learn about the women as well as the discourse we shared. I could not begin to interpret the significance of these hardships without the conversations between myself and the women (van Manen, 1997). Although we were not aware at the time, the women and I were trying to self-reflect together on what was being said about Residential Schools to garner the magnitude of the impact these schools had on their lives and those of their families. Understanding and interpreting what the women were conveying about residential schools and the overall impact became clearer to me as I was writing this dissertation. Going from listening to the audio tapes of the women's stories, reading the literature, thinking back to my clinical practice, and self-reflection, I was able to gain a more vivid picture of what Aboriginal people experienced in residential schools and the effects of colonization.

Residential school survivors are now realizing the negative effects of the schools on their lives and they are now coming forward to tell their stories (Knockwood, 2001). Since the government gave a formal apology in 2008, and a number of religious domains have also recognized their atrocities, some Aboriginal people are gradually verbalizing their personal experiences of living in residential schools. Laura's grandmother spent time in a residential school. Laura recalled that "my grandmother never talked about her stories till this money stuff [compensation for residential school survivors] is comin' out to them. And this is the first time [recently] she ever mentioned her residential school stories." Laura found it hard to tell the story about one Mi'kmaq woman's experience living in a residential school.

> She [the Mi'kmaq woman] was in residential school and she got raped by a priest, she was only 13 and when she delivered the baby she's pretty sure they threw her baby in the furnace. Yeah, a woman from around here so it's pretty, and I couldn't even imagine what my grandmother went through 'cause she never talked about it. (Laura)

My heart just sank when I heard this story. I felt sad and speechless. I recall I could not make eye contact with Laura for a few moments. Then I gradually responded by saying that Aboriginal and non-Aboriginal people cannot move on until the stories of residential schools are told and acknowledged.

Barbara was grateful that her own parents were not subjected to the appalling living conditions of residential schools. Barbara's sisters-in-law were not as fortunate. They suffered the effects of being separated from their parents and hence did not have the opportunity to learn the parenting role.

> My sister's children's father's parents . . . they were both at the residential school. And it affected the—children that they have, and it affected their relationship 'cause he [father] was so uh protective of them. And today they're not together. She had to separate [from] him 'cause he was getting too over-protective of the children. (Barbara)

Barbara knew that residential schools negatively affected generations of people. Her friend who spent time in a residential school "cannot bring herself; she couldn't even talk about it. Every time she wanted to she would break down" (Barbara). Similar to Jane, Barbara attributes living in a residential school to contributing to why Aboriginal women are forced to live on welfare. Financial compensation from the Canadian government cannot erase the injustices done to Aboriginal people who attended Residential Schools according to Barbara. Giving money to Aboriginal people is a way for the government to take responsibility for previous actions and a way to shift the guilt but it will not remove the damage that was done to survivors. Barbara believed that some Aboriginal people do not realize the serious effects of having been taken from their families and placed in these schools where children were verbally and/or physically abused and in some cases tortured. Barbara recognized that her father did not learn parenting skills because he missed out being parented by his own father. Instead he acted similar to what he experienced; controlled by people. Furthermore, with the amendment of the Indian Act in 1950s each province received federal funding for all Aboriginal children who were taken into child protection agencies. Removing Aboriginal children from their homes was known as the "Sixties Scoop" (Smylie et al., 2000, p. 1076). The percentage of Aboriginal children taken into care went from 1% to 30-40% by the 1960s (Smylie et al., 2000). Some of these children are residential school survivors.

Annette believed her father failed to show emotion because of living in a residential school.

> That really effects uh everybody whether they know it or not, whether they know why Dad's an alcoholic, well Dad may have been abused at residential school or by someone that went there or he didn't feel loved because my grandfather never hugged me but it was his way of protecting me. If I didn't know better, if I didn't have the education, I would never have known that, you know what I mean? If I was just some other kid I'd have been like my grandpa, don't love me. My grandpa loved me lots and he'd take us places, he just wasn't affectionate. He went to residential school; he was trying to keep us safe. To feel like we were in a safe place with him, and we'd hug him but he'd never initiate, he never, you know what I mean. (Annette)

Annette had great admiration for her father and all that he endured in Residential School. Because of her education on the history of colonialism and Residential Schools, she understood why her father reacted in such a manner and could accept it.

Barbara recalled a situation where a friend of hers was emotionally affected by Residential Schools.

> I feel bad for them. Like I know a friend of mine that um I worked with at the daycare years ago, she went to the residential school. She's older than me. And uh she went and she couldn't even talk about it. Every time she wanted to she would break down. And I said I know like it must have been bad and I read that book *Out of the Depths*. It was, it's hard . . . People don't realize too like they might hear it and all that compensation they're getting but they don't realize how it's affected them, their children, and their grandkids. (Barbara)

I asked Barbara if they have discussions about Residential Schools in the communities. She responded

> Yeah there's a group here, um they, I, I don't know how they get together in Truro, like the ones that did go to residential. So I think it's, I guess it's a healing process too 'cause they've been closing it up, building it up and, you know for years and since this um fight of getting money or whatever I think it's, to me it's not about the money, it's that healing. (Barbara)

Residential schools have destroyed Mi'kmaq language. Barbara stated "they [children] do not speak Mi'kmaq because it was forbidden in Residential Schools, Native language, and that's an affect that we see in the schools you know." For Barbara, bringing back

Mi’kmaq language is the only way that healing from Residential Schools can begin to occur. She proudly explained that her son is speaking Mi’kmaq which she strongly encouraged and supports. Barbara explained that “Life has so many roller coasters I would call it right” that she believed that having her own language would help her and her family deal with life’s difficulties. During our conversation, she was deeply saddened by the loss of language in her culture but was determined and committed to helping to restore it. By being an educator she thinks she can be a good role model. She stated that “There’s a lot of kids that’s what, that’s what’s holding them back if I, somebody else is going to make fun of them. But there’s some kids that do speak it, they’re the ones that hang around each other” (Barbara). Now that her son speaks Mi’kmaq, Barbara explained, “he is not shy to talk.” I wonder if this determination helps her cope with GDM.

Gadamer (1989) reinforces the importance of language as he states “For language is by nature the language of conversation; it fully realizes itself only in the process of coming to an understanding” (p. 446). Therefore, we have a responsibility to help Aboriginal people restore their language so they are better able to converse with each other and with those outside their culture. Perhaps if they could communicate more fluently in their own language they would increase their understanding of culture and be better prepared to bring about changes that they believe will benefit their people. Research has shown that loss of language is linked to suicides and mental health problems (Hallett, Chandler, & Lalonde, 2007) and loss of identity and culture (McIvor, Napoleon, & Dickie, 2009). For instance, Carol was frustrated because she did not feel she could converse appropriately to health care providers about her son's speech impediment. Although she tried to articulate her concerns, she found it difficult to get her points across about her son's condition. "We, we tried, like I noticed it [speech difficulty] a lot and what I explained it a lot, I tried my hardest to explain it. Sometimes my English isn't the best" (Carol). Language barriers continue to be a major problem for Aboriginal people as evidenced by Carol's experiences. Although Carol was referring to the English language in the above example, it is also important for Aboriginal people to speak and understand their own language. Competency in speaking their own language may result in feeling more confident conversing with non-Aboriginal people. Cultural identity is connected to Aboriginal people's well-being. Being fluent in a traditional language and connected to one's culture has been known to bring about healthy outcomes (McIvor et al., 2009). Grandparents and parents play a major role in passing on language which Barbara identifies as important for her community as well as other communities.

Bombay, Matheson, and Anisman (2009) claim that for decades Aboriginal people suffer significant physical and psychological effects from Residential Schools. They have emotional scars that may prevent them from ever reaching their full potential as citizens. "Considering the significant role that trauma plays in the lives of First Nations peoples, it is important to identify mechanisms by which the cycle of trauma and stress repeats itself across generations" (Bombay et al., 2009, p. 7). The effects of Residential Schools can have huge ramifications for their children and grandchildren as the generational knowledge, language, and wisdom will not be passed down to generations.

A few Mi'kmaq participants openly recognized the need and/or realized the severity of being forced to live in Residential Schools. They spoke about their concerns while other participants remained quiet. It may have been because I did not purposely address the issue but for those who did discuss Residential Schools, it just seemed to come up naturally as part of the conversation. The participants who did discuss it knew Residential Schools were one of the root causes of serious health problems, social problems, and language barriers that Aboriginal people face in their communities today. One of the participants explained that a lot of the community members are not well informed about the effects of Residential Schools. It is only recently becoming a topic that is being discussed in some First Nations communities. There are common threads between Residential Schools and another barrier, the Sixties Scoop, where in both instances Aboriginal people lost their culture and language leaving them feeling isolated and uneasy in their own communities and in the dominant society (Bombay et al., 2009). Likewise, the idea of taking Aboriginal land away forcing them to live on reservations is another colonial practice that has contributed to their poor health and living in poverty. Although the participants did not discuss the Sixties Scoop or the reservations, I would like to explore these topics in a future research study.

Making Ends Meet

As mentioned earlier, the SDOH have a huge influence on the health of Aboriginal people. The physical, mental, emotional, and spiritual domains of health among Aboriginal people during all ages are seriously impacted by social and economic barriers (Loppie Reading & Wien, 2009). The participants lived on a low income (approximately $185-$200 every 2 weeks) according to Jane and some lacked safe, secure, and affordable housing. For instance, some Mi’kmaq women shared their struggles with purchasing food. The women knew that when they were diagnosed with GDM, they had to follow a healthy diet but for some it presented a challenge because they either did not have easy access to grocery stories and/or they did not have the money to buy food, let alone healthy food.

Being frugal was the only way that Annette could make ends meet. Because her partner was not employed, she had to find ways to stretch her budget to provide for her family.

> Being thrifty is just, like my partner is not working and so I’ve had to, if I didn’t like for, Thursday’s a big deal for me because the flyers come out. I will get a coffee and if I can sit through them, go to the mailbox get them and just OK this is what’s on sale, this is where I’m going and I have a plan even if it’s not until next Wednesday or whatever, I know, you know what I mean, and I barely get by sometimes and so I wonder for the people that don’t have those skills, that don’t have that drive. I really enjoy shopping and I really enjoy the feeling of getting a sale, you know what I mean? I bought him a package of underwear for a dollar, him and his dad at Wal-Mart, that’s crazy. They are normally 10 bucks they went down to 5, and finally just a dollar for two packs of boxers. (Annette)

She found that when she shopped at different stores, she could purchase a lot of basic necessities and stay within her budget. Annette is proud of how resourceful she has become out of necessity. She feels she is successful because she has the knowledge and ability to develop and follow a budget. However, she wonders how other community members who are less fortunate than her are able to manage.

Inexpensive food is often all that Mi'kmaq women can afford to buy. The women expressed concerns around having to buy cheaper food because they knew it was not good for their health. Carol explained that in her community:

> They get their hot dogs, anything that was cheap for them to buy, for their children, it's the first thing they see on the shelves . . . I find that it, it's just too much money and like it's not too much money, it's cheaper stuff, it's bad for you. I find the cheaper the stuff it's bad for you, the more better stuff the more expensive for you. (Carol)

Annette explained that women had to send their children to school with pop some days because that was all they had in their house. She stated: "I know I've seen some moms send their kids with Pepsi. On the other hand, it's what they had that day, you know, what I mean it was, it was available and at least that kid had a drink" (Annette).

Annette believed that early education is a factor in preventing or minimizing the effects of GDM.

> I wouldn't have been so high risk and it, you know, early education, you get these moms now with gestational diabetes, and I know we're eating out but how we eat now, if I hadn't had this much education on nutrition as I have, like I try and send them [children] with good stuff and I try and make sure I know. (Annette)

Annette acknowledged the importance of early education so that she and other community members could be healthier and provide healthy food to their children. Likewise, Anne wanted to arrange more educational sessions on GDM and diabetes in her community.

In terms of employment, four out of nine participants were employed at the time of the study while one had seasonal work. Other women worked for short periods of time but nothing substantial to give them the income and financial stability needed to raise a family. Not having a job meant they had to resort to welfare which did not give them sufficient income to buy healthy foods or have transportation to go to grocery stores. Loppie Reading, and Wien (2009), among others, describe the disadvantages that Aboriginal people face around employment and income as a result of their socio-economic status. They have been denied opportunities to resources and conditions that would give them a healthy and prosperous lifestyle (Loppie Reading & Wien, 2009). The women recognize these inequities and want to take action to address poverty in their own lives and in their community.

Some basic things such as buying toilet paper were not possible for one mother because she lived on a limited budget. However, on the same day that Annette could not afford to buy toilet paper she kept her appointment with me to discuss her experiences with GDM. During the initial conversation it occurred to me that Annette considered this meeting very important and was willing to make sacrifices by offering to drive to my work place to participate in this study.

When I asked mothers if it was difficult to travel to grocery stores, one participant stated

> It's harder for other people, not for me, I own my own vehicle, but that's how I am, that's my priority, I feel like stuck, I get panicky, so if there's no gas in my van or it doesn't work or if I feel tied down then I'm just OK, I don't wanna do this anymore. Give me a job. (Annette)

Just having enough money to live was so difficult for Annette and her family. The sale flyers helped her manage her budget.

> I'm very much at that point a couple of weeks ago where I just like I've no money, no nothin', like having to spend every penny wisely and I still shop, I forgot my flyers, oh, sorry, it's just I'm religious about my flyers. But anyway like uh it, it wasn't just my hobby, it was my survival skill. (Annette)

Annette explained that the sale flyers gave her options to buy foods that were less expensive. She went to those stores for specific sale items. We discussed how amazing it was that sale items in various businesses around town could actually keep families "making ends meet." As I reflected on budget planning, I thought about how much time and energy this takes to plan. Pregnancy is a time when women need to eat healthy for normal fetal growth and development and in preparation for lactation (Perry et al., 2010). When women have GDM or diabetes additional dietary modifications are necessary to maintain normal blood glucose levels. Spending a large part of the time trying to find inexpensive foods to stay within their financial budget was difficult and for some was emotionally draining.

Insufficient money to buy groceries as described by other participants was not a problem for one participant because she said her “boyfriend works; he’s a fisherman . . . he always make me go buy health food” (Veronica). However, she pointed out that “everybody’s [members in the community] more into fast food. Um fast food ’cause it’s lazy, everybody’s lazy, you don’t have to cook” (Veronica). When I asked her if there were any stores to buy groceries she replied “There’s a store there, just up the road here another store, one, two, well we have two stores” (Loretta) but they are no grocery stores where they can purchase healthy food. I asked her if it would be helpful to have a grocery store, Loretta replied “Yeah that would be good, actually” (Loretta). Some women did not experience poverty and limited access to food but they acknowledged they were the fortunate few as more families were in need than not.

Acquiring appropriate housing was a major concern for two participants.

> My partner’s not working and we’re not in our house, we’re not sleeping right and the girls are getting us up at night, we’re [herself and her husband] cranky, and I was just done. They’ll have their own rooms, all of them . . . I’ll be able to sleep through it, well that’s the great hope is that I’ll be able to sleep through it. My issue last night, they were snoring, and dad was tooting . . . just, so it gets hard, and so I went and laid down in his room cause he was sleeping . . . just to have a little bit of peace. (Annette)

Likewise, Anne’s major concern when she got pregnant with the twins was acquiring a house. Living at her mother’s home before her twin boys were born was difficult because the area space was small. She knew she needed more space for her new babies in addition to her two other children. While Anne was patiently waiting for her home she said she often thought “How am I gonna raise two twins in one small room.” She had to be persistent. Finally she received notification from the Chief and Band Council that she had a home when her twins were two months old. When I met Anne, she was living in her new home. She explained how pleased she was to have sufficient room for her family. Although she appreciated her mother’s generosity allowing them to stay with her for a couple of months before her twins were born, she knew she could not live comfortably in the cramped quarters for very long. As I reflected on this cramped space, I found the work of Ellis (2004) helpful in understanding how place “enables or inhibits everyday life experiences needed by children” (p. 24). Place in a community is important for children’s mobility (Ellis, 2004). Everyday routines and interactions with family members occur in the home. This is where children learn about family roles, cultural values, and motivations that help them develop into adults. Classrooms in schools can be another place where children learn and develop. Any restrictions in these environments, such as home, school, and other places, in ways that prevent children from playing can negatively affect the behavior and identity of children (Ellis, 2004). Obtaining a proper place with adequate room to move was important to Anne in raising her children. When I asked her if it was hard for women to get houses, Anne stated “You have to be a part of this community. You have to have a band member and you have to have kids.” Women have to apply the year before by April 1st for housing explaining their situation before consideration is given. The majority of women have their houses in her community but they had to wait and go through a process similar to Anne. According to the PHAC

(2012), not only are experiences on brain development and being stimulated important in early life but studies have shown that healthy child development is effected by physical, psychological, and spiritual development. Early child development is directly influenced by housing, neighbourhoods, family income, parental education, healthy foods, healthy environments, etc. which is why proper housing and food are so critical to First Nations communities (Loppie Reading, & Wein, 2009).

According to the Health Council of Canada (2011) “poor living conditions, overcrowding and lack of housing, poor-quality drinking water, lack of food security have cascading effects on personal health and family relationships” (p. 20). Although some argue that diseases such as GDM and diabetes occur on the basis of genetics, it is important to seriously consider how changing traditional diets, limiting job opportunities, poverty and stressors in society, and access barriers contribute to ill health (Adelson, 2005). As previously mentioned in this study, the SDOH which are the economic and social conditions play a huge role in whether people are healthy and they shape the health of communities (Raphael, 2004, 2007). It was evident from our conversations that the women experienced varying degrees of lack of resources such as housing, food, and education, all elements of the SDOH, factors that limited their access to living a healthy lifestyle.

Communication Barriers and Miscommunications

The Mi’kmaq women conveyed that communication and respect was important to them. The mothers explained that they appreciated when the doctors and nurses took the time to explain their medical conditions while they were a patient in the hospital or when they were assessed in the health center or doctor's office. The most important thing was that the health care worker listened to the women's concerns. For instance, Carol recalled:

> When I went to the doctor I was like oh no I wonder how it's gonna be today. It was just like OK what are you worried about this time? Now you're going for your tests and for your gestation. They [doctor and nurses] took all my weights every day and they made sure that everything was OK and, and [the receptionist] she said god sent the angel. I thought the healthcare was just fabulous. I enjoyed it. (Carol)

Carol appreciated when the doctors and nurses were sensitive to her concerns, an example of cultural safety.

As I listened to the women's stories, the importance of sincere communication and understanding made a positive difference in increasing trust and respect towards care providers. The women appreciated explanation about their prenatal care including how to adjust to living with GDM. They were unhappy when the doctors or nurses disregarded their concerns or did not give them a voice to ask questions or give their opinion. Developing a genuine and caring relationship meant a lot to the women. Listening and responding back in a sensitive manner was often all that was needed.

As I engaged in Carol's and other women's stories, I felt transformed similar to the way that Bergum (1989) described as she entered the relationship with the women in childbirth. I felt the Mi'kmaq women recognized my sincerity and concern to their responses. They elaborated on their lives as though they wanted me to know all the details. They were eager to tell as much as they knew about their experiences with GDM and the experiences their own mothers encountered. Some participants had good relationships with the health care providers and were happy to share these experiences. Carol recalled "during um my gestation diabetes I felt, it made me feel than one I was when I wasn't diagnosed at all but I was really happy that they diagnosed it early, a wonderful doctor she's the best." Annette found "the band, like when I. They're the ones that you know, my band, helped like [health director] or community health nurse."

However some participants were disappointed with their care. This resulted in fear and a lack of trust in the health care system because of the way they were treated during pregnancy, birth, and/or during the postpartum period. The Mi'kmaq women expected that the health care professionals taking care of them were knowledgeable and competent to provide care. In some instances, their faith and trust were shaken when they discovered their care providers were disrespectful and/or negligent in the management of their care.

To illustrate this situation, Laura was particularly upset as she described how she had a serious reaction as a result of a major error in the insulin dosage as mentioned in the previous chapter. She was instructed to take 44 units of insulin instead of 4 units per dose. When she told her doctor during her appointment 2 weeks later about the error, Laura stated "he [the doctor] was even sweatin', he goes um I can't believe that I'm talkin' here to you and you're takin' this much insulin." Out of concern for herself knowing something was wrong, she explained to him that when she experienced an insulin reaction she discontinued taking insulin.

> I’m not takin’ this insulin anymore and I’m just gonna do what I think it’s right ‘cause um they uh, they tried to kill me with this and after he tells me um he, he was lookin’ at my sugars he tells me OK take 4 units in the afternoon, and take 6 units in the um, at supper time, don’t, not 44, not 66, and I just looked at him and said oh yeah. But I didn’t bother with the insulin, once in a while I took it, like um if I knew I was gonna go to a birthday party. (Laura)

In addition to this dangerous and incompetent care, the doctor missed an opportunity to re-establish trust with Laura. The other salient point is that nurses are required to check doctor’s orders to ensure that all medications are within normal range. Insulin is a medication that is normally double checked with another nurse before administering in acute care settings, whereas in community settings nurses check to see if the dosage is correct but administer on their own. I wonder where the error occurred. Also I wonder if the pharmacist was consulted to help clarify the error. As a result, Laura decided to manage her own blood sugars and insulin administration. Laura realized that she could have died if she had not stopped taking the large dosage of insulin. Since she could not depend on her care provider to outline the correct instructions to keep her blood glucose levels in normal range, she decided to manage her own care. She lost her confidence in health care providers. In this instance, medication orders should have been assessed for error and should have been clarified with the physician (Shapiro, 2010). The health care providers did not provide care culturally competent care. While not ideal, Laura knew she could not rely on the health care system totally and felt responsible to take care of herself and her babies. Although she needed appropriate access to care she did not really get it because it was harmful access.

During Kate's stay in hospital with her first baby, she recalled that when her baby was admitted to the Neonatal Intensive Care Unit for observation because of her GDM, she was annoyed with the doctors and nurses. She remembered nurses and doctors walking by making comments on how big her baby was in the incubator. Many of them had never seen a baby that size. Although she tried hard to control her weight gain during pregnancy, she gained over 100 pounds at that time. Her baby weighed 13½ pounds at birth. These comments hurt Kate because she loved her baby. She described feeling ridiculed for eating too much during pregnancy. Kate was only 18 years old and going to high school at the time. She was now a new mother who was trying to adjust to motherhood and needed support, not criticism on how she cared for herself during pregnancy.

> They [doctors and nurses] were more amazed and shocked and interested in his weight and his size rather than, to me, making sure that we knew what was goin' on with him and that, you know, if everything was, that he was healthy and, and things like that. And then it was another day before they realized that oh he has a broken collarbone . . . they passed those x-rays around for a whole day, you know what I mean, to other doctors looking at the fluid in the lungs, and then the doctor that delivered him, she wasn't my family doctor, they had, they had a different uh doctor deliver for me in case I needed a last minute C section, so um sh, when she

> was showin' the, she was talkin' to the other doctors, they were talkin' about his size and blah, blah, blah, and um they asked her if she had trouble uh delivering him, but I mean if she had trouble gettin' him out or whatever, and she said uh, she said no, she said, she goes the mother was actually really good and blah, blah, blah and it went pretty good and um one of the other doctors said oh yeah, he says 'cause one time I delivered a baby that was like 11 pounds and we ended up dislocatin' the, the baby's shoulder and the doctor that delivered for me she says oh she goes knock on wood I haven't, nothin' like that has happened to me yet, and another doctor was lookin' at the x-rays and says excuse me doctor, this baby has a broken collarbone, 'cause after she said it, you know what I mean like kind of braggin' or whatever that never had nothin' bad happen or whatever, then the other doctor kinda wanna you know, I think it was more, like a joke, look, re-lookin' at the x-rays tryin' to find somethin' wrong and he did. He's like this babe has a broken collarbone. (Kate)

Kate was left out of the conversation, yet she was present and heard the doctors discussing her baby's condition. They were disrespectful to her as they made joking remarks about the size of her baby and then almost failed to diagnosis her baby's broken collarbone. Kate's health care providers failed to recognize the importance of relational ethics. As a result Kate did not develop a trusting relationship with them. As Gadamer (1989) asserts "the verbal world in which we live is not a barrier that prevents knowledge of being-in-itself" but it is intended to broaden how we see things (p. 447). However, Gadamer (1989) acknowledges that certain linguistic and cultural beliefs view the world differently than others. Could it be that the health care providers did not recognize that they were being disrespectful to Kate? Did they realize they were acting in an arrogant manner? Did they fail to see the sensitive nature of Kate's situation? What about their failure to be competent in their diagnosis or at least omit that they may have missed the diagnosis if it had not been for one of the capable doctors in the group reviewing the x-rays. The encounters with some of the health care providers left her feeling disrespected and powerless.

When Kate went to her family doctor for her second pregnancy, her doctor did not want to provide prenatal care because of her previous complications with GDM. She recalled:

> I prob, I was diabetic and that it wasn't caught or whatever. So uh when I got pregnant for my daughter 4 years later I went in to go see my family doctor, told her I was pregnant and she laughed at me and she said there's no way in hell I'm treatin' you. (Kate)

The family doctor referred Kate to an obstetrician who was qualified to manage her high risk pregnancy. After reviewing her medical situation the obstetrician advised that the handling of her situation was negligent and that she could seek legal counsel. Because she was not diagnosed with GDM in her first pregnancy, her baby was large for gestational age[5] at birth. In addition, her baby boy had a broken clavicle which was not diagnosed until a couple of days after birth. Because her baby was overall healthy, Kate

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[5] Large for gestational age (LGA) is defined as "an infant weighing 4000 g or more at birth . . . or above 90th percentile on growth charts" (Wong et al., 2006, p. 821).

chose not to seek legal opinion. She knew her family doctor did all that could be done at the time and she did not blame her. Kate described her family doctor as “an older doctor, kinda old-fashioned maybe and I think she’s the ty, she’s the type of doctor I think that um tries to find natural ways for people to take care.” Kate had a good rapport with her family doctor. Initially she tried to rationalize why the doctor never told her GDM was suspected during her first pregnancy. She explained:

> I went to visit her the second time I was pregnant she had said something about like she hadn’t put me on insulin because um like it’s not confirmed or whatever, but she felt like in some cases that would make me more likely to develop diabetes later if I took insulin when I had gestational diabetes, like my body would somehow see a need for it or whatever and, and develop the disease quicker or, I don’t know how. (Kate)

She wonders now about the medical rationale her doctor used with her first pregnancy. It was not until she went to an obstetrician during her second pregnancy that she knew she should have been treated with insulin during her first pregnancy. Kate stated that the obstetrician told her “it’s a science to be able to control diabetes with just diet and exercise. It is a lot of work and you’re pregnant and you really don’t need that added stress of trying to manage this disease without medication” (Kate). Kate was accepting of this plan of care and when she was 4 months pregnant, her doctor started her on insulin.

Some of the participants were frustrated when health care providers failed to listen and communicate demonstrating a lack of respect and concern for them as people.

When Loretta went into labor with her first baby she begged for medication but they [nurses and doctors] would not give it to her. "Oh, I begged for drugs though . . . I begged, and he [doctor] said no, it's too late." I told her the likely reason for not being able to give pain medication was because the baby could develop respiratory problems if the drug was given too close to delivery. According to Wong et al. (2006), the baby's respiratory rate can be affected in various ways such as slowed, depressed, or absent if analgesics or anesthetics are given before birth. Jane was not diagnosed with GDM until her sixth pregnancy. Although Jane did not feel well, she did not suspect GDM until the diagnosis was made. During her fifth pregnancy though, she noticed that she did not feel well but the health care providers did not suspect GDM and as a result no diagnostic testing was carried out. Looking back she recalled

> I was really sick, I know now what it was, you know, and every time I went to the hospital it was like oh well we can't find anything wrong with you so it's just normal pregnancy aches and pains, and I'm like this isn't normal, you know, I've had like five kids and I've never went through anything like this. I'd go home and, and it was, it was just terrible, I, they knew nothin' then, you know, then it, it seemed like they didn't even take the extra step to see what they could find out. (Jane)

Although this pregnancy occurred 22 years ago Jane still questions why the doctors or other health care providers did not detect that her blood sugar levels were abnormally high, indicative of GDM. At that time, I recall the glucose screening was done with the other initial prenatal blood work and another glucose tolerance test was repeated at 28 weeks gestation. Therefore, I wonder what the laboratory results revealed at that time or if they were done, something we will never know.

As I reflected on the above situation, Jane’s symptoms and concerns were dismissed by the health care providers. They failed to understand their patient. Similarly in Browne’s (1995) study, the nurses failed to understand the seriousness of the clinical symptoms when a mother brought her baby to the nursing station in the north. The participants in Brown’s (1995) study saw this as having serious clinical implications because the patient’s symptoms were not considered a health problem. Although Jane made no reference to discrimination and no blatant accusations that the health care providers were discriminatory in their approach, the fact is that they did not listen to her concerns and this could have placed her health and her baby’s health in danger. Instead of treating the mother in a caring and respectful manner, health care providers failed to acknowledge her symptoms resulting in her receiving substandard care during the prenatal period. Jane was frustrated that although she continued to try to find out what was ailing her during pregnancy, the nurses and doctors disregarded her symptoms. She would go home feeling just as sick [meaning going into labor] as she did coming to hospital. To further try to understand how Jane felt, I stated “how did in the end did they diagnose you? Or did you get through that whole pregnancy and not even know [that you had GDM], you just kept goin’”? (researcher, field notes). Jane replied, “yeah and it [I]was miserable”. Her knowledge was not at all valued. While she was describing this situation, Jane’s face was solemn and she was close to tears (researcher, field notes). I could sense she was deeply hurt from being ignored when all she was doing was trying to take care of her health and her baby's health.

In order to better understand Jane's relationship with health care providers and the need for ethical care, I turned to Bergum's (2004) work on how knowledge in health care begins with the subjective symptoms that brings the patient to see the professional. A relationship begins as the professional, and in this instance the nurse, listens to the patient's descriptions of her health problem. Together, they try to understand the disease. Three kinds of knowledge that are needed to understand ethical care include: descriptive knowledge, abstract knowledge, and inherent knowledge. This knowledge develops through a collaborative and participatory approach. Descriptive knowledge is where the patients describe their symptoms and the health care professional listens and during this time forms a relationship. Abstract knowledge forms an objectification of the individual, a fragmentation, a way to examine the medical condition but the sense of holism is missing. A way to counteract the holistic limitation is to view the person from the "living whole" instead of the "objective whole" (Bergum, 1994, p. 73). Inherent knowledge places the health condition in the context of meaning of symptoms to the patient. The human experience is much more complex and interconnected than many health care providers realize (Bergum, 1994). Knowledge for ethical care can be developed through collaboration and participation at various levels in the health care system (Bergum, 1994). If the health care practitioners cared for Jane in a culturally competent manner, she would not have felt ignored (Archibald, 2001). Through the lived other (relationality) we are introduced to the other by a greeting and "gaining an impression of the other in the way that he or she is physically present to us" (van Manen, 1990, pp. 104–105). Although this was only a brief encounter with health care providers, Jane was discouraged by their lack of concern for her health and well-being. In a qualitative study conducted by Browne and Fiske (2001) on First Nations women living in a community in northwestern Canada, the women reported that their concerns were not taken seriously by physicians and nurses because it was assumed that there was nothing seriously wrong with them. One of the participants in Brown and Fiske's (2001) study attributed the assumption that there was nothing ailing the patient to their preconceived notion that the patients were Native and therefore stereotyped them. Likewise, Baker and Daigle (2000) reported that Mi'kmaq people felt misunderstood during their experiences with being hospitalized. In my previous study on Mi'kmaq women's childbirth experiences, the participants echoed similar feelings (Whitty-Rogers, 2006). Jane's encounter with the health care system, along with the experiences of the Aboriginal women in the aforementioned studies, reflects how much of this so-called misunderstanding occurs in Aboriginal populations. These examples bring to mind the importance of language when caring for patients. Heidegger (1971) explains that to speak to one another means "to say something, show something to one another, and to trust one another mutually to what is shown" (p. 122). This overall lack of cultural sensitivity and respect to the mother's voices is evident in Aboriginal women's encounters in the health care system.

Loretta's story is a classic example of Aboriginal women's hesitation to seek medical care because they could be accused of mistreating their children (Health Council of Canada, 2011).

> Taking care of my other daughter, and family members would be coming in, giving me a break and it was crazy but yeah thank God for a good family too. She [daughter] was all covered in bruises. She had bug bites on her ears, they weren't, they weren't healing. It wouldn't stop bleeding and then her bug bites were turning into bruises so my boyfriend said we gotta take to her hospital so I'm like oh no, they're gonna think I'm beating my child cause she's all bruised up so we took her in and they're asking me questions [referring to questioning her as to what happened to her daughter] and they got the blood work done and that's when they found out. (Loretta)

Loretta was actually relieved when the blood work came back revealing low platelets. Although she was worried about her daughter's health, she knew there was now concrete evidence that she or no one else could be suspected of beating her child. Because her daughter's platelets were low she had to receive a platelet transfusion.

> So we had to stay there and she had to have a platelet transfusion at night and she had a reaction to it. They gave her too much at one time. We waited a day and took her blood and no change so we had to do another platelet cell, platelet transfusion and thank God that one worked. (Loretta)

Although it is not unusual for parents to be questioned when their children have unexplained bruises on their body, it is concerning that Aboriginal people know they are more likely suspected of abusing their children (Blackstock &Trocmé, 2005; Health Council of Canada, 2011; Lavergne, Dufour, Trocmé, & Larrivée, 2008). "The results show that children of Aboriginal ancestry and from visible minority groups are selected for investigation by child protective services 1.77 times more frequently than are in the general population” (Lavergne et al., 2008, p. 59). Contrary to common beliefs, research has shown that Aboriginal children come into care under child welfare services for poverty and substance abuse and not because of physical abuse (Blackstock &Trocmé, 2005; Lavergne et al., 2008). Coming into care under child welfare services continues to be a difficult situation and perpetuates ideals of discrimination and colonial policies (Blackstock &Trocmé, 2005). According to Chief Phil Fontaine (2007), “For First Nations, children are our most precious resource. They are central to our worldview” (p. 1). The likelihood of improving the current situation for Aboriginal people as mentioned above will continue to be difficult as long as child welfare systems do not change and lack of accessible health care for social support does not improve (Blackstock &Trocmé, 2005).

Loretta agonized over her daughter’s health, especially when she had a reaction to the platelets. She continued to explain that the whole experience was “awful.” Loretta explained “Try and hold her down for blood work and she’s screaming mom. Like oh my God. Took four nurses to hold her down. And she’s only two but yeah. Well we managed through that one anyways.” Her daughter’s platelets have since gone back to normal. She is extremely worried about her children’s health and yet she has to deal with someone possibility accusing her of beating her children. Situations similar to Loretta’s encounter were consistent with the findings of Browne and Fiske (2001) and Browne et al., (2005) who report that First Nations women living in their community in northwestern Canada experienced discrimination during similar clinical encounters making them feel marginalized from society.

Some participants reported that they did not have good experiences in the doctor's office. Kate did not receive a warm welcome from her doctor with her first pregnancy. She had to rely on family members for information. She elaborated

> I went to a couple of prenatal classes um and like I said just talking with family members really um, kinda made me feel a little more at ease. Um the doctor that I had for [first baby] I don't think she really has a lot of um Mi'kmaq clients, I don't see a lot of people go to her, I don't know. I know she has a lot of patients but I don't really see a lot of people from my community [First Nations community] go to her. (Kate)

She wondered if the doctor was distant to her because she was Aboriginal, a question that cannot be answered. Race has serious consequences for people and exploring the reason behind these situations is important (McGibbon & Etowa, 2009). However, misunderstanding can result in inappropriate care which is a sign of racism (McGibbon & Etowa, 2009). Another incident in the same pregnancy left Kate wondering if she was not receiving appropriate health care because she was an Aboriginal teen mother. She described her annoyance with the doctor in the following manner:

> In a lot of them [other Mi'kmaq mothers] uh use another doctor, but um, my parents, she was my parents' family doctor. And she was my family doctor, who turned me down for the pill like the year before I got pregnant. She wouldn't give it to me, but um anyway yeah, so she's kinda old school and whatever. Um I

> think probably only one time I was ever really annoyed at her, and I don't know if the comment came at me because I was a teen mom or if the comment came at me because I was on Mi'kmaq teen mom, but I did at one time ask her if I should be taking some kinda medicine to, for uh like am I diabetic, do I need to take some kind of medicine, like I'm gainin' weight really fast and I feel gross and whatever, and um she said no you just need to stop eatin' so much, she goes I don't know about you guys, you just can't stop eatin' and I didn't a, I didn't ask her to clarify what you guys meant, whether you guys meant you teenagers or you Aboriginal people. I kinda, I kind of think it was a teen thing, I think she was more, she was kind of, she uh one of those doctors kind of annoyed at having a teenage patient. (Kate)

Looking back, Kate was angry that the doctor treated her differently because she was a Mi'kmaq teenager. The doctor conveyed discriminatory remarks as McGibbon and Etowa (2009) describe as "prejudice . . . a negative way of thinking and attitude toward a socially defined group," in this instance Mi'kmaq women (p. 18). Browne (2007) states that "Othering" practices can infiltrate clinical situations' initiating power situations and assumptions about the person's race, gender, and class. Othering refers to the "not-White" representing individuals, families, or community which is "outside the boundaries of whiteness" (McGibbon & Etowa, 2009, p. 71). The term "the Others" has been documented through photos, writings, and oral stories of Indigenous people (McGibbon & Etowa, 2009). I wonder what the doctor was thinking at the time. Did the doctor intend to covey discriminatory remarks? How did Kate deal with these feelings and try to prevent them from happening to her again. How do we educate doctors and other health care providers and how do we stop these discriminatory responses?

When I asked Annette about her experiences going to the doctor's office for her prenatal care she responded:

> Dr. [specialist's] receptionist sometimes when …would get in trouble she was kinda bitchy. I was really sensitive and I am generally like that . . . but if I don't feel welcome or if I don't feel accepted . . . I'll not get help and I'll just be like 'f' you I'm done here, see ya later. And I know for my own health and my child's health I had to keep coming back but it made it difficult when I felt, most other places aside from the doctor's receptionist, I really had a great experience. (Annette)

Barbara was upset because the doctors and nurses did not seem to understand the importance of her wanting to be with her baby when he was transferred by helicopter to an urban center. Her baby boy had a severe respiratory condition due to meconium aspiration and needed specialized and immediate care.

> I was not allowed to touch him. The nurses tried to stop me, they said you're not leaving, I said I'm going to [tertiary hospital], I wanna I, you know, I was with my son, and they said no you might hemorrhage on the way 'cause I was gonna get on the airplane right…we're [the nurses] refusing to let you go, and I said you can't do anything. (Barbara)

The nurses and doctors did not explain the health risks in detail with Barbara if she travelled on a commercial plane without medical attendance only 1 day after delivery.

Patients can develop postpartum hemorrhage within 24 hours or late onset after 24 hours up to 6 weeks (Perry et al., 2010). Infection is another risk after pregnancy and can occur up to 28 days after birth (Perry, et al., 2010). I wonder if the doctors and nurses had communicated with more sensitivity, Barbara would have understood more about the risks and perhaps elected to wait until she was less likely to develop complications. Barbara would have also had a chance to explain to the health care providers why she wanted to go with her baby. I wonder how much the doctors and nurses understood about providing culturally competent and culturally safe care.

I reflect back to my own experiences working as a nurse in a neonatal intensive care unit. The difficult decisions that have to be made and made quickly can leave the mother and family excluded from being part of the decision-making process, leaving them not valued as parents. I know the health care system is fast paced and health care providers have to act quickly but I wonder why we have not been able to improve ways to communicate with families during emergency situations. Why does the health care system fail at that time? I wonder if the doctors and nurses recognize the emotional “rollercoaster” for parents who have a sick baby. What is the nature of parenting for this mother (van Manen, 1984)? This mother has only been a parent since conception but embodies her child as a mother from that time onward (van Manen, 1990). Embodiment is like a lifeline to her baby as she is the person who is always going to be there for this child.

Veronica was in excruciating pain early in labor and explained that when she asked the nurse for pain medication,

> They only gave me laughing gas. I don’t know why they wouldn’t. I was like giving me something for the pain. We’ll give you this, and I was like what is it and they’re like laughing gas. Nothing funny about this. (Veronica)

Because Veronica was unfamiliar with the terms ‘laughing gas’, she immediately interpreted it as meaning something disrespectful. There was an assumption on the part of nurses that she would understand medical terminology. I explained Veronica that laughing gas was known as entonox, a combination of nitrous oxide and oxygen given to mothers who are in the latter part of the first or second stages of labor to inhale for the purpose of minimizing or eliminating labor pain (Wong et al., 2006). Although she was relieved to hear what this meant, she maintained that the nurse did not appear to understand the severity of her labor pain nor did she show any compassion or sensitivity to her discomfort. This situation was a prime example of how the health care system involves a powerful subculture with its own language and health issues and treatments that affect human beings (Gillet, 2006). Labour pain has been found to be unique to every woman and therefore only the women themselves can determine the severity (Pillitteri, 2003). Although childbearing is a special and memorable milestone in women’s lives, it is a frightening and potentially terrifying experience for some women (Maestas, 2003). Similar to my previous study on childbirth experiences of Mi’kmaq women, this mother reported a lack of understanding and respect on the part of healthcare providers (Whitty-Rogers, 2006). Providing information to patients demonstrates a respectful relationship and helps patients understand why they are receiving specific care and assists them in making decisions about their care (Brown, 1995; Browne et al., 2005).

The term “laughing gas” has been around for many years in obstetrics and has been used by doctors and nurses as a lay term to explain that the maternity patient will experience some comfort in labor if she breathes this gas in. Although, it was misinterpreted by Veronica as being disrespectful, it points to the need for seriously thinking about the language health care providers use in health care settings. As Alex and Whitty-Rogers (2012) point out, we need to examine the discourse we use with patients. Some discourse reflects historical prejudices and overarching authoritative medical models (Alex & Whitty-Rogers).

When Mi’kmaq women did not feel welcome, they too felt marginalized and hurt by the negative attitudes and behaviors of others. Annette did not receive a warm welcome from the receptionist at the doctor’s office. She stated “sometimes when. . . . would get in trouble she was kinda bitchy. I was really sensitive and I am generally like that . . . but if I don’t feel welcome or if I don’t feel accepted” (Annette). Anticipation of further negative encounters at the doctor’s office made it hard for her to continue receiving prenatal care. The only consolation was that everyone else that she encountered was pleasant to her.

> One of the specialists gave me shit, he gave me shit you know what I mean he did it in a good way and then moved on.” Like he kept talking and there was no moment when I had to respond or defend myself . . . he was just like you know how it is . . . and he would keep going and, or if I was doing good he would you know, but I always felt he accepted me and I really felt people were trying to make my day better ‘cause every week I had to be, at the end of all my

> pregnancies I had to be there and it was stressful even if I had to come back twice a week. (Annette)

Annette explained that she could accept the doctor's constructive criticism though about trying to keep her blood sugar within normal limits because he was doing it for her benefit, and not to be disrespectful. In order to better understand Annette's relationship with her doctor and the receptionist I turned to van Manen's (1990) lived other (relationality). Van Manen (1990) describes how we share "interpersonal space" with the other person as we get to know one another (p. 104). At this time we form an impression of the other person. In Annette's situation, she and her doctor had gotten to know one another during her medical visits. Annette developed a therapeutic relationship with her doctor. She shared the same space with her doctor as they engaged in conversation about her pregnancy. She explained that she respected and trusted him. Van Manen (1990) describes this "as we meet the other we are able to develop a conversational relation which allows us to transcend ourselves" (p. 105). Her doctor provided opportunities to understand Annette by listening to her and valuing her points of view (Bergum, 2002).

When Kate went to a small community hospital for confirmation and treatment of a broken ankle during her second pregnancy, she did not receive appropriate medical care.

> I went to the doctor in [rural hospital], told him [the doctor] I was pregnant, they're like no we're not doin' x-rays, we're not doin' nothin', they did an exam and I was like OK, it really feels broken, like it feels a lot worse than a sprain but they wouldn't take me for an x-ray, they wouldn't send me ho, they didn't have

> crutches or a cane or nothing to send me home in, so I was like what should I do, he's like well you'll have to go to a pharmacy tomorrow and get crutches and whatever, and so it was pretty much like a useless trip to the hospital, and should it just went to [my community]but anyway uh, so I had no way to get around, I had no crutches or nothing so I was hoppin' on one foot. I'd crawl over to the bathroom or whatever, so I didn't think it was a big deal. I woke up the next mornin', my pelvic bone felt like somebody just stomped all over it all night, I was in a lot of pain. (Kate)

After Kate left the hospital, she described how unbearable the pain was and her mother insisted that she go to see the obstetrician. The next day when she went to the obstetrician, he determined that she had a sprained pelvis and broken ankle. When Kate told him she initially went to a rural hospital for care, she said the doctor responded by saying

> I don't even know why they have a hospital there but anyway . . . doctor told you to do, he says, he goes you did tell that doctor you were pregnant didn't ya, and I said yeah, he said well and you told him how far along you were, I said yeah, and he said well he should've known better than to tell you to put pressure like that on one, only one part of your hip. (Kate)

Kate was troubled by the medical incompetence and overall treatment at the rural hospital. As I listened to her story, I found myself essentially speechless and angry at the lack of competent health care. Van Manen (1990) describes this type of situation as "something we might call epistemological silence," a silence that we encounter when a situation is appalling (p. 113). It behooves me to think that some health care providers lack the assessment and diagnostic knowledge and ability to give appropriate care. There is the Society of Obstetrical and Gynecological Standards that guides perinatal practice in Canada, yet this situation and others may never be reported. Although the community hospital was not equipped to care for an obstetrical patient, they certainly had the means to refer her to an appropriate health care facility. Having worked in a tertiary and regional obstetrical unit where obstetric patients are carefully assessed for labor and/or complications, I find it is inexcusable to hear that patients are not properly assessed and transferred to a facility where they can receive high quality perinatal care. All I could do was to listen to Kate and show compassion for the pain she endured. Inside, I was feeling angry and frustrated that Kate received substandard care. I wished the hospital was closed so Kate would have had to go to a larger center where she would have received appropriate health care. I wonder how these situations can be used to advocate for changes to emergency care. Kate was angry and felt powerless as she could not convince the doctor that she had a broken ankle. The imbalance of power between health care professionals and in particular doctors and nurses and patients continues to exist in healthcare facilities. Lazarus (1997) explains that medical knowledge, similar to most knowledge, is rooted in social relationships. Lazarus (1997) claims, “it is unequally distributed, therefore, and connected to matters of power and control” (p. 138). In the doctor-patient relationship, power dominates, thus leaving the patient dependent but not cared for appropriately. Foucault (1980) believes that “power is not to be taken to be a phenomenon of one individual’s consolidated and homogeneous domination over others or that of one group or class over others" (p. 98). It is not about who has power and who does not have power (Foucault, 1980). It is not to be housed or owned by anyone but everyone should have an opportunity to exercise power. How do we help patients exercise power?

In Kate's scenario, she did not mention seeing nurses at the hospital; rather the doctor was the focus of her conversation. I wonder if a nurse assessed her in the outpatient department before the doctor saw her. Generally nurses do the initial assessment. Where was the nurse(s) in this situation? Assuming they were likely present, they were nursing in these areas where the women access care. If they were knowledgeable and present for the patient, they would have immediately recognized that this mother should not have been sent home without adequate assessment and health provisions in place to address her inability to walk and cope with excruciating pain.

As I was recently reflecting on the pain and fear that Kate endured during that night, I recall my recent personal experience of being a patient in an emergency room for an unexpected kidney stone. While I was lying on the stretcher experiencing unbearable pain in a foreign hospital in the United States, I could relate to what Kate was describing being in a foreign hospital and not knowing what was going to happen. All I hoped for was relief of pain. The nurses present advocated for me and ensured that I received pain medication and appropriate care. They gently started my intravenous and wanted me to be comfortable as quickly as possible. The doctor was equally kind and informative. I had a wonderful experience because the health care providers worked as a team and I felt like a human being and not a number. Even the clerical person was amazing. After obtaining all of my person information, she asked me if I wanted a warm blanket. When I said yes, she was back in a moment with a warm flannelette blanket. This is the way that Kate should have been cared for. Instead she came in as a vulnerable Mi'kmaq woman with severe pelvic and ankle pain whose symptoms were trivialized and was sent home without proper health care. Gastaldo (1997) writes that vulnerability comes to a point in the body of the patient, prisoner, most vulnerable. Breaking the silence is difficult for nurses and even greater for patients. We discussed this incompetence and I acknowledged that it was good that her mother insisted that she make an appointment to see the obstetrician the next day. Kate's mother was concerned about her daughter's health and wanted to ensure she received proper healthcare.

> My mom had come down, my partner went and got her in the middle of the night and brought my mom down. So my mom got up she said you should call, she called [doctor] and she explained to him what happened and uh he's like bring her in right away, he says I'll just, I won't make an appointment, just bring her in right away, when you get here tell them to let me know (Kate).

Her mother did not hesitate to phone the physician the next day. Also her mother's immediate response to seek appropriate care for her daughter highlights the persistence and self-determination of Aboriginal women. This example of caring for her daughter is something that is entrenched in her traditional teachings as First Nations women believe they are blessed to have children and these children are special to them (Sokoloski, 1995). Because children are valued, Kate's mother saw it as her role as a mother to ensure her daughter's rights to health was upheld. If "women's roles as leaders are undermined or unvalued, the collective good of a nation is also undermined" (NWAC, 2007a, p. 5).

Lack of communication and understanding about the women's own care and the care of their babies often left the women feeling frustrated. Not knowing who to talk to or where to go next with their concerns regarding their pregnancies or their children's health was troubling for the women. Their stories were important to them and they did not want to let go of their thoughts or feelings. They vividly recalled their life experiences around GDM and questioned why they did not receive appropriate health care. The women needed to resolve their anxieties and unanswered questions about their health care but they knew this was not going to happen overnight. We discussed each of their health care encounters. During these discussions I observed how the women instantly recalled their experiences as if they happened yesterday. Their experiences were very much alive inside of them and they wanted to get them out. They also had unanswered questions that they wanted to get resolved. For example one mother wondered why she did not receive pain medication in labor before she had her baby. These conversations gave the participants a chance to explain their experiences and to know that this is valuable knowledge. During the conversations I explained to the Mi'kmaq women in layman's terms what happened when their baby experienced meconium aspiration or when one takes high doses of insulin and acknowledged when health care was inappropriate. I found that I was inserting myself in their stories and reflecting on my own personal and professional experiences as I listened to their stories. Listening to their stories helped me to understand their feelings but I often went away feeling a sense of unrest and a need to implement strategies to help health care providers understand the negative impacts they have on Aboriginal women's health now and the long term affects. It may be a potential research project.

Women's interactions with health care providers were considered important sources of support. Supportive nurses answered participant's questions and communicated respect. Although there were situations where Aboriginal women did not feel supported, there were instances when the women recalled that health care providers were concerned and provided helpful advice.

Although I have been immersed in this literature for a long time, the richness of the women's stories actually magnified the problem around power. Many people who feel powerless continue to feel powerless in systems such as hospitals because relationships with doctors and nurses tend to perpetuate colonialism. This often results in Aboriginal people concealing/suppressing their feelings because they do not think they have a right to speak up about their concerns. The participants wanted the health care system to accept them and give the care they deserved as a human being in a culturally competent and culturally safe manner however this was not always the case. Loss of a normal pregnancy, lack of knowledge around cultural sensitivity, and lack of independent decision making were evident in the participant's experiences of becoming a mother. Foucault (1980) asserts that "power must be analysed as something which circulates, or rather as something which only functions in the form of a chain" (p. 98). Thus power is exerted in various places such as organizations. People can exercise power and be subjected to power (Foucault, 1980). How do we help Mi'kmaq women and other patients understand the dynamics of power and help them to feel empowered in these clinical encounters?

Conclusion

Having appropriate access to healthcare was a great challenge for Mi’kmaq women and their families. Some of their greatest hurdles included transportation, lack of financial security, influences from Residential schools, lack of cultural competent and culturally safe care, as well as communication and language barriers. Although they found ways around the barriers, it was not without huge frustration and sacrifices. Issues around access to care, social support, and utilization of health care resources all contribute to less than optimal health outcomes (Spitzer, 2005).

Sometimes I felt the women were bewildered and I was living this bewilderment as I listened to their stories and observed how they actually lived and coped with health problems related to GDM, encounters in the healthcare system with physicians and nurses, and the effects of Residential Schools during my time in their communities. The effect of Residential Schools has had a serious and, in some instances, catastrophic effects on women and families. Because of these Residential Schools culture, language, and family relations have been impacted.

It was during these conversations with the women I could see the effects and persistence of colonialism and why their lives have become so complex with no easy ways to address these issues. When there was a sense of support, understanding, and respect from some health care professionals, their health problems were perceived to be manageable as they knew there were people who were going to help them have healthy birth outcomes. They wanted to feel the health care system accepted them and would give them the care they deserved as a human being and in a culturally competent and culturally safe manner. However, this was not always the case.

Communication and language barriers were a concern as the women found it difficult to convey their concerns and questions to health care providers. As a result, they often went away feeling like they did not have a choice and no one was listening. Health care providers have a responsibility to understand health from the patients' perspective (Spector, 2004). Being close-minded and insensitive to clients' views on health only perpetuates misunderstanding and creates barriers to health (Spector, 2004). Despite the barriers to healthcare, the women were interested in finding answers to their questions and yearned to have health care people provide explanation and be understanding of their health care concerns.

Chapter VII

Theme III

Social Support During Pregnancy

Social support as one of the SDOH is a well-known concept. In some literature, social support has been shown to be a health protective mechanism (Health Council of Canada, 2011; House, 1981; Reutter & Kushner, 2010; Zachariah, 2009). A woman's perception of lack of support during pregnancy can affect the health of her, her baby, and family (Zachariah, 2009). Social support is a possible "modifiable psychosocial factor" (Zachariah, 2009, p. 394) which has proven to lessen stress and improve the mental health status of women (Orr, 2004). Situations that impede postpartum recovery can interfere with healthy relationship outcomes for mothers and families (Aktan, 2012). Social approach is needed to address diabetes where people work together to make changes to improve their health (Spero, 2006).

In this chapter, Social Support During Pregnancy will be presented. Sub-themes associated with social support identified in this research included: Introducing Social Support, The Value of Midwifery, Aboriginal Families, Valuing the Community Health Nurse, Valuing the Community Health Representative, The People's Center, The Band as a Source of Support, When Family Support was Insufficient, and Health Care Professionals.

Introducing Social Support

Social support is defined "as support accessible to an individual through social ties to other individuals, groups, and the larger community" (Lin, Simeone, Ensel, & Kuo, 1979, p. 109). It encompasses seeking and receiving care. The greater the support that people receive the less chance they have of becoming ill (Lin et al., 1979). The CNA (2005) adds that "social support helps give people the emotional and practical resources they need to get through life" (p. 4). In the Aboriginal population, as is the case of other populations, women who have high risk pregnancies experience increased levels of maternal anxiety and stress. Therefore they require social support to help them achieve healthy pregnancy outcomes (Zachariah, 2009). According to Bombay, Matheson, and Anisman (2009), social support in Aboriginal communities can come from various government organizations but the most beneficial support comes from their own communities.

Social support from family, friends, health care providers, and communities was important to the Mi'kmaq women because it gave them someone to confide in, listen to their concerns, transport them to their appointments, and assist them with childcare. During the prenatal period, support occurs when the nurse begins the first assessment of the woman in the hospital or in a clinic (Perry et al., 2010). One community health nurse explained that she usually knew the Mi'kmaq women living in First Nations community before they required prenatal care so getting to know one another and building a trusting and professional relationship had already been initiated. The community health nurse often sees the women before the doctor because they go to her for their initial pregnancy test (Community Health Nurse, personal communication, September 26, 2012). Once it is determined a woman is pregnant, the community health nurse assesses the woman's weight, vital signs [temperature, pulse, respirations and blood pressure], and arranges for prenatal blood work. She then informs the woman to make an appointment with the doctor in their community. If the woman is diagnosed with GDM, she is transferred to the care of an obstetrician or another medical specialist outside her community for high-risk health care. The community health nurse assesses the mother later in pregnancy between doctor appointments to ensure mother and baby are doing well. She does a lot of patient education at this time (Community Health Nurse, personal communication, September 26, 2012). Since there is no dietitian or nutritionist on staff at the health center, a referral is made to them outside the First Nations community.

Communication and collaboration between health care providers and women and families are essential. For instance, Annette was pleased with the support she received from a number of health care providers.

> They [health care providers] kept on me [positive help] like when I got my diagnosis from my doctor, he had . . . you know what I mean, my family doctor, I'm pretty sure my family doctor ran me through most of my pregnancies and then referred me to [obstetrician] in my file not 100% but I'm pretty sure that . . . and then the insulin and all that, but you know. They're the ones that you know, my band helped, like [health director] or [community health nurse] talked to me. (Annette)

A collaborative relationship allows time to get to know the extent of support the pregnant women receive from their family and other people in their lives.

Family-centered care is an effective approach for providing support to women during pregnancy and birth. It is a philosophy that includes respect, collaboration, and support (Wong et al., 2006). Aboriginal women value these attributes and consider this approach a means of providing culturally competent and culturally safe care (ANAC, 2007). In a family-centered care environment, the diversity of individuals in the family are recognized as well as their goals, actions, educational needs, and family support (Wong et al., 2006). Since Aboriginal people are a source of significant support to each other, a family-centered care approach is highly valued by Mi’kmaq women.

The participants identified their parents, partners, children, community health nurse, health director, band, and other health professionals as integral in providing social support to them. For example “the most successful people that are doing well with managing their diabetes, is because either they have a parent or a child helping them and supporting them” (participant #3, talking circle). The First Nations communities view it as their role and responsibility to help women achieve healthy pregnancy outcomes. One participant stated “it takes us [people in the community] to look out for ourselves” (participant # 2, talking circle). During a talking circle session one of the participants thought that results of prenatal education and health outcomes would not likely be evident until the next generation.

> Some of the education that we’re getting we’re just not gonna see until our kids are older ‘cause that’s what ends up, when you give education to moms, that’s

> where it ends up, in their children ‘cause you know what? Pop and chips were a staple for me and I know it took being a diabetic to change that. (participant #1, talking circle)

Participant # 1 believed that the knowledge she obtained from educational sessions will benefit her children. She said it takes time to see the effects of changing the way Aboriginal people eat and engage in other health care practices. Aboriginal people believe the future generation is the way to pass on Indigenous knowledge and traditions (Iwama et al., 2009). Aboriginal people learn through “subjective experiences and introspection” (Ermine, 1995, p. 102). Aboriginal people’s language and culture are integral parts of transforming how they live (Ermine, 1995).

Aboriginal women generally have a close connection with their immediate and extended family and also with their friends. In my previous study on childbirth experiences, support was described in different ways such as allowing time for discussion, listening and validating concerns, and providing information that helped women gain more knowledge, confidence, and autonomy (Whitty-Rogers, 2006). They remarked on how positive they felt when they received support from family, friends, the community health nurse, and other health care professionals (Whitty-Rogers, 2006). Similarly, Annette found that attending a workshop on budgeting was helpful and it provided the support and education she needed.

> You get people at a table, like yesterday we had a workshop on budgeting, through our welfare program . . . budgeting your power, budgeting your f, like food like that’s, we had the basic shelf workshop, or basic shelf cookbook and

> then we cooked out of that. Nova Scotia Power came in and gave us helpful tips on how to reduce power. Like I know it was a workshop, it was a day that we spent together and [someone for] Housing and [someone for] Welfare, sat there and I visited with them and I learned about them, that about them more as people and the fact that any of them could learn from me . . . holy shit, yeah, right. (Annette)

Annette realized that the women learn from each other. She was also pleased that others learned from her.

If a strong family/community is not intact, "we are weakened psychologically in our abilities to situate ourselves respectfully and comfortably in a world of many cultures, societies, and nations" (Weber-Pilwax, 2001, p. 168). Without healthy family relationships, individuals are unable to reach their full potential (Weber-Pilwax, 2001). Van Manen (1997) states "we experience our parents as the solid ground, the home of our existence" (p. 90). What happens when children become parents and in this instance, girls become mothers? What amount of support do they expect from parents and families? Although the women were not demanding of their families, they wanted assurance of support from them when needed. However, they tried to do their own part to fulfill their roles as mothers. For example, Annette attended educational workshops as they not only provided new knowledge but they also provided a space for a social gathering. Annette stated: "I like comin', this is part of my socialization. After 8 o'clock my kids are in bed and I'm home. That's my day normally. So when I come out I get to visit with everyone for a bit." The evening meetings worked well because she did not need a babysitter as her husband was home. The workshops were held in an environment where the lived space was supportive and liberating (van Manen, 1990). Liberating meant feeling she could speak freely about an issue and not be criticized or silenced. She was comfortable asking questions and sharing her opinion.

Social support was demonstrated in the form of love, caring, relationships, being present for each other, education, taking care of the children, having resources such as someone to mind the children, educational resources, and others. Carol had great admiration for her doctor as she remarked:

> She's [doctor] a sweetheart. I was telling Doctor she says are you ready to tie your tubes? I said yeah, I said if it's not a girl well that's OK, tie my tubes, she says don't worry Carol, geez you know that I tied my tubes when I was 42 is what she told me. She had, she had her ch, uh ti, at 42 so 42 ain't bad she told me. So that was pretty good so uh she's a fabulous person, it's unbelievable and GDM she helped me through it so much it was just like there's so, oh they take care of you so well. (Carol)

Social support is a pillar on which the women lean; it provides a means of hope and strength, and it helps revitalize people. Although the Mi'kmaq women were afraid when they were diagnosed with GDM, they were comforted by this genuine loving support during pregnancy, birth, and extending beyond the postpartum period.

The Value of Aboriginal Midwifery

Midwifery approaches give women more confidence, respect for their lives, and empowerment (NAHO, 2004). Midwifery practices, including those in Aboriginal communities, were flourishing prior to World War I. By the 1950s, there was a shift and almost all births occurred in hospital because births at home were considered unsafe. As a result, many ancient and traditional forms of pregnancy and birth practices were lost. The removal of birth from the community has resulted in a loss of Aboriginal identity (NAHO, 2004). The loss of this valued support has resulted in leaving only a few Aboriginal midwives to pass on Indigenous knowledge. According to Gadamer (1988), speaking about dialogue, “the art of using words as a midwife is certainly directed toward the people who are partners in the dialogue” (p. 331). Here Gadamer (1988) speaks about how words themselves bring forth new meanings and understandings when in dialogue. Due to birthing being removed from Aboriginal communities, these same meanings and understandings formed between the Aboriginal midwife and the woman do not occur. Thus the woman is required to engage in an alternate culture for birth. Again the women and babies experience a lack of what could be. Aboriginal midwifery encompasses the holistic elements of the mother and baby as part of the ceremony of birth, herbal medicines, and education of the mother and family about the childbirth process (Ross Leitenberger, 1998). Without having the Aboriginal culture around the woman living with GDM and where they give birth, health care providers have to work that much harder and stay open-minded to manifest the Indigenous principles as outlined by Battiste (2000) in the relationship. Health care providers have to be sensitive to and respect their cultural beliefs and values, allow for music, dance, and other traditional ceremonies, understand how their language is connected to their land, have control over their research, etc. Hence, without consideration for Indigenous principles the views of the women, the sharing of pregnancy experiences, and birthing knowledge are repressed.

The loss of Aboriginal midwifery meant that Aboriginal traditional medicines and knowledge were not always passed on. Since the 1980s Aboriginal women have been working hard to regain their role in childbirth (Carroll & Benoit, 2004). Herbal medicines were important in preventing complications in pregnancy and labor (Carroll & Benoit, 2004). Some people believe that the loss of traditional medicine has led to an increase in postpartum depression, other mental health problems, and consequently alcohol and drug abuse (Skye, 2010). I recall a small number of Mi'kmaq women in my previous childbirth study felt strongly that Mi'kmaq women should have the choice of delivering at home or in a health care facility located in the First Nations communities under the care of competent midwives in addition to nurses and doctors. Midwifery regulation began in Nova Scotia in 2009 (Nova Scotia Department of Health & Wellness, 2011). Midwifery has since been implemented in three districts in Nova Scotia. When I asked the participants if midwifery would be something they would like to establish in their communities, a couple of them replied that the midwife comes from the hospital. Loretta stated "we have midwives that come once a month. I did not have a midwife because I was high risk, can't touch you." Because she was not having a normal pregnancy, the obstetrician was brought in to manage her pregnancy instead of a midwife. Midwives are only involved when there are no maternal or fetal complications.

They assess the women in First Nations communities but the women have to deliver in an acute care setting. The Aboriginal and non-Aboriginal women do not have the option of delivering at home. As soon as women's condition changes, specialists are involved in managing their care.

Anne thought that midwives would be helpful in her community. Anne stated: "midwives provide prenatal [meaning prenatal care at the local hospital] and they do but they usually have that clinic that's in the hospital, they come down [the First Nations community] once, I don't know why." When I asked Annette the following question "do you think the midwives would play a key role if we had them more involved in the community?" (researcher, field notes), her response was as follows:

> Even our nurses [community health nurses] getting educated to be able to have her [midwife], to be able to do prescriptions. So it changes the kinda care that's what she's going to get, [community health nurse] our nurse here. Well it's just the midwife is just that. Because [community health nurse] is here for everybody like. You know diabetes is such a big part of our culture and we talk a lot about gestational and getting diagnosed, well we've had people that have, have had other complications uh what did Edward die of, but diabetes made it worse, something to do with his bones. Anyway and he was on steroids which made him big and put his sugars up 'cause he's diabetic. And so he got fat. Like all of those things and then to have to deal with going to the doctor and coordinate all of the services required uh for him it would just have been easier if [community health nurse] could have done a lot more, like she's a part of our community. She

> doesn't live here and she's not Native but I think sometimes she's more part of our community like and, and, and trying to put a healthy focus on us has, has made her more health conscious for herself. She ran in the marathon or walked or did something in the marathon. They do got acc [access], not midwife, they had access to you know the medical centre here. (Annette)

Although Annette could see some value in having a midwife, she thought it would be more beneficial to have the community nurse do this work because she has more general knowledge and skill. Midwives are primarily trained for maternal child care whereas a broader scope of knowledge and skills are required because of the nature of the illness in Aboriginal communities. Likewise, Barbara did not think midwifery would be something she would like.

> I always watch like shows like there's 'cause I know I've seen a show on it or a movie or whatever. For me I don't think I'd be comfortable with but I know some people are like but I don't think there's anybody here that I've know that had a midwife like they always go to the hos [hospital]. (Barbara)

In Barbara's community, the women do not have midwives coming to assess low risk women. Perhaps when midwifery services expand in Nova Scotia, her community will have an option for this care. A question that came to mind here is whether the women's perception of the doctor as expert–western medical trained as more qualified, instilling greater trust than traditional knowledge that midwives practice–has been influenced by colonialism

Midwifery is grounded in the relationship with the mother, coming before technical knowledge. James (1997) describes how the midwife directs her attention to knowledge and skills and the mother as a person in order to provide care and support to her during pregnancy and birth. Midwifery care allows for relationships to blossom as mothers and families develop trust, have choice, and experience home births where the focus is on the mother as a woman (James, 1997). Zimmer (2006) believes that the human relationship grows slowly over time to the point where one cares deeply for the other. Because of the shorter duration of time spent with mothers, Zimmer (2006) claims that perinatal nurses do not see the mother the same way that midwives do. Obstetrical nurses come from the perspective that because of time constraints and in a foreign place [meaning outside the hospital setting], birth is considered "primarily the means to an end" with the aim of finding the "best solutions" (Zimmer, 2006, p. 254). On the contrary, mothers get to know the midwives much more than the obstetrical nurses because the relationship has time to develop over several and long prenatal appointments. Midwives develop their knowledge from being able to assess the women during pregnancy and get to know the family before the baby is born. Because of the extensive amount of time they can spend with the mothers, they develop a better understanding of the mothers within the context of their homes and communities.

In collaboration with the Mi'kmaq women, we discussed what would work best for their community. They indicated that we should advocate for the community health nurse to have broader knowledge and capacity to do more clinical skills in their community, similar to a midwife. In speaking with the community health nurse in one community, she agreed that her role should expand and initial discussions have begun in one community. She is currently nearing completion of the Family Practice Program[6] which has given her new knowledge and skills. However, as previously stated, one questions whether this is another example of western practice and skill development being elevated above developing traditional expert knowledge. A new Maternal Child Worker has been hired. It is anticipated that she will help with making positive changes to prenatal care in this community according to (Community Health Nurse, personal communication, September 26, 2012).

Aboriginal Families

Traditionally, Aboriginal families have always been "close knit." In the past the bands were made up of groups of families (Baker, 1998). They were/are considered the social group in the Mi'kmaq communities (Baker, 1998). Doyle-Bedwell (2008), a Mi'kmaq woman and lawyer, claims that mainstream society is more concentrated on the individual whereas the Mi'kmaq people focus on the family and community as a whole. I also found that Mi'kmaq women highly valued their family. For instance, when I asked Barbara how many children she had during our initial meeting, she stated:

> I have four children (million dollar family), two (boys and girls) of each. I could have gone either way or you know whatever. And for me to have my children by

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[6] "Research has shown Family Practice Nurses are integral members of the collaborative health care team . . . providing preventive care, health education, continuity, telephone triage, health assessments, immunizations, prenatal, well baby, well women exams and many other key services" (Family Practice Nurses Association of Nova Scotia, 2012, p. 1).

> my side means so much to me. I'm so grateful that I wake up and know that they're there with me. (Barbara)

A million dollar family meant that she had everything she could possibly want; her children are healthy. Barbara regarded her children as the most treasured and valuable gifts she could ever receive in her life. Even though her first baby was ill, she still thought of him as special. Barbara explained: "He was good size baby, uh he was uh 9/10 when he was born but he ended up being sick instead."

Annette considered mothers the backbone of the community and felt a high priority was to educate them.

> You know, you need to educate them that they educate their children or they educate their partners. Because if you, the, that's, that's the backbone of our people that, you know, is, is our moms and most cultures it's the moms 'cause they give 'em their language. (Annette)

Barbara was grateful her family was present during the baptism when her baby was critically ill as she stated: "they [nurses] brought the priest in, they baptized him and my family was all there." Having family present was comforting and made her feel they cared. Barbara could always count on them. Events involving the family always included the extended family and friends. No one was excluded from ceremonies or gatherings. Even some children in the community want to adopt Annette's parents.

> We had a birthday party at the house, at my mom's house and all three of them are like can you be our grandma, and my mom and dad were like grandparents and they're like yeah, and then like my, my sister had to bring up [her son] the

> other day to visit my mom because he was havin' a fit 'cause he wanted to go visit his grandma. (Annette)

This was another example of close ties among family and community members.

Carol was comforted when I acknowledged that it is difficult for mothers to cope with everyday life when they are worrying about their children's and/or family's health. We discussed the notion that language and how we speak and communicate is vital for children to learn early in life. In response to Carol's concern about her son's speech problem and the importance of communication, I stated: "helps them [the children] feel good about themselves and you're right to say well I'm concerned, because in the future if he [son] grows up as a man with a speech impediment that that could be uh very difficult" (researcher, field notes). Speech helps children build their confidence because it provides a means by which to communicate with others. Language is rooted in dialogue and it is how one understands (Gadamer, 1989). Human language is "a special and unique process since, in linguistic communication, a "world" is disclosed" (Gadamer (1989, p. 446). Therefore the world becomes a common place where people talk to each other and understand each other (Gadamer, 1989). Carol provided the context from which her older son tried to provide support to his younger brother who had a speech problem.

> The oldest one [son] he takes most of it because he's the older brother and if I was to send him somewheres like a playground he takes all the stress because he's got to answer to all and if he doesn't sometimes he goes to other kids and other kids will pick on him then he's running to the rescue. So he's like 100% buddy he

> says he has to be there all the time with him just to let him know . . . And he works very hard on it. (Carol)

When we explored further details around his birth, Carol replied, “he [son] was perfect.” No other members in Carol’s family had speech problems. She recognized that seeking medical attention while he was young made a significant difference in improving his speech in the long term, and she wanted to pursue additional help. However, she anticipated that it will not be an easy journey having to communicate her concerns to other health care professionals because she found they did not always understand what she was saying. She stated: “I noticed it a lot and I tried my hardest to explain it, sometimes my English isn’t the best but I tried to explain it to a lot of people and a lot of people see that he does it” (Carol). I responded: “you have a right, you probably know this anyway, to talk to your family doctor and say look, I’d really like to find out the origin of this [speech problem]” (researcher, field notes). I reassured her that she was acting out of concern for her children’s health and well-being. I sensed that she was relieved with this response as I tried to validate her concerns.

The Mi’kmaq women frequently talked about their family, primarily their children and educating the children from what they themselves have learned. Carol’s children were playing outside the health center while we were meeting. Her eyes lit up and she smiled at her children as they peered through the window. Loretta had an invitation to attend a family wedding in the afternoon following our conversation while another mother was going to a children’s birthday party after we finished meeting. In these instances, as well as others, regardless of what topic we discussed, the family, especially the children, were central to the conversation. Families play an important role in shaping Aboriginal women's impressions of what is desired and acceptable in their relationships with others (Devries & Free, 2011).

Families-The heart of the women's lives.

It quickly became evident from the conversations with the women that their hearts were with their families. The participants live in their own homes and not with their parents, but they had frequent contact with them. Close proximity to their parents was especially important when they had a family crisis. Parents were often a huge support to the women during those times. For instance, Anne's family helped her out when her partner passed away while she was living in another First Nations community.

> He [partner] passed away and then I moved home 'cause I had to, in order to heal, I had to be with my family, my immediate family. They helped me get through my grieving process so when I moved home, I changed my band back because I didn't get help up there. (Anne)

Anne now has a new partner and he helps out with taking care of the children. However, sometimes the frequent visits from her family and friends made it difficult for her to get rest when her partner was away. Anne stated: "I try to get laundry done, dishes done, supper on the go. I got a lot of errands done today 'cause their father was here for a visit." She needed her partner's support to help her with the twin babies. Sometimes her family did not realize that "dropping in" was not the help she needed. Having her partner present all the time would have given her the rest she longed for. This discussion began to deepen my insight into partner support and without it, how do mothers actually complete all their daily tasks. Because her partner was coming home for short periods of time and leaving, she did not have continuous support.

During this study, I began to reflect further on the meaning of support. Sometimes in the past what I thought was good support to patients was not the support they needed. I thought that as long as the partner provided some support and was involved in helping the mother, even if he did not live with her, it would be fairly reasonable support. However, in more recent years with my experience working in nursing and nursing education, I realize that continuous partner support is needed. Anne wondered how she was going to communicate the support she needed. Although she shares an interpersonal space with her partner (van Manen, 1997), she does not know how to help him understand how she felt with GDM. Heidegger (1971) states "that the reflective use of language cannot be guided by the common usual understanding of meanings, rather it must be guided by the hidden riches that language holds in store for us" (p. 91). For Anne, usual words fail when she was trying to explain how she felt. The usual meaning of support that women expect when they do not feel well may not be what their partner is even thinking. How does Anne explore her partner's understanding of support? I wonder how he perceives his role as a father and partner.

Contrary to Anne's situation, Loretta expressed gratitude at having her boyfriend in her life. It was evident how much she valued his support. Loretta stated: "I'm lucky I have the father. My boyfriend's in my life and it's both of us raising the kids and his parents, when they come down to visit, they're very helpful." Her parents are equally helpful. Loretta explained:

> Same with my mom and my dad and my sisters. I have a great, luckily I have a great uh, if anything happens like, like just recently my daughter was hospitalized. She had ITP [Idiopathic Thrombocytopenia] [7]. So I'd been in crazy but yeah thank God for a good family too. (Loretta)

Although Loretta was worried about her daughter's medical condition, she had the time and freedom to concentrate on her. She could rely on her family for support.

While reflecting on Loretta's story, I thought back to my own story when my eldest son had to have surgery for an undescended testicle and hernia repair. He was only 8 months old. The surgeon had no bedside manner; he spoke in a cold and condescending manner. If it was not for the support of the pediatric nurses asking me how I was getting along and telling me I was welcome to stay on the unit in the room where he would recover from surgery, I think I would have been more anxious until he returned from the operating room. In the women's descriptions of their concern for their children's health and in my personal story, we are viewing our children through the lived body. We cannot separate the illness from ourselves (Van Manen, 1997). Van Manen (1998) refers to this situation as coming "into being under the eyes of someone else" which is known as "the experience of encumbrance of the other's body" (p. 7). The other

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[7] This is "an acquired hemorrhagic disorder characterized by (1) thrombocytopenia excessive destruction of platelets; (2) purpura, a discoloration caused by petechiae beneath the skin; and (3) a normal bone marrow." (Wong et al. 2006, p. 1616).

person's body (i.e., my child's body or Loretta's child's body) which we are watching becomes my own experience or Loretta's experience.

Through our intimate knowledge about mothering and the strength of our love for our children (Rubin, 1984), we experience the illness or pain through our children. Mothers generally have a strong bond with their children and therefore are sensitive to and concerned during the phase of illness. Because GDM and giving birth are embodied experiences we sometimes want our own mothers who gave birth to us and others who nurtured us around when we experience a bodily event. It was a form of reciprocity as we were able to both sense/share our identity as mothers about our young child's health (Bannister, 1999).

When her son was transferred from a regional hospital to a tertiary care facility Barbara's family covered her airplane expenses. She explained: "My uh uncle and um, my uh mother-in-law, they spoke to each other and they said they were gonna pay, pay for everything, the flight for us" (Barbara). Barbara was forever grateful for the generosity of her uncle and mother-in-law during her son's illness following birth.

Veronica proudly talked about giving advice and support to other mothers in her community. Her mother had given her valuable knowledge about life and support and in turn she shared her knowledge when possible.

> And they [other mothers] like talking to me. They do. They will come to me and they'll ask me, OK I'm having trouble with this and I'm like all right well don't let that stuff bug you. My mom told me that. Don't hold it in. And so she always

> told me that. Don’t hold it in and so I was like all right, so it’s not like I was always crying but I cried when I needed to. (Veronica)

Veronica had deep admiration for her mother’s advice. When her sister lost one eye her mother was there for her.

> And my younger sister she held it in ‘cause she got shot in the eye. Yeah, with a paintball gun and she lost it. Well she still has her eye but she can’t see out of it and so um now she wasn’t very emotional so now she um takes panic attacks. She shakes and she starts freaking out and she’s on pills now to help her out with that and I’m like you don’t need to be on those. You just gotta change the way you think. Don’t let nobody bug you and she [her mother] still goes keep talking to her like that but after a while it gets a little better. (Veronica)

Her mother helped her and her sister cope with difficulties in life. Close friends are another source of support when you can share your true feelings in a way that you do not feel judged and/or reprimanded. Veronica found that discussing problems with people she could trust helped her cope. Evoking Bear’s (2000) views, Aboriginal people value relationships. Sharing stories helps people maintain balance and also helps them have good feelings.

Story telling evolves into the important role of women supporting women as leaders which transcends their familial role. According to Meadows, Thurston, and Lagendyk (2004) in their qualitative study with 40 Aboriginal women, there is evidence to indicate that women who focus on the future in terms of their own life and/or those of their grandchildren can be the change agents for their communities. The women in

Meadows et al.'s (2004) study reported that they acknowledge the terrible experiences of living in Residential Schools and did not know how to parent their children. However, they held their traditions and values close to them. The women in Meadows et al.'s (2004) study focused on their grandchildren to help them build healthier lives as well as they devoted time to their children. Social support in this instance means passing on relevant Indigenous knowledge to a future generation as a way of improving health in their communities.

This reminds me of bell hooks' (1990) work where she describes how black women "resisted white supremacist domination by working to establish homeplace" (p. 44). Even though being black gave the women this role, it did not concern them. What mattered most was they took on this traditional role in caring for each other rather than succumbing to anguish, which contributed to helping them achieve freedom. The Aboriginal and black women's experiences in the past and present day parallel one another as both groups of women stand up for their and/or struggle for their rights in society, all the while they look out for and support their families. Their resistance is grounded in their culture. They demonstrate incredible resistance which I believe is credited in helping them pursue some of the most difficult challenges around socioeconomic and political barriers to health. Mi'kmaq women's resistance is evident in a number of areas such as their determination to restore their language and their determination to be educated on GDM. Using the Mi'kmaq women's knowledge can change the way they are eating and their general lifestyle. According to Annette, Mi'kmaq women continue to suffer but they continue to resist domination from the western world.

Veronica acknowledged that her mother's support and guidance has given her great coping skills for life. Social support is embedded in family life in Aboriginal communities. Richmond (2007) refers to this support as intimate sources of support "because of the love, commitment and obligation they feel towards family, friends and members of their social networks" (p. 350). Social support derives from an individual and community perspective and is related to the amount of connection the individuals have with their community (Richmond, 2007). The relationships that people have with their communities are affected by the person's thoughts, feelings, and actions, which in turn influence their health (Richmond, 2007).

Participants in the talking circle affirmed that the best help was family support.

> I find that's what happens to us a lot, is we forget that we still need to, like I mean the most successful people when they, when they lose weight are people who are supporting people. Same thing with a diabetic, the most successful people that are doing well with managing their diabetes, is because either they have parent or a child helping them and supporting them. (participant # 3, talking circle)

The talking circles provided a place and space for the participants and created a space to bring ideas together and discuss daily life for women in their community. As part of PAR principles, improved social practice provided a forum for consciousness-raising about GDM and diabetes in their community (Henderson, 1995; Koch & Kralik, 2006). Being present and providing emotional support (House, 1981; Orem, 2001) are considered helpful to Mi’kmaq women. Support helps to enable people to do something to improve their health without feeling overwhelmed (Orem, 2001).

> Kate’s aunt was looking out for her health and well-being during her first pregnancy. My aunt was the same way, she was always diabetic only when pregnant and then after her last kid . . . my aunt really was the one that experience, you know, explained a lot to me and she says you know I’m not a doctor and I don’t know how to explain it exactly like a doctor would or why it happens or whatever, she said but, basically ‘cause she was upset that my doctor wouldn’t induce me. (Kate)

Kate’s aunt learned through her own experiences that Aboriginal women need to be followed closely, especially since diabetes was prevalent in their families. She did not want the same thing to happen to Kate as happened to her; she eventually became a diabetic. Kate stated “my aunt was the same way, she was always diabetic only when pregnant and then after her last kid, right between her last two children, her son and her daughter, in between there she was diagnosed with diabetes.” Caring for one another’s best interests was a common finding in my conversations with the women. When they described their relationships with families and friends, there was a genuine love and concern between their family and friends and themselves. As Robertson, Demosthenous, and Demosthenous (2005) describe mothers play an important role in communities by being able to preserve their knowledge and providing guidance and direction to children. The person may not actually be the biological mother but instead a grandmother, aunt, sister, cousin, or other who assumes the role of mothering a child in the community (Robertson et al., 2005).

Valuing the Community Health Representative

The Community Health Representative (CHR) was another source of support. According to Richmond (2007), CHRs were first introduced in Aboriginal communities in the 1960s by the Medical Services Branch of Health Canada, later renamed the First Nation and Inuit Health Branch (FINIB) for the purpose of developing health promotion strategies in Aboriginal communities. Because of their basic health education, being Aboriginal, and their connection to the communities they are a valuable resource when health care providers are not available. They also work collaboratively with health care providers in translating medical instructions to clients, home visiting, and other tasks (Richmond, 2007).

Annette was proud of her own mother's role as a CHR in her community.

> The difference between my mother's role, my understanding, and the nurse's is it's more of an informal way 'cause the big problem with our children right now is they're not getting their early assessments that they need for a variety of things. And so problems are being found out a little later when they're a little harder to deal with sooner. (Annette)

Kate recalled in one First Nations community the CHR "immersed herself in the community, and you know she started a community garden, and …when they harvest it, teaching them [families] you know what you can do with the different vegetables and stuff like that."

These positions are key roles in their communities because the workers are local Aboriginal women or men which mean that they are not regarded as the authority and can relate to the women in their own culture. CHRs understand the needs of their community and, knowing Mi'kmaq, can relate to them in their own language. According to the Eskasoni Community Health Centre (2004), "CHRs continue to act as liaisons in the community. They provide assistance in the diabetic clinic, visit patients in their home, listen to community concerns, monitor blood sugars and blood pressures, and do referrals" (p. 1). Returning to Gadamer (1989), he reiterates that "language has its true being only in dialogue, in coming to an understanding" (p. 446). Reaching an understanding can sometimes be difficult when the health care providers are non-Aboriginal or outside the lived experience of the community or if the health care professionals are working with Aboriginal people. The difficulty can be in understanding the language if the Aboriginal person does not speak English or if power relations and social conflict occur (Browne, 2007). Having CHRs who are members of their own community and who understand the culture and the language is invaluable.

Valuing the Community Health Nurse

Receiving education and support from the community health nurse was valuable to all the participants in this study. Seeking prenatal care was often based on whether or not the Mi'kmaq women trusted the community health nurse. Annette recalled

> She [the former community health nurse] did all her immunizations until she couldn't do it no more [nurse died] and . . . that's why I went. I got a lot of emotional support from her and . . . there's that's confidentiality and when I feel like saying something it's not all . . . that's really important to me. (Annette)

This relationship between the community health nurse and the mothers is considered a mutual caring and respectful relationship, one where they create a relational space (Bergum, 2002). This relational space provides for "equal attention to the needs, wishes, expertise or experience of both parties" (Bergum, 2002, p. 11). Although this community nurse has since died, she continues to hold a special place in Annette's heart. She provided health care, emotional support, and kept information confidential. The nurse, who took her place, also earned the respect of the previous community health nurse. Annette considered the entire community as her greatest ally. Annette explained: "I would say one of the biggest things for me, like the biggest supports would have been my community, knowing that they supported me and stuff." Her relationship with the community health nurse was strong. She stated: "I really had a good relationship with our nurse" (Annette). She viewed the community health nurse as a member of her community even though the community health nurse was non-Aboriginal and lived off the reserve. One of the important roles in teaching prenatal classes every 2 weeks included:

> I really liked, like when we had prenatal. You know, there'd be new prenatals coming in and, and she'd try and catch them right away and one of their first things is nutrition, because there was the diabetes, and a lot of our younger girls

> are getting it so, so a lot of, you know, we get some teenagers and stuff that aren't eating right. (Annette)

The community health nurse had their best interests at heart as she was a caring and responsible person. She worked hard to encourage the women to come to her classes. This effort did not go unnoticed by some of the participants who knew the value of prenatal education. Annette described the value of support as follows: "that's the security and that's the, the major information link . . . for my son that's where I got most of my information." Likewise, when I asked Veronica about her experience with prenatal care, she was pleased with the education and rapport she had with the community health nurse. She felt it helped her cope with the pregnancy. Her boyfriend also noted the positive effect the community health nurse had on her emotional state. Veronica explained:

> That's what, that's even um my boyfriend said 'cause when the baby was born he wasn't crying all the time, he wasn't . . . he [boyfriend] said I think that's the, the way you were. You weren't always crying when you were pregnant 'cause the baby feels your emotions? And I, I just, I was all right with it 'cause I was happy. (Veronica)

Community health nurses require a specific set of skills and knowledge to understand the needs of communities (Kushner, 2010). The community health nurse's role is to prevent illness, disease, and injury and to promote the health of individuals, families, and communities (Kushner, 2010). Although the community health nurses were non-Aboriginal, they gradually learned the cultural traditions, beliefs, and values about pregnancy, birth, and postpartum as well as the Aboriginal people's ways of life. I observed how the community health nurses and Mi’kmaq women spoke to each other in a calm and respectful manner. I could sense the trust and comfort that they had with each other. The community depended on their knowledge and ongoing nursing support. Because of the community health nurses’ genuine interest to learn about the Mi’kmaq culture and cultural sensitivity, they gained and maintained respect from the women and their families.

Community health nurses need to be aware that ethical issues can arise in nursing practice and require an immediate response (Salas & Cameron, 2010). They must be attuned to the presenting cues they find when they begin their assessment of people in their homes (Salas & Cameron, 2010). In the home setting, ethical dilemmas may arise where nurses need to use an ethical framework to address the situation (Cameron, 2004). Bodies of knowledge and clinical practice guidelines are behind the scenes as situations present themselves to nurses for them to act in the best interests of the patients (Salas & Cameron, 2010). However, nurses are careful not to disregard their nursing knowledge at the moment or their practice guidelines but they have to adjust to the current situation. Trying to understand the situation as it unfolds can be challenging.

Returning to Bergum (1994) and relational ethics, this provides a means to assist nurses in understanding the complexities of ethical practice as they are situated in a relationship between nurses and patients. Bergum (1994) talks about knowledge needed to give ethical care which includes first, descriptive or subjective knowledge which is the patient’s symptoms and how they affect the person; secondly, abstract or objective knowledge which refers to exploring the causes of the symptoms; and thirdly, inherent knowledge or the living I, where one understands the person and gives meaning to the person’s illness. If these areas are respected then there are three shifts that happen in the delivery of health care. The three main shifts include a move from 1) dominance to collaboration, 2) abstraction to context, and 3) beneficence to nurturance. In this case the first shift occurs when the community health nurse works alongside the Mi’kmaq women in a collaborative and participatory nature providing care in an open, calm, and non-hierarchal manner. This way of ethical action (Bergum, 1994) shifts the clinical gaze (Foucault, 1973) to the relational space between the health care providers and the person and family. Here nothing is yet determined; both sides and many sides try to understand what is needed in this complex situation.

I observed how relaxed and natural the nurse was in conversing with the women during prenatal sessions without dominating the conversation. The Mi’kmaq women asked questions spontaneously while the children played around them in a large meeting/lunch room at the health center. When I visited the health center I would often see her engaged in conversation at the reception desk with the women and their families. It was as though the community health nurse and the women were family, interacting in a relaxed and engaging manner. I observed how they smiled at each other and there was a sense of contentment and a bond between them. The community health nurse is held in high regard in this First Nations community. The second shift from abstraction to context is necessary for the community health nurse to understand because it is the Mi’kmaq women who truly know what hopes they have for their lives, their children’s lives, and, as Bergum (1994) states, “to know her as a living I” (p. 76). The context must be embedded in clinical practice as a person's beliefs and desires are influenced by the society in which they live. The community health nurse takes into consideration the context rather than the abstract where the women live. For instance, the community health nurse is aware that many Aboriginal women do not have sufficient money to buy healthy food. As part of the prenatal classes, the nurse discusses foods that are healthy and inexpensive. The nurse is also a supporter and organizes educational sessions where there are draws for gift cards so the women can use them to buy groceries. Annette stated:

> So they might have a $25 or you know two $25 cards and be like OK we're gonna draw names, you know everybody sign in or whatever and you have to be there for so long. But really and that's a big part of our dollars goes to um door prizes and for the getting the people in the doors is the hard part. (Annette)

The community health nurse knows Annette in the context of how she lives and is aware of the financial struggle that Annette and other women bear in their daily lives. The third shift involves moving from beneficence of helping another person with good intentions in mind to nurturance (Bergum, 1994). A stronger form of beneficence is nurturance where the focus is placed on helping an individual (in this instance the mother) to choose what she thinks will work best for her. For example, the community health nurse encourages the Mi'kmaq mothers to bring their children to prenatal classes because they learn better when they do not have to worry about finding child care services.

Respecting others is foundational to relational ethics–the aim is not the control of one by the other but rather involves everyone being valued. Austin (2008) reminds us that “an individual or group may be severely disadvantaged when decisions are made: their voice may not be heard, their needs not given priority. Relational ethics points to such vulnerability” (p. 19). Furthermore, Porr (2005), in her work as a community health nurse, suggests that we need to know the person and grasp the meaning of how she/he experiences their situations in life. In a truly caring relationship, the person is appreciated for their unique qualities and various life experiences (Porr, 2005).

The People’s Health Center

The participants considered the health centers a safe place to go, not only for health care and education but also to socialize. It became a space for the women to congregate; there was a welcoming feeling as I opened the glass doors. It was bright and cheery with the main reception area in the center of the room. Many social gatherings occur at the health center such as summer games, community meetings, prenatal classes, cooking classes, educational workshops on topics such as diabetes and healthy eating. For external meetings/consultations with other First Nations communities and other agencies video conferencing equipment is available. The health center is the community’s link to the rest of the world, one which gives them a sense of security and a place to gain knowledge about health and other topics. For example, Annette remarked “we have courses in the basic shelf um cookbook and we get it, I’m . . . going to workshops or anything like that, part of it is my social outlet ‘cause I’m not a real comfortable with people in my home.” She can use the health center at any time and not feel like she has to meet with people for medical care or discussion on any matter in her home.

The First Nations Health Center provides a “safe haven” for women to learn about improving their health and their family’s health. It is a welcoming and engaging environment that is culturally safe.

> It’s a safe place to visit, ‘cause my house always don’t look the best and my partner and my . . . say I‘m very hard on myself but I’m not comfortable with people in my home when it’s messy . . . I go socialize outside my home. I go to all of these courses and, and days and parenting to get the support that I need. (Annette)

Annette did not like to spend a lot of time at home because she found it hard to keep her house tidy but more importantly she wanted to be with people in her community. She enjoyed the camaraderie and informal conversations with other First Nations people. The health center as home or a special space experience means that all aspects of ethical knowledge are able to be unleashed or shown here–subjective I, objective I, and living I (Bergum, 1994).

Annette attended extensive educational workshops on health issues such as GDM, diabetes, obesity and healthy eating. Annette attended primarily because she wanted to learn as much as possible about keeping healthy. Because of her frequent attendance there was increased opportunity for her to be eligible for a grocery gift card. However, Annette believed in sharing with others as she explained:

> There has been cooking classes where we did, I don’t know somewhere around $40 or $50 worth of groceries. Sometimes I’ve had to back out just because I get all this stuff. If there’s somebody else that wants their name on the list then fine, like I’ve had, I’ve been in so much programming but I like it, it keeps me connected to my community. (Annette)

The cooking classes serve as not only a place to learn about healthy ways of cooking and sharing recipes, but also provide a place to socialize, increase, and preserve their traditional knowledge. Traditional teachings and knowledge give Aboriginal people their “positive self-image and healthy identity” (King, Smith, & Gracey, 2009, p. 78).

Loretta pointed out that the health center invited people from the Mi’kmaq confederacy of Nova Scotia to speak with women who had GDM. Loretta stated: “they’ll only talk about, well do diabetic stuff, gestational diabetic, with like um, with prenatal classes, they’ll send somebody from um, from the confederacy, within the health . . . just like a diabetic clinic, teach you what to eat.” She found these sessions helpful.

During a conversation with Kate I asked if there’s more patient participation in making decisions about their own care. She remarked that the health center has been a key resource.

> Um I have a young friend, she’s, she’s 17 years old, she’s pregnant with her first child and she’s getting more constructive and healthy advice from the health center . . . and from other moms. (Kate)

During one of the talking circles, the women mentioned the value of having the parent support program at the health center.

> I think it can, but you know, to get people to come to little workshops like this it's kinda hard. Like we got um a parent support group and it depends on um I don't know, it depends. Sometimes we have a good turnout, sometimes we don't. Sometimes it's just a slip of a mind, or people need uh reminders to go. Um what I find sometimes what really brings out the people is like if they a, advertise it in a newsletter or on their Facebook um with door prizes like we go, good incentives to bring them, bring them out. (participant # 2, talking circle)

According to Health Canada (2011), children's early years are a critical time for growth and development. Children need to be safe and have lots of love and security to help them build self-esteem and be healthy people (Health Canada, 2011). The health center helps to provide that support and security for their community.

The Band as a Source of Support

Some participants believe the First Nations Band Council plays a significant role in educating the women and providing support in education. The support was in the form of educational sessions on diabetes and other health problems, financial support, emotional support. and encouragement. Annette recalled: "The band . . . my health stuff, the band they kept on me, like when I got my diagnosis from my doctor, he had . . . you know what I mean, my family doctor." Another Mi'kmaq woman who attended the talking circle spoke about the good work of the Band Council. She informed the group that "I'm part of the Band Council and usually if there's workshops or anything that goes on, staff are usually allowed to attend or encouraged to attend" (participant # 4, talking circle). The Band Council reaches out to the community to ensure they help in educating their people.

Although Annette thought the band was helpful, she also believed they could do more for the community. Annette stated "Our leadership [Band Council] needs to take an example who they are because that's who our young people look up to and one of our councilors." Annette was empathetic to the band councillor's health as she commented "she's the councillor always lookin' out for the family and shit [getting diabetes] like that, right? . . . I was very proud of councillor for starting to walk, I don't think she's doing it, but you know." The point Annette was making was that her community highly respects the Chief and Band Council and they have the power to influence change. She stated "you want to tell our people to change, you can have a million experts come in and tell you but it would say so much more if Chief and council . . . I'll go for a walk with you" (Annette). When I asked other mothers during the talking circle about their relationship with the Chief and Band Council and whether they influence decisions, Laura responded: "Try, I don't like, it's hard, I don't really bother myself with the politics anyways. It's really hard like the communications, that's the word. Communications between the Band and even anybody really were difficult." These participants wished they could develop better communications with the Chief and Band Council.

The support of the Chief and Band Council is talked about at a personal/individual level but from my conversations with the women, they had not taken their concerns directly to them. Raising their concerns with the community health nurse and CHR was common but taking it the next step of actually bringing their concerns directly to the Council (for instance around the difficulty with getting transportation, inadequate funding when they are pregnant with GDM, hiring an ADI worker, addressing the gambling and substance abuse and other policy-related concerns) has not been done by any of the participants. However, many of them would like to bring these issues forward and perhaps they just need strength in numbers.

When Family Support was Insufficient

Some Mi'kmaq women needed more support from their families. If their family members were working, they were often not available during the day to offer support. When the extent of support needed was not available, they felt like they had no one to turn to. In Annette's situation her sisters and mother were working so she did not have a close family member to go to during the day to discuss how she was feeling during pregnancy. Annette expressed that "I need the emotional support, my sisters all have, you know, but, they're off at work, and I need the support, but I take program there, I take anything I can at home." Her partner helped when he could. She explained "my partner does when he can but he works" (Annette). Yet there are young women in Annette's community who do not have support from partners or families. Annette commented: "you got a lot of single moms out there and they have to support themselves" (Annette). Her main concern was to ensure single mothers received support and guidance.

Carol was concerned about her sister who has diabetes. She is also afraid that her sister's children will develop diabetes. Carol thought that her sister should be teaching her own children about ways to prevent diabetes. However, her sister lacks the knowledge on preventing diabetes. In an exasperating voice Carol stated "the children, there's nobody support there for them. There's, there's no support tellin' them or even their mom's sometimes ain't showin'. . . because they don't have the information either." Carol was concerned that her sister's children were missing out on a chance for a healthier life.

Jane was annoyed because her partner lacked knowledge and understanding about how GDM affected her body. She did not receive support from him when she was pregnant. Lack of understanding created a strain on their relationship as mentioned previously.

> He [partner] works outside of this community . . . when I developed diabetes or developed, when I got that darn thing, my family or my partner, he didn't realize like what this does. They, to him I was lazy, you know, why don't you get your ass out of bed and get the house clean, you know, or cook supper or do something productive other than lay there and do nothin', sleep all day. (Jane)

Jane claimed that if her partner was educated about GDM and diabetes she thought he would show more support.

A participant in a talking circle remarked that she found it hard to give her husband support. She stated: "I do tell him when he, when he did live with us, . . . I feed him one evening, sometimes of knowing that he didn't have his medication . . . Like I don’t know . . . But it’s hard to give the support” (participant # 4, talking circle). Sadly when she goes to the drug store, the pharmacy says that her husband’s prescription for insulin is ready. She explained “I’ll see somebody say oh [ex-husband’s name] name is in the thing for you know, . . . I said at least he’s getting his own prescriptions now but I wonder how long he has not had them” (participant # 4, talking circle). Aboriginal women see it as their responsibility to take care of their men and children, regardless if they are living together. These women feel the burden of care “falls on their shoulders.” Yet they do not complain about their roles as women, wives, and mothers. Their biggest concern is finding resources and learning ways to successfully help their family stay healthy. hooks (1989) claims that women will only be able to become involved in making changes in the world and the eradication of patriarchal domination when the concepts of sex, race, and class are actually explained as ways that marginalize people as well as the way these problems can be ameliorated. Given the situation of the women (being ill, raising children while ill, anticipating more illness with diabetes, caring for others in the community, translating their culture and values to others), there is little time to concentrate on an action plan to combat the underlying issues of the community, of being caught in the wheel of the lasting effects from colonialism.

Health Care Professionals

The Mi’kmaq women reported instances when they received wonderful support while other times they did not have anyone to turn to. Lack of support created feelings of fear and disappointment.

Welcoming support.

A number of participants were pleased with the education they received from the dietitians at the local hospitals. Some mothers commented on how wonderful the dietitians were in educating them about healthy meal planning and foods to purchase that were low in fat and sugar. Laura remarked that [the dietitian] “was helpful too, like yeah helping me out with you know potatoes turning into whatever and it turns into sugar, I didn’t, didn’t know that part.” Since then she cut down on the volume of potatoes she eats daily. Likewise, Veronica found, “going to that nutritionist helped a lot.”

Barbara recalled the kind nurse who contacted her family when her baby’s condition deteriorated to the point of needing more intensive care. Barbara stated “the nurse already called up my parents and um my husband and uh, my husband was there within 15 minutes, they [nurses] brought the priest in, they baptized him and my family was all there.” The nurse’s compassionate approach meant a lot to Barbara’s family.

Carol valued the care she received from the hospital staff. She stated: “the hospital time that I spent with my baby that was just up most the best. I was really happy that they diagnosed it [GDM] early, doctor a wonderful doctor. I just loved it” (Carol). Annette appreciated the doctor’s office at the hospital accommodating her office visit schedule. She recalled “I would be at the diabetic clinic and I’d see doctor . . . that’s five appointments, every time I went in, so they knew that and they’d accommodated me. They tried, I’ll squeeze you in, just show up” (Annette). Both mothers were amazed at the kindness displayed and willingness of the hospital and doctor's office staff to accommodate them in any way possible.

Lack of support.

Although there were instances of support, there were times when more support in the form of caring and education were needed. As mentioned in the previous theme, Barbara described the tense situation between her and the nurses when her sick baby was being prepared to be transported to a tertiary care intensive care unit. She recalled the situation to be emotionally upsetting.

> So we were in [regional hospital] and they said they had, he has to be airlifted 3 o'clock that afternoon, Saturday afternoon and uh I wasn't allowed to get in the helicopter 'cause just in case somethin' happened. And uh they're trying to keep him stable until the time he was about to be taken away and um, uh, it was so, like it's har, it was hard. (Barbara)

Barbara was worried about her baby and found it difficult to watch him being prepared for transport while she was not permitted to accompany him. Despite disapproval from the nurses and doctors, Barbara left the hospital and flew to the high risk center which was approximately 425 kilometers away. The concern for her baby's safety was of primary importance. Since this is normally the time when bonding and infant attachment begins, she naturally wanted to be by her baby's side. According to Barbara, the doctors and nurses did not outwardly show compassion or support for her and her family. This situation depicted a lack of respect and sensitivity, similar to the research findings of

Baker and Daigle (2000) on Mi'kmaq participants' hospital encounters of feeling insecure because they did not understand the hospital routines or what treatment to expect. To gain a deeper meaning of insensitivity in failing to understand the person, I turned to Heidegger (1971) who states that "when I can follow you in dialogue, I succeed. Left alone, I am helpless" (p. 33). Heidegger (1971) shows that in talking to clarify and understand meanings of what is being said, individuals are more willing to follow the advice or let what needs to happen happen. By failing to show consideration for Barbara's concerns about her baby, she understood this message to mean they did not care about her. If they would have explained more to Barbara about why they had to place their entire focus on her baby; if they would have listened to why she wanted to accompany her baby she would have appreciated this and would have been assured that they understood what she was going through. Instead the health care providers portrayed that they did not understand why it was important for Barbara to accompany her baby during transport. Barbara's understanding was that they were concerned about potential medical complications that could occur during the trip (vaginal bleeding being a major complication and no medical backup on the commercial flight). Although she understood they wanted her to be medically stable to travel, she was upset with them not understanding her desire to be with her sick baby. Arranging for sick babies to be transported to a major tertiary center via air ambulance is common practice in this facility. However, it is not usual practice for mothers to travel unaccompanied by a health care person on a commercial flight.

Nurses and doctors working in this unit are competent in and pride them themselves in early recognition of the need for more highly skilled medical personnel when a baby's condition worsens or recovery is not eminent. Having worked as a neonatal and obstetrical nurse for many years, I know the attention tends to be on the baby and less on the mother, father, and other members of the family at the time. Although it is not intentional, parents often feel left out while the staff are preparing the baby for transport. Tensions run high during these stressful situations. Recalling back to my own experiences as a neonatal nurse I remember how important it was to keep sick babies as stable as possible before the air transport team arrived. Although we provided support to the mothers and families as best we could, I believe we tended to down play the severity of the baby's condition to minimize the stress on parents and families. Thus, we were insensitive and/or unaware of the fear and perhaps terror that was going through the parents' minds at the time.

Some health care providers do not fully understand the meaning of caring or know that caring means a lot to patients. This nonchalant or business-like attitude creates a dissonance between the mothers/families and health care people that may never be resolved. It can leave them feeling like no one is really interested in or has no consideration for the woman as a mother who has worked hard to transition into motherhood. Some health care providers do not recognize that Mi'kmaq women want to instill in their children goodness and knowledge to carry on holistic traditions of Aboriginal culture. Commitment, one of the attributes of caring, refers to "a quality of investment of self in a task, a person, a choice or a career, and therefore a quality that is so internalized as a value that what I am obligated to do is not regarded as a burden" (Roach, 2002, p. 62). How do we change the philosophy that caring takes time or is a burden to health care providers? How do those who believe in caring as helping patients heal physically, psychologically, emotionally, and spiritually help others to understand the value of caring as a way of providing support?

During our conversation, Barbara described her baby's condition immediately after birth. He was born 2 weeks past her due date. Because her GDM was controlled by diet, and she experienced no other medical complications she did not anticipate having a sick baby. Similar to the belief of other mothers, having a good size baby was, to her, an indication that everything was normal. However, this was not the case.

> Good size baby, uh he was uh 9/10 when he was born but he ended up being sick instead . . . all through my pregnancy was good, everything was normal . . . he had a hard time breathin'; they used a paper cup with a tube in it to put it over his mouth, the mask didn't fit on him so they used a little paper cup, he was in the incubator. (Barbara)

When she was describing the meconium in her baby's lungs, I recalled my own nursing experiences taking care of babies who aspirated meconium and were in some instances severely asphyxiated. The very first sick baby that I cared for on a respirator was diagnosed with meconium aspiration. I can still vividly recall the first time I saw this baby–a long, emancipated, pale infant who lay in the incubator motionless and connected to a respirator. There was intravenous and ventilator tubing everywhere. He was asphyxiated at birth from being two weeks post mature and his lungs were filled with meconium that he swallowed at birth. This baby was in critical condition when I was assigned to care for him. I was a young nurse just beginning my career in neonatal nursing and feared caring for him because I was an inexperienced nurse. I had to suction him every hour and sometimes more frequently to clear his lungs. Talking with Barbara brought back scary memories for me. I was reliving my experience as a neonatal nurse. I recall how afraid I was that I could dislodge his endotracheal tube during suctioning. I did not feel I had the knowledge or experience required to care for a critically ill baby. Thankfully, an experienced neonatal nurse who I was working with stayed close by my side to assist me and through this experience I was able to gradually build my confidence. Unfortunately, the baby died approximately a week or so after I began caring for him. Now, as I look back, I do not remember talking to his parents. I never understood what they were going through. I know that his death bothered me for a long time; I can still see him on the respirator connected to so many tubes and a big green oxygen tank. I can vividly see his pale, emaciated body lying motionless many years later. I find this study helps me relate back to my own nursing stories to gain a better understanding and sensitivity to what women like Barbara were going through. Using my own personal stories helps to keep me close to the women's lives.

Not only did Barbara encounter feelings of fear and uncertainty when her baby was transferred to a tertiary care facility for severe respiratory distress, she also hung onto hope, waiting to see if her baby was going to live. Her Roman Catholic faith gave her some comfort and support.

> That first week, on a Friday, they [the doctors] called us up to the office, me and my husband, and they told us they can't, they don't see him [their baby] getting' any better and they were uh gonna have to disconnect him [from the respirator]. They told me that uh prepare yourself to disconnect him, sorry. So I'm glad to just say like I didn't, they couldn't see him getting any better. (Barbara)

When Barbara was confronted with the most difficult news and decision in her life, she could not bear what she was hearing. One thing she knew, she was not going to give consent for the doctors to disconnect the respirator. She immediately went to the parent room and she and her husband cried together. She described the situation as follows:

> It was hard. But um we were praying and we were just sittin' in the room all pitch black, and we're uh Catholic so we were, we go to church a lot, so we were praying and oh my God, Joanna that time we were sitting there pitch black in the room and uh this flash of green, blue light went across the room and my uncle passed away um in '95, we got married in '96 and uh he had cancer, but he wanted us to get married right. (Barbara)

She prayed to her deceased uncle hoping that he could bring about a miracle. She and her husband sprinkled holy water and placed a religious pin on their baby. Prayer is powerful and using prayer is another way of Aboriginal knowing (Ermine, 1995). They waited patiently and quietly for her baby's recovery from respiratory distress. Eventually, his condition gradually improved. I felt as though Barbara and I were trying to figure this puzzle out as to why her baby had meconium aspiration and developed respiratory distress. Barbara started thinking back to her pregnancy and although she had GDM, she was able to control her blood sugar by diet alone. She wondered why her baby was so ill when she took good care of her health during pregnancy. Eating nutritional foods and not requiring insulin did not prevent her baby's complications.

> I didn't really understand um when I was told that I have a diabetic pregnancy, still to this day it's kind of like little confusing but I knew like I had to watch my sugar 'cause I'm not a diabetic myself. But it's in the family so during my pregnancy all through I ate like good food and . . .I followed whatever they told me. (Barbara).

There were moments where I felt we were both immersed deeply in the discussion, struggling to figure out what may have happened as Barbara was totally taken by surprise by her baby's illness. Sometimes I felt I was Barbara's source of support as she was reliving her experiences. Barbara stated "I'm starting to remember stuff." She was happy that she could remember the details yet she was emotional because the memories were still fresh in her mind and painful at times. At one point when she was describing her baby's illness, her eyes filled with tears as the memories of this horrifying experience came rushing back. Barbara and I were eating our lunch together when suddenly, she had to stop eating. She became speechless and so did I for a moment. As Barbara's eyes filled up, I responded "you can slow down, if we don't get all this time we'll get it [the story] the next time, don't you worry" (researcher, field notes). "Once I get going with him [telling the details of her story]" (Barbara). "Because you relive that story" (researcher, field notes). "Yeah" (Barbara). After a minute or so, Barbara wanted to resume describing her experience.

> They [doctors] were pretty good, like explaining stuff and uh they said it's uh the stool that he swallows just before I had him [son] and he took a lot and they showed me his lungs, they are all covered, all the way up to both lungs. (Barbara)

I am drawn to the seminal work of Simpkin (1991) who clearly demonstrates in her research that the memory of women's birth experience is "vivid and deeply felt" (p. 203). The birth experience too has a powerful long-lasting negative or positive effect on women. She reiterated "it's hard even every time that day comes when his [son] birthday I get emotional" (Barbara). "Yes and it's really good to talk about it" (researcher, field notes). Despite her painful memories and little support, Barbara found it helpful to discuss the series of events leading to her baby's illness as the discussion helped her gain more insight into what happened to her baby when he was born.

Lack of support left Carol uncertain as to who would offer information or assistance.

> I didn't have any, anybody to talk to when, when I had [son] and I thought it [GDM] affected uh, like it was good for me to keep my sugars in place and it was good for me, that's what I was always told but the outcome after your gestational diabetes and I took the needles, I never had any other output over anything at all after. (Carol)

She was referring to not having anyone to discuss her concerns with after she had her baby.

> I just didn't really have anywhere's to go with it, there was no other person . . . the only time we did talk about it is during the pregnancy when we had the little

> meetin's for uh prenatal . . . there was never any follow-up on, if it did affect the kids' when they get older.". Today I still wonder and, and that's why today means so much to me that I can actually you know have somebody to talk to and because right now at my kids' is age [her son] was gestational diabetes and he is the most one that worries me. (Carol)

Carol explained that having someone to talk to about her concerns would have helped her at the time.

Having a women's support group to share each other's stories is one way Carol thought would help increase her knowledge about GDM and serve the women as leaders with an empowered source of support. According to Makokis (2008), Aboriginal women believe that their stories and understanding of traditional roles will give them insight in their lived experiences. She believed that talking sessions would be very helpful. Carol stated "I think that um whatever kind of gatherin' or groups at all, that could be made to, for information sessions and stuff um, I'm pretty sure a lot of them [women] would go to it here."

As I reflected on Barbara's story and other mothers who delivered sick babies, the discourse around ethical space that Bergum (2002) describes is important to consider. Nurses are called on to attend to patients and families and to engage in dialogue with them. Bergum (2002) states that we need to nurture the space between patients and nurses as it provides support to our patients. Understanding people from different cultures, language, and lived experiences is critical in order to truly understand the needs of the patients. Looking back on caring for my patients, I wondered if I nurtured this space. Often the labor/delivery unit was so busy that we [nurses] were running to attend to each patient. I wonder if the patients felt ignored and/or lacked support. Sometimes it felt like an assembly line and a guessing game as to when mothers were going to deliver prematurely or develop complications depriving them of their joy and excitement of having a healthy baby. Because of the frequency of babies having complications following birth, I was focused on ensuring the technology was working properly and that the laboratory, diagnostic imaging, and respiratory departments were notified of impending complications and asked to be on standby. I wonder if we always considered the importance of support to mothers and families. Was our compassion visible and tangible to them? While I know mothers and families needed support, I am not sure I was in the same space as they were at the time. Although I subconsciously thought about their social situation and ethnic background, I did not reflect on the "bigger picture" i.e., the experience of having a high risk delivery. A high risk pregnancy is "one in which the life or health of the mother or infant is jeopardized by a disorder coincidental with or unique to pregnancy" (Perry et al., 2010, p. 189). Van Manen (1997) suggests that we need to look at the person's world, their profession, what their background is, where they were born, and other factors in order to gain a deeper understanding of their world. Sometimes, particularly during emergency situations, I only had time to learn their name and their immediate medical condition. As I write my thoughts on paper now, I feel my adrenalin rushing similar to situations of life and death with my patients. Knowing them as a person, the lives where they interact with others, and where "life happens" was a mystery during those moments. Often my only recollection of the situation was seeing a baby or mother connected to intravenous therapy, a heart monitor, respirator, or fetal monitor. Sometimes it was my last memory of the patient. Because of the critical nature of the situation I was frequently oblivious to the fundamental aspects of their lives that were important to the women and to the families; understanding their lived space (van Manen, 1990) was virtually non-existent.

In instances where I had more time to get to know my patients, it did not occur to me to invite them to my space and to a place where they were going to deliver their babies. Looking back, I realize that my patients were required to have their baby in a space and place that was foreign to them. All Mi'kmaq were required to deliver their babies outside their First Nations communities, away from their familiar and comfortable support. Although we were making changes to the Perinatal Unit where I worked with more sensitivity to cultural competence and cultural safety 11 years ago, I did not think about what a foreign environment meant to patients. It is only now, many years later, that I am beginning to see how a strange place can affect a person's space. According to Eyles (1989) place is viewed as the center where the experiences and wishes of others occur. It gives meaning to life. Being attached to a particular place such as a community is a basic human need (Ellis, 2004).

Some participants found that health care providers failed to listen, communicating a lack of respect for patients. Kate recalled one of the doctors was "kind of annoyed at having a teenage patient." Kate further explained:

> I don't know if it was just she was kinda brushing away my concerns or, or thinkin' I was being um oversensitive or whatever because I was young, like oh

> that's natural, you'll go through that's whatever, that's normal, that's whatever. And I always just felt like my concerns were just bein' pushed aside but, you know, like I said, totally opposite with my daughter [second pregnancy]. (Kate)

This situation depicted a lack of culturally competent and culturally safe care. Women embrace different views on many issues including pregnancy, birth, culture, and families (Health Canada, 2000). Although women share different philosophies on life, they all expect to receive sensitive and respectful health care (Health Canada, 2000).

As previously mentioned cultural safety addresses power inequities between health care providers and patients (ANAC, 2007; Ramsden, 2002). Woods (2010) asserts safety is relatively new and provides a good starting point for educating health care providers when power imbalances exist between them and their patients. The nurses and doctors are understandably engaged in ensuring safe delivery and nursing care, but what they do not understand is that by not providing cultural safe care, they are themselves providing unsafe care. It is unfortunate but many are unaware of the concept of culturally safe care. Woods (2010) claims that "A cultural safety approach essentially challenges the traditional role of nurses as fully competent cultural practitioners" (p. 716). Nurses need to realize they can never truly understand the context in which people live and as such need to start from a perspective of having limited knowledge about people's culture (Woods, 2010). The need to reflect on their own attitudes and experiences and how this can impact on their patient's care is important. This approach helps to minimize the idea of culture as the "other" person (Woods, 2010). The RCAP (1996) states that medicalization continues to be the main philosophy that dominates health policies and services to Aboriginal communities. Inequities in the health care system and social streams cannot be blamed on lifestyle, behavior, or cultural situations but instead need to be recognized as indicators of the historical, socioeconomic, and political circumstances (Browne & Smye, 2002; Browne & Fiske, 2001).

The participants found it helpful to validate their concerns. Establishing a collaborative approach where the women felt comfortable to talk and look at ways to possibly address the need for more social support and identify unprofessional behaviour of some health care providers was a starting point.

Conclusion

Social support is an important component of healthcare. Support was evident in various ways such as allowing time for discussion, listening to concerns, providing information and financial support to help the mothers gain autonomy, and giving them knowledge and skills to empower themselves. The Mi'kmaq women received support from family, friends, community health nurses, the band council, and other health care professionals. There was evidence in this study of how the community health nurses were highly respected by the Mi'kmaq women and other members in their community although they were non-Aboriginal people. This speaks highly to their commitment and accountability to their roles as health educators in First Nations communities. As a result of their cultural knowledge and cultural competence, the community members sought their advice and guidance and valued their role in the community.

Although social support was available in many instances as described, there were situations when the women did not feel respected and listened to. Sometimes the signs were covert while other times it was quite overt. At times, physicians and nurses did not listen and/or ignored the Mi'kmaq women and families' requests or concerns. Cultural competence and cultural safety practices were sometimes lacking outside their First Nations communities.

Women learn from their own experiences. However, social support can enrich the experiences whereas lack of support can impede transition to motherhood. The women's thoughts and stories of support shed light on the necessity of culturally safe care. The women identified when care was culturally safe and when it was not. They also identified a great hunger for learning in their role as educators of children and keepers of the health in the family.

Chapter VIII

Theme IV

Feeling Compelled to Take Action

Despite the challenges associated with GDM and the access barriers that Mi'kmaq women encounter in their lives, they were anxious and determined to overcome them with the hope of improving health outcomes for themselves and their communities. This fourth theme describes the actions the women took, or recognize they have to take, to create a healthier world for themselves, their families and communities. The specific subthemes identified included Self-Determination, Health Education, Health Promotion, Women as Leaders, and Informing Policy-Related Actions.

Self-Determination

As previously mentioned self-determination refers to Aboriginal people feeling they have their own autonomy to take charge and make decisions with the best interests for themselves and their families (NAHO, 2003). It means exercising the right and having independence over one's land (NAHO, 2003, 2007), thus being able to determine their economic, social, and cultural growth as well as address their political concerns (NAHO, 2007). The Mi'kmaq women demonstrated self-determination in making socio-economic changes in their communities and identifying areas where more action was needed. They have identified some major issues and want to bring these forward to Chief and Band Council.

Restoring cultural knowledge is integral to self-determination. For instance, Jane wanted to learn the Mi'kmaq language. We discussed how some communities lost their language. There was excitement in her voice as she stated "Yeah actually I'm supposed, she's supposed to be teaching, teaching me the language, [Elder]. But I wanted to get one of those little thingies [digital tape recorder] here" (Jane). She thought a digital recorder similar to the one I was using for my study would be helpful for taping conversations between her and the Elder as a way of learning the language. This would be a way of reviving the Indigenous language as Jane could play it over and over and she and other community members could listen. Annette wanted to ensure her children acquired traditional knowledge. She used every opportunity to take her children to education sessions.

> And, but that's how our people learn and that's what bothered me about leaving them home. Um we lost so much of our, our culture and so much of our, our, our oral teachings because of residential school. But that's how our people learn, like that's how you, I grew up and my godmother would, would sit there with her 1 year old and her 5 year old and me and I was 18 and teach us the same things. 'Cause those are things that they needed to learn and they could answer a lot more questions about culture and about the significance of certain things more than adults. 'Cause they sat there and they listened and because they weren't afraid to ask a question. And you're supposed to educate your children as you go even as you're going but we need to teach our kids. (Annette)

Gaining knowledge about one's culture helps to strengthen a person's sense of self and helps to address the effects of colonialism (Kirmayer, Dandeneau, Marshall, Phillips, & Williamson, 2011). Bringing back the Mi'kmaq language is the way that healing from Residential Schools is going to occur according to Barbara.

> Those families they don't speak Mi'kmaq. They understand it but they don't speak it. And you could see it from their children and their grandkids. They don't speak it 'cause they at the residential [school], they're weren't allowed to speak there. We don't know how, how many years down the road it'd be before it gets to our school, but at least there's eight of us [teachers] that take it from here, and when it's time we'll be ready, you know, speak our native tongue which is great. So, and I try to speak um Mi'kmaq to my students in here as much, as they understand but they're getting more you know. Luckily my kids, all my kids understand um Mi'kmaq. And I, I just told my mom uh yesterday um my oldest son is starting to speak Mi'kmaq. He's the highest in the class right so uh when just uh, when he was a baby until kindergarten I spoke, I spoke to him I still do all of them, I spoke Mi'kmaq in my house . And uh any book I read to him I spoke it in Mi'kmaq even if it was written in English, I would tell him in Mi'kmaq words. So he picked up the language. (Barbara)

Jane had no respect for the Canadian government because they tried to destroy Aboriginal language.

> They took, they spend millions of dollars to take our language. You know all our, our relatives in these Residential Schools and beat them and abused them, and you

> know they couldn’t speak their language and I think the government and the church should take money and put it back into the communities so that while we still have our Elders that have language, and start doing stuff to put it back you know. Put it in our school, get our Elders to teach in the community. There’s no money for that you know. We have Elders that you know they’re not gonna be with us for much longer. And you know who talks about it and uh. (Jane)

Jane referred to one of the Elders in the following statement “Yeah that’s, and uh she speaks the language and this is you know what she talks about. And all that money they [white man] spent to try to destroy us and we’re here.” Jane was angry about the way the Mi’kmaq language was destroyed. She wanted the Canadian government to be held accountable. She recommended that before the language is totally lost, Elders should be encouraged to teach the language in their school system. The work by Iwama et al. (2009) acknowledges how the Mi’kmaq people have “suffered staggering damage” from colonialism (p. 4). According to Iwama (2009) et al., “In Unama’ki, the English language has so supplanted Mi’kmaq that the knowledge Mi’kmaq youth have acquired amounts to, as Albert explains, everything from the mainstream and precious little from the Mi’kmaq” (p. 4). Destroying the linguistic forms that protects the health of communities prevents the healing to occur. Bear (2000) maintains that “language embodies the way a society thinks” (p. 78). By speaking and engaging in the language, people learn how their culture thinks (Bear, 2000). Aboriginal people pass on their cultural traditions and beliefs about health through oral modes of transmission.

Preserving the Mi’kmaq language will help with understanding their health beliefs about pregnancy and birth.

In Unamaki (Cape Breton Island)], Alberta Marshall, a well-known Mi’kmaq Elder and educator, explained that the English language has taken over the Mi’kmaq language to the point that their youth have learned more from mainstream society than from their own culture (Iwama et al., 2009). When language is threatened or lost, optimal health of the Mi’kmaq people will never reach full capacity (Iwama et al., 2009; King et al., 2009; Stout, 2012). I wonder how long it will take for the majority of families to learn how to speak Mi’kmaq. How are the Mi’kmaq schools going to catch up? It is like a “race against time.” The women are determined to help restore their Mi’kmaq language.

Health Education

The Mi’kmaq women acknowledge that health education is a high priority for addressing GDM and diabetes. Although there is an urgency to address GDM as depicted in the Mi’kmaq women’s stories, they realize changes cannot happen overnight; the changes need to be gradual with awareness of why the changes are necessary. Their approach was to take slow steps. Educating the community, their family, and children were among their priorities.

Educating the community.

Because the participants were high-risk mothers, they had to be proactive if they wanted healthy outcomes for their babies and themselves. Jane stated “What can you do, you can’t go back, right? They’ve [First Nations communities] come a long ways as far as like educating people. I think we need more [education] in our community, you know, especially on gestational diabetes.”

A number of the participants recognized that some health conditions such as diabetes and high blood pressure have a higher incidence in Aboriginal communities than in mainstream society. For instance, Annette stated “education too at the beginning of my pregnancies could, because we knew more about First Nations getting GDM. Like I was already kinda educated, oh and the dietician, I see the dietician.” She elaborated by saying

> During pregnancy and how that affects their children and that’s what their children see and that’s what they want and it’s scary, those kids are probably gonna have, you know, and I’m not tryin’ to be judgmental or whatever but I know. And learning to um eat right needs to start here see, and you’re not only teaching your moms about their health and their gestational diabetes, they need to understand the whole cycle of it. And you know I get a lot of education but I’m also very proactive, not everybody is like that. (Annette)

The notion of the “whole cycle” can be understood through the work of (Bear, 2000). Everything in life is in constant motion (Bear, 2000). This leads to a cyclic or holistic view of the world. By applying this philosophy one could see that in order to understand

GDM in Aboriginal women, a holistic perspective is needed. Moreover, it means that GDM is interconnected with everything the women do. Porr’s (2005) work made me wonder about Annette’s and other Mi’kmaq women’s situations from the perspective in which they speak and the language in which they impart. Similar to Porr’s (2005) question, I wonder who the women are beyond the person with GDM. They have an open mind and are willing to do whatever they can to be healthy. They have health risks and therefore have become proactive about their health. When their health is not felt to be in equilibrium, their body is unpleasantly affected physically, emotionally, mentally, and spiritually (Bear, 2000). Therefore, Aboriginal women strive to keep all things in harmony so they feel a sense of balance and contentment as they journey through life. They are taking responsibility by recognizing and applying a traditional understanding of their health.

Annette wanted to motivate the community members to learn more about diabetes and healthy living.

> You get some moms that are gestational and go into the programming, like we have a program set up at home that we go to prenatal, you go to so many, there’s incentives to go, there’s door prizes if, sometimes even more from guest speakers or whatever um, and then there’s things that we get at the end. Like we get a gift that they get us. Welfare covers a crib but this program will cover like a car seat or something like that. (Annette)

Because the women lacked financial means to buy some of the necessities of life such as nutritious food, they found incentive programs helped them obtain additional resources, yet it left them depending on these programs to help them manage on a limited budget. This example shows that Aboriginal women have been denied access to resources to maximize the SDOH that so largely affect their daily lives (Loppie Reading & Wein, 2009; NWAC, 2007b). Colonialism, racism, and discrimination have denied Aboriginal people the right to everyday resources that are needed to have healthy outcomes (Kurtz et al., 2008; Loppie Reading & Wein, 2009).

Anne verbalized that some women are uninformed about the high amount of sugar in some foods.

> They [women] have no, no, no um education on when you're pregnant, 'cause I was sitting there listening when, after I was doing the training [Aboriginal Diabetes Initiative] and I wasn't pregnant yet or anything but I was listening to these girls talk. Oh the doctor told me oh eat lots of fruit. I said no. Eat lots of vegetables. Fruit is high in sugar. (Anne)

Following Anne's educational training on diabetes, she has more in-depth knowledge about this condition. She wants to share this information with her community.

> They [Elders] still carry on . . . traditions now, and um like all the Elders around here are so used to the homemade bread and bread's high in sugar because it's white bread that they eat and, you know, they're so used to their old ways that you can't stop somebody. (Anne)

Likewise Carol believed that more has to be done to educate community members about their health. She believed that "Everyone in the house has to know about diabetes and has to work together. "It could be like WHIMS[8]; have this information on your fridge" (Carol). Her refrigerator served as a practical place where information was posted for everyone to view.

Carol was concerned that the ingredients that Mi'kmaq women use to cook increased their blood sugar level.

> There's a lot of people, like I know my sister . . . they made this homemade bread and I thought well I'll take a little slice of it in a cup of tea, but you never realize uh, uh what you take, so I took that slice of bread in my tea and I drank it, I checked my sugar, it when up to like 27 point something. It's because they're makin' homemade bread and every Indian woman makes it, every house you look on every reserve makes loosginagin, it's just homemade bread but uh my sugar to when up to like 27 point something. Salt, starch, the lard, they must put a big piece of lard in it and some people put milk and sugar in it anyways so uh just that small slice, small skinny slice that I had and it just blew it [blood sugar] right up . . . a lot of people don't know this, they think they're making a good thing at home but it's hurtin' them. (Carol)

We discussed the need for community members to review recipes they are currently using and look at substituting ingredients such as lard and sugar with healthier ingredients. She was excited about this action as she responded "that's why this information would be so good because Aboriginal people want to make their food from

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[8] The Workplace Hazardous Materials Information System (WHMIS) is Canada's national hazard communication standard. The key elements of the system are cautionary labeling of containers of WHMIS "controlled products," the provision of material safety data sheets (MSDS), and worker education and training programs (Health Canada, 2010, p. 1).

scratch" (Carol). She explained that women in her community enjoyed cooking and baking and would welcome new recipes and would share them with others.

Eating traditional food was important to some participants.

> You know, to garden and to hunt and, and, and I see that we're losing that, you know I, my kids were brought up on um moose, deer, eels, fiddleheads. You know, we had all that stuff, mackerel, it was in our freezer, like we always made sure our, our freezers were filled, and now it's like most of them are grown now and gone and I have like maybe two or three at home and my husband he has to work away from the community so it's just not the same, . . . I raised them on moose meat, salmon, the, stuff like that, seafood. When my daughter was away going to school she just couldn't wait to get home and have moose meat 'cause she didn't have it where she was in school. (Jane)

Aboriginal people's concern for their community is connected through their land. Their land is linked to the cultural, spiritual, emotional, and physical dimensions of their lives (Kornelsen et al., 2010; Wendt & Gone, 2012; Wilson, 2003). The plants and animals are precious commodities from the land as they provide food and medicine (Kornelsen et al., 2010; Wilson, 2003). What happens on their land (their community) directly affects the Aboriginal people. Mi'kmaq people, like other Indigenous people in the world, have suffered because their relationship with the land and with each other has been destroyed due to colonialism (Iwama et al., 2009). The Aboriginal people are working hard to restore those relationships with the hope of improving their mental health (Iwama et al., 2009). They believe their health is connected to their Earth Mother.

With everything in their life being connected to the land (Battiste, 2002) the land unites their entire community which is why Mi'kmaq women in my study view health as critical to their existence. Their Indigenous knowledge is connected to not only their land but to their ceremonies, stories, and medicine. In order to pass down accurate Indigenous knowledge through generations, their land needs to be protected and preserved (Battiste, 2002).

The participants verbalized that there was not much time left to prevent and/or manage diabetes. Jane stated "Time is up" meaning their community members must change their current eating and health practices if they want to see positive health outcomes. The women were often solemn as they spoke but they gently smiled when I nodded and acknowledged their points of view. I sensed my responses were reassuring and validated their health concerns (Driscoll, 2001).

Loretta had similar concerns about the future of her community as she stated "with all these mothers now having babies and they're gestational, like wait till my kids grow up and it's just going to continue . . . it's [diabetes and gestational diabetes education] gotta be like drilled into people's head." Diabetes affects being able to do the things they once enjoyed.

Some participants were concerned about young girls having babies. Anne explained: "we're getting a lot of teens that are pregnant. We had one teen, she had a baby and she's 15. She just turned . . . 15 now. The majority are teens, they have no education on when you're pregnant." Annette was equally concerned as she discussed in the following excerpt.

> And even like with the diabetes, I know some of these young girls got it and I'm like gee wow, oh like and, it you know it, it's hard to 'cause I'm not real close with a lot of the . . . well come on, you know better, 'cause they'd all like pretty much tell me to F off but at the same time I, like I know what that's like and I know what it's like to just feel so done and just. (Annette)

The Mi'kmaq women were concerned about young girls becoming pregnant because they did not have the necessary knowledge or the financial means to maintain good health during pregnancy.

Kate identified the Community Access Program (CAP) as a good place for learning because computers are readily accessible in the community gymnasium.

> It's [Community Access Program] not used probably as much as they'd like it to be, um I'm not sure why, I don't know if it's because there's not really anybody manning it or whatever, but it's in the community gym. And for the most part the gym's open all day. You know another one of those things that just sort of needs to be promoted a little bit more. And you know you only have so many people in the community that um you know like [community health director] and our community event planner . . . and you know I don't wanna overtax them with OK on top of planning a bunch of events and keeping things organized . . . make sure that people know about the CAP site and are coming and, but she does her best when she puts out her newsletter, she reminds people that the CAP site is there . . . also set up if people wanna stop in and make a craft . . . she's starting to gather up, um I'm gonna drop off some books to her before I move, but she's also um

> you know taking in some novels and kids' books and stuff to leave up in the craft room. (Kate)

Kate thought that having a multipurpose area would benefit her community. Anne had similar concerns about providing educational services and wanted to organize an educational session on diabetes.

> I just hope we maybe get something going with the community. Like even if it is an open session . . . just to see how many people you can gather . . . there's some old people are stuck with their old ways . . . But there's a lot that are willin' to change and take, approach to a new route but it's on who you, what you believe. There's a lot of people around here that are, they're out there and they're struggling with diabetes. (Anne)

Some participants attended presentations on GDM, diabetes, and other health conditions with a focus on health promotion and health prevention. For example Carol remarked:

> To talk about it [health conditions] and let them know about it so they can answer questions, and it's pretty good because if it's, if it's here [their First Nations community] and it's everybody, everybody knows each other so it's more of, it's more like a talkin' session, like it's more comfortable enough for them to be able to talk and say things about it. (Carol)

These women were showing that they were increasing their educational effort by attending educational sessions when possible to help them change their current lifestyle.

Educating the family.

Many participants were concerned about other family members. One participant described the prevalence of diabetes in her family as follows:

> I have a lot of relatives that have lost their eyesight, that have lost their, part, parts of their toes or their feet or their legs or, and it's just, it's robbing them of their life, it's robbing their family of them and it's you know quality of life. I, my Uncle [uncle's name] lost a toe it, became diabetic and he's not, it wasn't even gestational, it was just poor, poor eating habits, 'cause there was no way, he never did drugs, he never drank, he never, the only thing he did, he liked was eating, and he had a quadruple bypass by time he was 40 or 43. (Annette)

During a conversation with two of the participants I asked if men attend prenatal classes. Annette informed me that Mi'kmaq men do not attend prenatal classes because other mothers are not comfortable to discuss their personal situation around them.

> All of the other things that you'll talk about and are comfortable with your wife but not with, I don't need to know how flatulent she is or her cravings, and that's just how they, you know, all that and, and that's my partner's perspective, I can't tell you for everyone. (Annette)

When I asked Barbara if men attend prenatal classes in her community, she replied "Not that I've heard of." Barbara supported this idea because she thought it would help the men understand what women go through with GDM.

> Have a better understanding instead of like saying there's nothin' wrong with you, you know you're just pregnant and. You know but all these emotions that

> woman, it changes you. You know the feelings and you get all these mood swings, he'd understand it better, you know what the woman is going through. I think they should, I, I think they would they would, they would I hope. (Barbara)

Traditionally, Mi'kmaq women were known to be modest and pregnancy was a normal part of life (Battiste, 2011). Men did not attend prenatal classes nor were Aboriginal women comfortable to be around men who were not a close family member (Battiste, 2011). Yet I wonder what other ways there might be that these men can receive health education and support during pregnancy. Discussing pregnancy openly is changing and Elders commented that Mi'kmaq women are presenting themselves as being pregnant earlier. They are wearing relics now in their second trimester of pregnancy (Battiste, 2011). The relics were considered a "special comfort to the participants as they believed in their power to protect and save" (Battiste, 2011, p. 83). Since Annette or Barbara did not speak of relics or changes when Mi'kmaq women disclose their pregnancy, I do not know if these traditions are prevalent in their communities. I did not raise this issue with the other participants, in the study. I wonder what would be an appropriate men's program. I wonder about making GDM information explicit in the prenatal program–the goal being specifically to include men so they would have a chance to understand GDM.

Although the Mi'kmaq men were not able to attend prenatal classes, they were invited to participate in cooking classes. Engaging the men in cooking classes was flagged as important by one community health nurse and the health director. Annette explained that the community health nurse sets up a cooking class for men.

> We’ve had a men’s cooking class. Uh my partner was signed up for it and didn’t go but he feels like he knows enough about cookin’. He cooks the same dish in different spices and thing, it’s like the same because it’s like a goulash, uh there’s a meat, there’s like a potato, rice, or whatever, pasta component and then there’s a sauce. (Annette)

Cooking classes taught men how to cook healthy foods and to learn about the most nutritious ingredients to use. Annette’s partner tended to cook similar food and although she appreciated his cooking, she wished he would use more variation. She did not mind cooking herself but she needed to purchase a new refrigerator with glass drawers as she explained “ if I don’t see it I don’t cook it . . . the one I’m getting you’ll be able to see everything . . . I buy vegetables and I’m like geez I thought I had tomato and I won’t remember that they’re under whatever” (Annette). If she had a new refrigerator, she would more likely use these foods to cook with but when they are hidden from view she tended to forget they were in her refrigerator.

Although there is some collaboration between the Aboriginal communities and non-Aboriginal health care providers, more opportunities for a partnership to promote, value, and increase collaboration are needed. According to Charlotte Jesty, RN, an Aboriginal Community Health Nurse, (personal communication, July 10, 2012), Aboriginal women value education from non-Aboriginal people but in her experience they prefer receiving it from their own people. Carol appreciated the help she received from the speech therapist, a non-Aboriginal person.

> And so easy for me to talk to them and then they know [son] since he started speech therapy so it's a really good help. They do it in my home, they come at my house on Mondays or Tuesdays and then they spend about a whole hour and a half with a kid's beautiful, especially if it's in your own home. (Carol)

Carol was grateful to the speech therapist for coming to her home as well as school to work with her children. Coming to her home was convenient because Carol then had a chance to discuss her concerns and her children's progress with the speech therapist in the comfort of her own environment without feeling rushed. Also, her children benefitted because they too were naturally more at ease in their home environment.

Annette reached outside her First Nations community for mental health because it was not available in her community. She knew it would help her cope with the issues that concerned her and would ultimately help her family.

> I go to mental health. But, I don't mind it, it's so different what people want, some people want somebody with you know from our culture [First Nations] and stuff and other people want nothing to do with it. I don't care, I'll take what's available and what's I can, I take my culture over someone else's, but what can you do. I'm ready for it, and I really am risk for diabetes. (Annette)

Mental health therapy has had a positive effect on Annette. For instance her therapy sessions have helped her realize what health areas she needs to improve such as increasing physical activity and as a result has also helped her sisters lose weight.

> I overeat is my big thing, like I try to eat healthy but you know I had some chocolaty thing last time . . . some kid's crackers but I'm really, I'm aware of

> risks and I know that's why like I said I'm at mental health because sometimes I stop and anytime it feels like work I'm like "No" and I want to so I'm um gonna get some money and I'm gonna go to the [city] to get the, this guy does hip hop abs video. Two of my sisters lost weight on it last year, it was fun. (Annette)

A person's mental state can affect one's appetite as some tend to eat a lot of high fat food while others may lose their appetite. Annette knew that her mental state was an important factor in staying healthy. Annette would like to see more mental health programs in her community.

> [First Nations community] had a lot of problems in the last couple of years. And that's the thing, when there's something wrong in our community everyone knows like that, like it's just, when something hurts it's hard to pick yourself up. (Annette)

Laura was concerned about her sister's poor eating habits now that she was starting her second trimester of pregnancy. She was hoping to prevent her from developing GDM. Laura was frustrated because she did not know how to encourage her to change. On the one hand, she did not want to frighten her but at the same time she had to find a way to protect her and her baby from harm.

> Like my sister, she's pregnant, she's 13, 14 weeks. She has thing called blah, blah, I don't know what's it called but it gives her high risk of becoming diabetic in the future. And now that she's pregnant she thinks that she's gonna have that gestational diabetes. She thinks it's nothing. And then so . . . she goes in my cupboard and grabs a bowl of um Froot Loops right. I'm like if you're scared of

> being diabetic why are you eating Froot Loops. You shouldn't be doing that. So she thinks it's nothing. (Laura)

Educating family as well as community members about making changes in eating habits was a beginning step. According to Vogel, Anderson, Raine, and Clandinin (2001), GDM has been addressed in communities under the "Healthy Start for Mom & Me" program in Winnipeg, Manitoba. The program provides a broad prenatal nutrition program aimed at high-risk and teen mothers with a goal of education, community participation, and capacity building. These types of programs may be helpful to First Nations women. A kitchen table approach using food and talking about nutrition is a way to help build skills and confidence, and provide support to women. The goals of this kitchen table approach are similar to what some of the women in my study proposed such as improving nutrition over lifestyle to prevent GDM and diabetes. This is a potential future action that the women may want to develop in their community

Educating the children.

Laura tried to introduce her children to different foods so they would eat a variety of healthier foods.

> Like I was thinking as long as he [her son] is fed, he is OK. He is trying new foods, different foods. Now he eats pasta with the sauce . . . introducing new foods is hard. Try introducing new foods with the kids–this is what the community has to do. (Laura)

Carol and her son both had their gallbladders removed. Since then she has encouraged her son to eat healthy. She found frequent reminders helped. Carol explained:

> Too much fried food, 15 years old he went under the knife and they took his gallbladder out. Two months after I never got so sick in all my life, I went to the hospital they took my gallbladder out . . . 2 months after both of us got our gallbladders taken out. I's so glad about this session [our conversation] because even, I didn't know very much, that's why my son's at the age he is right now and he's wonderin' what's he supposed to be takin' to make his body a lot better. So I keep on and he's eatin' good now, he's eatin' all kinds of vegetables because it scares him. I'm the one who's out there buying the stuff, I'm the one who's going to the store, mind you I didn't have a lot of m, money, I was grown on the same things that when they were younger I probably bought the cheapest thing, hot dogs, baloney, Kraft Dinner. (Carol)

Carol worked hard to educate her children about healthy foods to eat and to use small portions as she stated

> Small meals. Yeah, so like what we did at the house now is we don't have no large plates anymore, they're gone. I don't do large plates, not even for the kids, we just do a limited plate and that's it, you don't have to have any more dinner, plus we put the buns and that on table so that's, if you put a bun on your plate and something else you already made a big plate any ways and [husband] turned around and said was time for the salt to go too, so I change that. Got rid of the salt, yeah, so we're trying to do the best for us, doing it for the kids too. (Carol)

The participants were continually trying to educate their children about being healthy.

Health Promotion

Health promotion is "directed toward increasing the level of well-being and self-actualization" (Pender, Murdaugh, & Parsons, 2006, p. 37). According to the WHO (1986), health promotion assists people to have more control over their own health, resulting in better health. A number of participants identified health promotion as ways they have undertaken, or plan to adopt, to help improve their health, their children's health, and the health of their communities.

The Mi'kmaq women described the changes they made in their diet and physical activities after being diagnosed with GDM. Their goal was to decrease the chances of developing diabetes later in life and prevent their children and families from developing GDM and diabetes. In the case of two participants who have diabetes now, they are trying to stay healthy to decrease the chances of developing further health problems.

Although the participants described their personal struggles, they overcame them in a way similar to the women in Evans and O'Brien's (2005) study of 12 women living with GDM. Most of the women in Evans and O'Brien's (2005) study were White and came from diverse cultural, social, and educational backgrounds. Gaining a balance between their pregnancy and dealing with their physiological and psychological reactions was something the Mi'kmaq women had to work hard at during their pregnancies. It meant having to prudently plan their meals. Scheduling meals and other household activities accounted for most of their day but it was the only way to achieve a healthy balance (Evans & O’Brien, 2005). Consciously thinking about what they were going to eat created a heightened awareness around meal planning. Both groups of participants had to maintain a healthy diet to keep their blood sugars within the normal range. This concept of changing habits to achieve balance can be understood through Merleau-Ponty’s (1962/1992) notion of incorporation into one’s body. According to Merleau-Ponty (1962/1992), “Habit expresses our power of dilating our being-in-the-world” (p. 143). Using Merleau-Ponty’s (1962/1992) work, habit in this study means that if the women regularly followed a healthy diet they would have a greater chance of not developing complications during pregnancy and less chance of developing diabetes later in life. So in this sense the women have better health because as they continue to form good habits they dilate their own world or expand their way of life. Hence their world gets larger and healthier. Caring for one’s body with GDM gradually becomes a habit where women incorporate insulin and nutritious food in the body to keep healthy and to function normally. Their children and communities benefit equally from changes they have made.

Barbara advocated for a breakfast program in the school in her community.

> You were talking about the food um remember that time I was telling you um I wished they had a breakfast program here. They started that in September. So that is something we were all pushing like all the staff were pushing it and I kept pushing it because my sister works at the other school and she’s the cook there. It’s free, it’s free for the children. So they’ve made that um, they started that here in September which is really good and it, you can see the difference too with the

> kids, they ate, they work better in the classroom. Even one teacher told me today. (Barbara)

When I asked Barbara if the breakfast program made a difference in the children's ability to concentrate, she happily replied "yeah they have energy you know."

Annette volunteered with the breakfast program at the school in her community. The program is designed to give children a healthy start to their day. Poverty, one of the SDOH, has direct results on what foods people can afford to buy which is the situation that many Mi'kmaq families find themselves in (Loppie Reading & Wein, 2009). Annette was worried that children who were identified as not having breakfast at home would be at risk of being apprehended by Children's Services.

> I've had students at my school and they've come and, and that's what their team, their teacher said. Like I've, I, ya know I've said something but I don't make it a big deal 'cause at least you know he's got somethin' in his belly and he can at least think when he's at school. 'Cause you can tell when some of these kids are you know, they don't have breakfast or they just don't show up if they don't have lunch, that's why there's the lunch program. And even still some kids won't because they're afraid you're going to call Children Services and take their kids [them] 'cause they don't have a lunch. (Annette)

Annette is like a mother to all the children in her community and as such is concerned about their health and well-being. Van Manen (1990) believes that when children experience a "sense of support and security" (p. 106) this attention helps them develop into healthy adults.

Changing eating habits.

Annette developed diabetes a year and a half after the birth of her third baby. Although she was grateful that she did not have to take insulin, diabetes has created more stress for her. Recently becoming employed has helped because she has to eat regular meals. She explained:

> I was diagnosed last Christmas, not this one that went by but the one before. I am on diet. I do the stuff, like I do the blood work and all of that. And he [doctor] says he's very happy with it. And in general I eat good. My work schedule keeps it um good. Like I usually have a grapefruit and a couple of packages of instant oatmeal or, or some waffles and mostly the oatmeal though. (Annette)

Likewise, Carol made some diet changes. She stated "I was told that's why we're doin' it more vegetables now, we're like knock the salt off, we tried to take the sugar out of the house, there's a lot of things we're trying to do at home" (Carol). She conveyed a sense of pride in being creative and successful in making healthy food choices. Barbara remarked "Instead of buying the Fruit Loops buy the, like cereal with lower you know, sugars. I don't let my kids put sugar on their cereal." She tried to carefully monitor what her children ate. She feared for their future if she did not try to instill healthy eating habits into her children early in life.

> My son is 13 now and I still don't let him. I say until you're old enough to realize what's good, you make it for him [make decisions] 'cause I'm trying to be better too with my health. So I don't but if they even stay somewhere else and

> overnight or anything, they let them. They'll sneak in the sugar, put the sugar . . . They get sugar so why can't I. I'll say well you're gonna grow up you're gonna want it more. Then you'll put more in there. I try to buy like cereals that aren't, a lot of sugar like Bran Flakes. (Barbara)

Likewise, Annette was fearful of diabetes. Being a responsible role model, mother, and guardian to her children and family was something that Annette and the other mothers took seriously. However, it was hard to monitor their eating habits all the time, especially when their children stayed overnight at their friends' homes where the emphasis may not be placed on healthy eating.

Laura did not consider limiting high fat and sugar intake as cruel but rather necessary to maintain good health. There was no time to wait and gradually introduce changes. Her children were disappointed when she stopped buying unhealthy foods. She explained "I didn't buy ice cream, I didn't buy candy, I didn't buy pop, I bought diet pop and I switched our juices. I was buyin' those um, you know, those fruitopia juices and stuff" (Laura). She knew she could not be slack; vigilance was required.

Barbara developed health promotion strategies during and after pregnancy.

> All through my pregnancy, not even junk food or nothing, I ate well. Because I, I always would, even though I'm a single mom but I try my best to buy always fruit, I hate junk food. You know I had like, my kids have it once and awhile but I won't buy it. I won't buy pop at home or anything like that. I was on Weight Watchers before so I always look at the snacks, how much calories there are, how much salt is in there . . . Special K, granola bars so they [her children] have

> snacks at school they don’t know what I’m doing. I’m trying to get them healthy as possible you know. (Barbara)

When her son was 13 years old, he decided to become more active. Although Barbara was happy about his decision to become more physically fit, she felt a sense of guilt as a mother because he had gained so much weight. She explained:

> That’s one thing he’s done to even for himself. Like I’ve been pushing him for, like he’s on hockey which is from October to April, which is good but um his weight’s been, he’s a little overweight like, at that time but not much right but um he also had a lot of stress over the years with um, me and my husband but anyway that’s another story. (Barbara)

Being a good mother meant having to make choices about what her children should eat, something that Barbara could do but that was not easy. Similar to Barbara, Annette struggled with being fair–giving her children the same opportunities as other children, yet being responsible as a mother to ensure her children had a healthy diet. Annette found it difficult to prevent her eldest son from eating excessively but did not know how to say no, as she explained “you know tryin’ to find moderation and you know I don’t like telling my son no and then again I don’t want him to eat me out of house and home.” The participants wanted to be strong role models to guide their children in health promotion activities, yet not be too harsh and still let them know they were loved.

Annette and the other participants knew that something had to be done to break the cycle of diabetes. Reminders from her family situation with her own mother and uncle having diabetes made Annette more aware of the disease and more determined not to develop it.

Starting a community garden.

Veronica was anxious to begin a garden even though there was a trailer on part of the land that would be otherwise available to use. Veronica explained "we used to but then they put a trailer there. They never moved it." When I asked if it would help to ask the Chief if the trailer can be moved, Veronica responded:

> Wouldn't even have to, just make a spot and start a garden 'cause I could, I could do it right now if I wanted to I was thinking if doing it next year. I grew up not eating my vegetables and stuff, but when after I had [son] I wanted him to eat all of that and so that's how he eats now. He would rather eat grapes, banana other than chocolate bar and chips. (Veronica)

Likewise, Loretta would also have liked to start a community garden. She stated "a community garden would be nice; we had a garden before just over there [near Health Center]. It was like my family garden, it was just nice go there and pick fresh tomatoes, carrots, to make stews" (Loretta). We discussed the idea that a community garden would be something to involve the children in. Carol was proud of her own community garden.

> We had a community garden here. . . . We got a garden at home and my sister was up yesterday, wanted some green onions for her stew so went home and chopped some down. I got the green onions this year, I got cauliflower, I got cabbage this

> year, I got tomatoes this year, I got peas and green peas this year and watermelon. (Carol)

Carol enjoyed spending time in her garden. She stated “we do our compost so everything’s compost wise and we just grow it ‘cause for the last few years doin’ a lot of plantin’ , ‘cause right now like you [researcher] said the vegetables cost a lot more” (Carol). We discussed the food value and the cost savings of having one’s own garden. The women could see the value of a community garden and thought it would be a relatively easy project to implement.

Annette thought that a community garden would be convenient as she explained “Can you imagine having pre-natals being able to go and get their own carrots or have a little greenhouse and be able to get your cilantro, here’s your whatever, let’s go inside and cook it” (Annette). Laura has to rely on family to drive her to the grocery store until she gets her driver’s license. Having a community garden would decrease the amount of driving to the grocery store, approximately 40 minutes of driving per trip.

Becoming more active.

Barbara’s sisters have joined walking with her on a regular basis. Barbara stated she has been trying to walk on the track near her home on a regular basis. “I made a little goal, I said I have to walk five days a week at least a week unless it rains. But I have a treadmill at home now” (Barbara).

Some participants acknowledged that they have to establish better time management in order to incorporate physical activity into their day. We discussed different forms of exercise such as going up and down steps and taking the baby for a walk in the stroller that were easier to incorporate into their day. Exercise was hard to fit into Annette's day because she had a number of other commitments but near the end of the study, she managed to fit exercise into her schedule. A typical day for Annette included:

> I spend a lot of time going to Kids First, it takes almost the whole day just, I know it only goes to 11:30 but if I run an errand or two then you gotta have lunch, then she [baby daughter] takes a nap and then he comes home and then I gotta cook supper, their dad's home, we eat then they get ready for bed, and boom its 8 o'clock just like that. I was actually looking at workout videos too, I need to get active. My friend uh just gave me a double stroller, it was the second hands what she used with her grandchildren, but whatever. I'm gonna clean it up and it's somethin' that we can do when, especially when we're in our new house and cruise. (Annette)

Carol found yoga classes personally fulfilling as she explained:

> To have somethin' like that, some kind of activities, I even uh went to the gymnasium and told 'em that we have so, such a big building down there they could even had done, had somebody there for exercise classes for the ones that are, have diabetes. I took an hour off of class to do yoga, [worker at health center] had somethin' goin' down at the, she had yoga for parents. (Carol)

When I asked some of the women about the area where they walked they replied "At the Village School. There's a track there, walking track" (Barbara). Barbara also encouraged her children to become active. She stated:

> And there's a playground there. When I take my kids I can see them while I'm walking and so it's a nice firm track, but you can't go there like after dark, there's a sign there. But after supper or after school we used to go there. So we could see the kids right there. It's nice and clean too. (Barbara)

As mentioned earlier, play is a very big part of children's lives and recreation. Since children spend so much time sitting down in school, having a recreation area nearby is a reminder of the need for children to be active during part of their day (Ellis, 2004). I wonder if the mothers feel more at ease because they can see the children as they walk. I also wonder how the children perceive this situation as they too can see their mothers. It is daylight. The night creates an uncertainty for children even in a world they are familiar with (Kirova-Petrova, 1996). Children want to play in a place where they feel connected to their community (Ellis, 2002). Creating a place that is safe, where both parents and children can play, is an action that the women partake in and one they consider a good health promotion activity.

Barbara found that phone texting helped her connect with her friends and family when she was planning to go for a walk. She explained "since July. So whoever could join I'll just text, let them know I'm, I'm at the school if anybody wants to come over. And you'll, one of them will show up anyway." There was no pressure to participate; everyone was welcome.

Some parents encouraged their children to be involved in sports such as volleyball. When I asked about other sport activities, Barbara stated, “Oh there is Tai Kwon Do too”. Barbara also pointed out that more Mi’kmaq children were becoming active in her school. She became involved as she explained:

> It’s good here too like the gym, there’s more kids now that have um like volleyball and that, so there’s more activity, going on. And I’m taking over Grade 4, 5, and 6 after Christmas for boys and hopefully I’ll be able to do volleyball or floor hockey. Play games. ‘Cause they couldn’t get anybody to do it and I was kinda reluctant at first then I said ah I might as well do it. (Barbara)

She viewed it as an important health promotion activity and a relatively easy activity to fit into her daily schedule.

Although hockey is expensive, Annette believed it was worth the financial sacrifice to enroll her son in this sport. Parents are not as active as their children according to Laura.

> The children, they have the volleyball, floor hockey. They’re all at separate ages. So it’s from I think the youngest is Grade 4 and they also have it like for the older ones. Like the teenagers. They have separate times for that. So it’s pretty good Grade 4 to 12 about it is. They’re active. And they’re, I know there’s a lot that are participating, a lot of kids. But parents, you’re not gonna really see them ‘cause, we’re [parents] lazy. (Laura)

The word “lazy” referred to not being active; content to be inactive. Annette had no difficulty getting her children to become active but did not know how to effectively motivate herself. Having mothers contribute to health promotion role modeling created additional awareness of the value of physical activities.

Women as Leaders

The Mi'kmaq women were beginning to mobilize their health knowledge and efforts to take on leadership roles to raise awareness about their health and the health of their children and communities. Kenny (2006), a Native from the Choctaw band and an academic, shared the following words of Margaret Lavalle, an Ojibway woman from Sagkeeny: "When the women heal, the family will heal. And when the family heals, the nation will heal" (p. 551). Thus one of the ways of healing is by searching for answers. As Aboriginal women continue to take on leadership roles such as seeking answers to their questions and gaining insight into their experiences, their families and communities will benefit.

Searching for answers.

Many participants were searching for answers to their questions about GDM and diabetes. Searching for answers is a fundamental right that Carol and other participants were realizing they had. Evoking the work of Austin (2001), "Health as a universal right means equal opportunity of access to quality health care, regardless of gender, race, social, economic and geographical facts" (p.186). The conversation with the Mi'kmaq women gave me an opportunity to inform and reinforce their Mi'kmaq women's rights as a person and as a patient.

Although the Mi’kmaq women sought support from their community and health care providers, they accepted their role as women, mothers, and citizens in their community and as such knew they had to take responsibility to help their people. Indigenous people use their knowledge as a guide in taking responsibility for their own actions (Battiste, 2002).

Until recently, research on women’s health was “based on the premise that women’s health experience is universal and has essential features” (Meleis & Im, 2002, p. 214). Often times, the health care providers’ primary focus is taking control and telling patients what is best for them (Grant, Giddings, & Beale, 2005). On the contrary, Aboriginal people want to preserve their traditions, beliefs, values, and language and do what they think is best for their community (Native Women’s Association, 2007a). Evoking Gadamer’s (1989) writing, “Long before we understand ourselves through the process of self-examination, we understand ourselves in a self-evident way in family, society, and state in which we live” (p. 276). Gadamer’s (1989) writing helped me to consider the importance of Mi’kmaq women affirming their own beliefs and values.

The participants were eager to engage in leadership activities that could improve the health of people, a PAR principle guiding this study. For instance, Loretta completed a survey about a highway going through her First Nations community. She believed this action would help lead her community to prosperity. She stated:

> Just recently they were doin’ uh, um surveys about the new uh highway goin’ through and one of the ones about uh groceries, like where do you do all your shopping? And how much do you spend? So I don’t know if they’re, when the

> set-up, when they set up the new highway and we get our gas bar up there, it'll be like the power center in another town. See I don't know if they'll have a grocery store or, I don't know what they're gonna have. But that'll be comin' soon. (Loretta)

As mentioned earlier, Annette saw GDM as an omen for an urgent call to action to address the problems of gambling and substance abuse now. Otherwise, the cycle will perpetuate. She continued by saying "Because if you, the, that's, that's the backbone of our people that . . . it, is our moms" (Annette).

Gaining insight.

I found many participants tried to gain insight into why GDM was so prevalent in their community. They asked questions on policy-related topics pertaining to access such as transportation, funding, and setting up support groups to address suicide. They were taking on their leadership role as women to find answers to these questions around GDM. Van Manen (1990) finds people who are doing "hermeneutic interviews that the volunteers or participants of the study often invest more than a passing interest in the research project" (p. 98). The mothers in this study were immersing themselves whole heartedly in gaining insight into their health in order to find solutions to GDM. They conveyed concerns about the complications of GDM such as diabetes, hypertension, premature labor, vaginal bleeding, macrosomia, and other health conditions related to themselves and or their babies.

The back and forth conversations with the women enabled them to gain insight into their pregnancy and delivery. Veronica found talking about her miscarriage helped her to better understand what happened and that she and/or other mothers would benefit from sharing this knowledge in the future. The conversations helped to reassure her that she did not do anything wrong to cause the miscarriage. She explained “I didn’t know I was [pregnant], got this stomach pain, I was just so sore I thought I was sick or something so I just lied in bed . . . The next day I went into the bathroom and it [baby] came out” (Veronica). It was a painful process. Her and her partner had been trying to become pregnant for a while. She did not know how far along she was in her pregnancy when the miscarriage occurred, however she described the baby as very small. She did not go to the hospital, nor did she feel it was necessary to tell her doctor at the time but indicated she probably would tell him in the future. I explained that it would be important to inform her doctor so that he would be aware in the event of future pregnancies. Also, we discussed the importance of receiving medical follow-up at some point because the doctor would need to assess her early on for potential complications. She responded “Oh yeah really eh? I never thought about that. Just thought oh, it wasn’t meant to be” (Veronica). We discussed some of the causes of miscarriage such as unexplained reasons, malformations, and incompetent cervix. She listened intently as I explained these possible causes.

Informing Policy-Related Actions

During the conversations with the Mi'kmaq women, several areas for discussion and policy implications required assistance from the Chief and Band Council. Funding policies can change depending on the needs of Aboriginal communities (Health Council of Canada, 2011). As some of the participants were aware of funding challenges, they thought it was important to raise their concerns now about health issues with other community members and the Chief and Band Council.

The Chief and Band Council work with the health center to develop and establish programs for their community. The participants thought that their political leaders needed to know how imperative it was that action needed to be taken to address their concerns. "An integration of Aboriginal women's perspectives is critical to all policy discussions" (NAHO, 2007, p. 4).

Advocating for Aboriginal Diabetes Initiative (ADI) position.

Anne recognized the need for an Aboriginal Diabetes Initiative (ADI) position. Nine First Nations communities were selected to participate in an in-depth study to try to reduce the incidence of diabetes in their communities in Canada from British Columbia to New Brunswick and from the southern part of Ontario to Nunavut (Health Canada, 2011). Anne was sponsored by this government initiative. As part of her program, she did some practice teaching on diabetes in her First Nations community.

> So I had to come home [own First Nations community] and I did a lot of my work on the prenatals and the mom and babies . . . , it worked out great because where

> my instructor told me where my position MCH [maternal and child health] she said you work with mom and babies and you work with prenatals so your best bet is just to focus on that area. It is in-depth training over a 6-month period. (Anne)

Anne was proud of her accomplishments. She was keen to teach prenatal mothers in her community. When we discussed how to advocate for this type of position in her community, Anne responded “I have no idea, I, I, I don’t know really. That’s why I was lookin’ into it [job] myself” (Anne). She was convinced that if she was hired as an ADI worker, she would make significant contributions to her community.

> I want to at least, you know, try, start to learn to put my training to use. Why did you guys [Chief and Band Council] send me to this training if, if I can’t present it to my community? I heard, I’ve noticed a lot of gestational women, not just me but like women that are thin and still manage to have gestational and not, they have no clue, like they’re saying oh I gotta go diabetic clinic. Oh I gotta get needles. I said you know, needles are not that bad. I know this reserve does need, you know, like it does got two ADI workers, that’s my, my thing is how to go about to get them started or, you know. Working with the community being able, you know you, you were taught something you know, you’re supposed to bring it back to your community so why not, why not just bring it back and the people are much more receptive when it’s from people in your own community. (Anne)

We discussed this as an action to be recommended from this study.

Anne had a worried expression on her face all the while we discussed the need for changing ways of eating and overall lifestyle. It was as though Mi’kmaq women like

Anne and others consider their community an extension of themselves, the same way van Manen (1990) describes the lived body. They experience their community like their children as physically close. Their community is very important to them and they want to protect and ensure everyone is given equal opportunity to maintain their health. To the Aboriginal women, the body is seen as a communal concern affecting everyone in their community. What hurts one person hurts everyone.

Annette emphasized that women in her community learn by example. She thought that more community members would change their lifestyles if they saw the Chief and Band Council taking a leadership role. She stated "just the idea that knowing Chief and Council or my leaders are trying to make themselves better" (Annette). When I asked Loretta what her views were on the Band support, she replied "Um not as much as I'd like, as anybody would like really. The only thing they support, well help us out with is, help people out what I should say, is uh welfare [income] (Loretta). She would also like to see more relevant health issues discussed and more actions taken to address these issues in her community.

CHR influencing policy.

Kate talked about the CHR's invaluable role and one which has a direct link to the Chief and Band Council. She thought this person can help to influence policies in their communities and can advocate for the health needs of the Mi'kmaq women with GDM. She described the role in the following manner:

> Very key to facilitating the rest of the community towards better quality of life and healthy living and things like that. It’s, it’s our CHR speaking up at you know community events like hey, hey, hey, you’re, you’re expecting, what are you doing? Don’t, don’t eat that, or you know yes you can go play baseball even though you’re, you’re pregnant, go ahead, you need to get some exercise, that’s healthy for your baby, and that’s, to me that’s how I see the CHRs working in a lot of the communities. Even when she’s not technically working you know, she’s out in the community at an event or you know at a birthday party or something and sees a pregnant mom or oh hey you know you, you look kind of like you’re retaining a lot of water, you look kind of puffy you know you should go see the doctor . . . there are really key it, it’d be really great if um Chief and Councils and, and government or whoever would recognize a little bit more. (Kate)

She thought that more emphasis should be placed on elevating the importance of the CHR role. They are not employed in all First Nations communities (Charlotte Jesty RN Aboriginal Community Health Nurse, personal communication, July 17, 2012). Fortunately both communities where I conducted the study had a CHR. In contrast, an ADI worker role is more specific to educating people on diabetes and gestational diabetes, and they are required to cover a number of First Nations communities. In communities where there are CHR and ADI workers, they work together to educate Aboriginal people on diabetes and their overall health. However, there is work to be done as the scope of the ADI worker is not yet understood (Community Health Nurse, personal communication, September 26, 2012).

Kate thought utilizing CHRs would be the best approach to improving Mi'kmaq people's health. The CHR in her community does a lot of work such as sending out newsletters on what is happening in their community as well as going to the Chief and Band Council with concerns in the community. They also arrange prenatal classes and perform many other tasks as needed.

> Each CHR is the direct line to the Chief and Council. You know what I mean? The CHR reports to Chief and Council. Um, but in most communities, the healthcare side of the budget is the healthiest. Is you know usually a guaranteed, they usually have um a good source of funding for healthcare-related activities, recreation programs, things like that. Often times what's happening in quite a few communities is because the healthcare portfolio does have guaranteed funding, and does have you know. (Kate)

The CHR in Kate's community is a key person in the community. With this position in this community comes a lot of responsibility and this person has a lot of influence over the budget.

Addressing gambling and substance abuse.

According to Annette, gambling is a serious problem in her First Nations community according to Annette. She wants to see the Chief and Band Council put policies in place to control the amount of spending and abuse of people's money on these types of activities.

> I've tried to talk to them [Chief and Band Council] different times about gambling 'cause they're putting machines on my reserve, I hate that. I like to gamble, but I know people that are never gonna make it off that friggin' reserve with their $184 ration cheque, or however much, and what do you do when you can't bring home food and, and I know it's on a person . . . And but Chief and Councillors say we're not gonna help and you can't dig yourself this hole . . . But I have great concerns . . . how can you be worried about diabetes, this is just my thinking when you're worried about how to buy any groceries because all you got left is 40 bucks, you blew 'em on a machine or you bought beer or whatever it is, right? What do you do, what's important then, you know? (Annette)

Annette explained that the Chief and Council who are the "go to people" and who the community holds responsible are not listening. Annette admired the courageous young girl who stood up to them and voiced her concerns about the huge amount of gambling in her community.

> This is a really hard thing for a lot of our people 'cause a lot of them don't know the difference between drama and trauma and perpetuate the cycle and, and how do you worry, you can't just worry about one part of a person's health because they all affect each other, you need to take a holistic approach to dealing with, 'cause you can't just deal with these women, you need to deal with their children.

> You need to educate them that they educate their children or they educate their partners. (Annette)

Alcohol and drug abuse were raised as addiction problems. Some of the participants wanted the Chief and Band Council to address those problems. For instance Victoria admitted that she drank alcohol early in pregnancy but stopped once she discovered she was pregnant. She attributed her boyfriend's support in helping her stop drinking. Loretta was concerned about Mi'kmaq women in their 20s developing GDM. She thought alcohol was a contributing factor to developing GDM. Loretta considered workshops helpful in getting people together to discuss substance abuse. She stated "I know the [health director] is always tryin' to get those kinds of workshops" (Loretta). Loretta also mentioned that there was a lot of prescription and street drug abuse. She explained "nowadays it's a lot of pills too, just recently people are into pills . . . prescription pills. Yeah for a high" (Loretta). Although both men and women use drugs, she thought that the incidence was higher among men. She explained:

> What it's doin' to their relationships and their families now. It's not good. 'Cause we never really had a problem with pills down here [First Nations community]. It was mostly just drinkin' and like Ativan, I'd say mostly men now, but ya just never know. (Loretta)

We discussed the hardship on the family when people take drugs for recreation purposes. "That must really, 'cause the alcohol, that's hard on a family" (researcher, field notes). "Yeah. But just like seeing from, seeing people around here, what it's doin' to their relationships and their families now. It's not good" (Loretta). Loretta explained that a drug and alcohol worker was hired less than a year ago. She was hoping his work in the community would make a difference.

Addressing suicide.

Annette knew she had to raise concerns with Chief and Band Council about the increasing incidence of suicide. She recalled “there’s my brother who lost his best friend [to suicide], he’s dead and he’s terrified um of losin’ me” (Annette). She further explained:

> Feelin’ any more pain, and so, you know, all, everywhere there’s some sort of strain because of we, you know, it was my grandmother, it was my auntie, it was my whatever, you know what I mean, and it’s everywhere like that and we’re all tied together so closely. I had one friend who lived in [another First Nations community], one friend and I could feel her pain and whatever when she’d come to school and it was her safe place and whatever, and she’d talk about all these different people and I’d be like yeah, I know how she’s feelin’ ‘cause she’s feeling it this way, she’s feeling it that was . . . everything was so intertwined and tight, live in these communities and you become a part of these communities. (Annette)

However, she was not sure how to approach this issue with the Chief and Band Council because she relied on their support for welfare services. But she knew her people were going to die and/or experience serious problems if she did not act. Annette demonstrated incredible inner strength and was determined to challenge the status quo but needed time to think about how to bring the problem forward. Because of a recent suicide of a pregnant girl in another First Nations community and the fact that some of her family members had died as a result of suicide, she recognized the need to raise this issue as soon as possible. She also knew that her recommendations would be coming from this study and so she felt that at least they would be raised. Indigenous adolescents often have a number of health problems which are related to the determinants of health so appropriate resources and early intervention is required (Gracey & King, 2009).

Communication between Aboriginal and non-Aboriginal people.

The conversations highlighted the need to explore ways to help Aboriginal people feel comfortable talking to professionals. Likewise, non-Aboriginal people need to learn how to communicate better with Aboriginal people. For example Carol recognized that she has difficulty knowing how to communicate with non-Aboriginal health care providers about her son’s speech. As a result, Carol was placed in a vulnerable position because she had no one to turn to for advice on what she should do. Carol did not know that she could request to see a specialist about her son’s speech problem. Although the speech therapist would be working with him, opportunities to be seen by a specialist outside her community were not suggested by her own doctor.

Jurisdictional issues regarding health services are complex in First Nations communities (Fiske & Browne, 2006). Health transfers to communities can give Aboriginal women more chances to address issues but they are labeled as the “Other” which works in opposition to what the health transfers were meant to do. First Nations people then have to go between their communities and the medical system for care. In these situations in small communities, First Nations women have little chance to seek personal choices in areas such as health and advocating for policy changes (Fiske & Browne, 2006). Furthermore, "to be refused service may well be experienced as a gesture of exclusion, no matter what jurisdictional mandate underlies the gesture or how supportive individual practitioners may be" (Fiske & Browne, 2006, p.103). Regardless of the jurisdictional guidelines or good intentions, First Nations women are burdened by "racializing and discrediting practices" (Fiske & Browne, 2006, p.103). From my discussions with the women, there does not seem to be much discussion around opportunities for consultation with specialists outside their communities.

Needing other resources.

Several participants went to the local hospital to meet with the dietitian when they developed GDM. Although the health center in their community provided a lot of education, it was not enough. Loretta contended that a dietitian needed to be employed fulltime at the health center.

> That'll come in that's doin' workshops and stuff. And like a dietician will come, I wanna see you Loretta, alright . . . I think we do have a dietician but I don't know if she covers all reserves. She's not here constantly, so. I'd say a dietician, people would benefit from a dietician here. (Loretta)

Similarly, Carol stated "We need a diabetic educator; diabetes has reached a peak and the situation is a big warning." Carol and Loretta, like other Mi'kmaq participants, were grateful to have this service yet they thought a permanent fulltime dietitian position was required.

Loretta suggested that having a local food bank would help First Nations communities, since there are no local grocery stores nearby. However, she was encouraged by recently being asked to complete a survey about what her community needs are. A new highway is being built near her community so Annette was hopeful that there would be economic prosperity in her community in the future.

> When we get that overpass that might change, but I don't see for another like 10, 15 years at least. And because we have land on the other side of the highway and for the last I don't know how many years, three decades our band has been asking them 'cause they know that highway's coming through can you put that overpass there so we have access to that land over there. She envisions with expanded space it will be more spacious for healthy living once they gain access to the additional land, so it will co [come], we, we are very, getting very cramped where we are. (Annette)

The First Nations population is growing and they need more space to expand. More infrastructures such as business and health services are needed. According to Aboriginal Affairs and Northern Development Canada (2010), the Aboriginal population is the fastest growing sector in Canada.

Loretta, like others, are hopeful there will be more shopping centers near the community so they do not have far to travel. Annette pointed out that "it's, and it's sorta strange because we're very rural, we're out there and there's nothin', yet my next door neighbour's as, could be as close as your door, you know what I mean." According to some participants, in one First Nations community rural meant 20 minutes by car from a shopping center and grocery store. Since transportation is a problem, having stores within walking difference would make a huge difference for accessing food and other essential commodities.

Another resource that is needed is having a place for the women to exercise privately. For example Laura was trying to organize a time where women could exclusively use the gymnasium in her community.

> I was trying to even um, I asked um someone if they could uh have a, even an hour just for women 'cause there's a lot of men in that fitness center. There you won't see a lot of women over there. So I even asked um [fitness instructor]. She works at the center if there could be and even an hour or something for just women, whoever wants to go there, girls. Yeah 'cause some people are insecure uh. Yeah. I, I wouldn't feel comfortable. I don't go so, you know. Yeah you feel really intimidated. Yeah. There's guys will do big dumbbells and, yeah. And they're not even wearing shirts. And you're there sweatin' . . . There's like nothing for, . . . like something for women. (Laura)

During one of the talking circles, three participants expressed a need for a women's gymnasium. They want a private place to exercise away from men. As Battiste (2011) notes, Mi'kmaq women are traditionally modest about themselves. They did not want to be around men when they exercised. We discussed the possibility of talking to the Chief and Band Council about allocating an area for women to exercise.

Kate viewed the gymnasium as multipurpose area for gatherings. She elaborated on the fact that the building was left open all day and nothing was taken from it. "They just kind of leave it open and there's um, built up a, a good level of trust with the young people and the community members . . . are respectful and things don't go missing and . . . so it's been good" (Kate).

The participants identified several areas where changes in their community would mean some policy revisions and or guidelines. The thought of the aforementioned changes would contribute to improving health in their communities.

Conclusion

The Mi'kmaq women recognized their roles as mothers, wives, partners, parents, nurturers, and protectors of their children, families, and communities. Because they love, value, and respect their people as well as their language and cultural traditions, they see it as their responsibility to safeguard their health. They identified actions that they think can make a difference to their health and their families'. The conversations we had helped to raise awareness around the strategies they have already undertaken on their own and envision the possibilities if other actions are taken in the future.

The women were motivated and committed to those actions which would not have been possible without their self-determination and resilience. They demonstrated the capacity to organize and carry out some personal actions that did not always need to mobilize actions by others. According to Kirmayer et al. (2011), the Mi'kmaq language with its "rich repository of knowledge" about not only the "local ecosystems but also of indigenous concepts of conflict resolution" has helped them significantly maintain their values and traditions (p. 86). This, in turn, has given them the strength and courage to respond to the effects of colonization and in turn assisted them to preserve their culture and to maintain their health.

Some of the actions that the women discussed included using their refrigerator as a place to post information about healthy eating. Establishing a community garden was another initiative that some women had developed in the past, while other participants thought it was a good idea to initiate. The latter group stated they would need some help and anticipated that others in the community would help. Since Mi'kmaq women like to make foods from scratch, reviewing current recipes and changing the ingredients to include less fat and sugar was another important action raised.

The importance of hiring an ADI worker for the First Nations communities was identified as a necessary and valuable addition to the current group of health care providers. A dietitian on a full time basis, mental health care workers, and midwives were also items raised as needed on the health care team. Decisions such as these would require approval and support from Chief and Band Council, Health Directors, CHRs depending on their role in the health center and others as they have policy implications.

A number of the Mi'kmaq participants attended and/or are planning to attend educational sessions and workshops on diabetes, mental health, and other health conditions. The communities had incentive programs to encourage members to attend. Some women commented on how helpful it was to receive food vouchers to help stretch their budget.

Some women thought that having a support group would be beneficial in learning about GDM and diabetes. They thought a woman's gymnasium would help them engage in meaningful exercise. A couple of women helped with the breakfast program at school. Keeping their language alive by promoting Mi'kmaq language being taught at home and in schools was identified by some participants as very important. Seeking help from non-Aboriginal health care providers was also seen by the Mi'kmaq participants and others as important.

Although the women know there is a lot to be done to address GDM and diabetes in their communities, they are hopeful that positive changes will occur as a result of their health promotion activities and ongoing health education. In some Aboriginal communities there is evidence that they have the capacity to change their communities to become more prosperous and see a future for the generations to come (Warry, 2007). The Mi'kmaq women in my study are showing a similar capacity to change their communities for the better.

Chapter IX

Discussion

As I draw a closure on this study, I find myself thinking about how the Mi'kmaq women convey hope and self-determination in coping with and trying to gain insight into the effects of GDM. These women acknowledge they have a high probability of developing diabetes later in life and want to do everything possible to avert this disease. The findings in this research suggest that Mi'kmaq women, children, and families encounter situations that create barriers for them to receive necessary resources including income, housing, access to health services, culturally competent, and culturally safe care. The SDOH provide the appropriate framework for the study. The framework offers clarity to the complex nature of GDM and the serious challenges Mi'kmaq women and their families face in their daily lives.

From a critical perspective, the factors that affect health care are embedded in the broader social context and frequently are, in subtle ways, expressed with serious consequences to the patient-professional relationships (Browne, 2007). Research has shown there are issues of power and tensions between patients and physicians, especially when people are cared for by individuals from a different class, gender, or ethnicity (Browne, 2007; Reimer Kirkham, 2003). Similarly, there is evidence of some difficult relations with health care providers, as well as trusting and respectful therapeutic relationships in this study.

Four major themes emerged from the experiences of women with GDM living in two rural Mi'kmaq communities. They included: Uncovering the Experiences of

Gestational Diabetes Mellitus; Barriers Limiting Access to Equitable Health Care; Social Support During Pregnancy; and Feeling Compelled to Take Action. This chapter will address the original research questions outlined earlier in this study. They include: 1) What are the experiences of Mi'kmaq women with GDM? 2) How are these experiences affected by a variety of social determinants of health? 3) From the perspectives of the women, what are possible actions that can help Mi'kmaq women mobilize to respond to needs with GDM.

The Experiences of Mi'kmaq Women with GDM

The Mi'kmaq women explicitly shared their experiences of living with GDM. In sharing their experiences they were investing their emotional self in this study and it became a dialogue in which both the participants and I learned. They appreciated receiving health information related to GDM and other conditions associated with pregnancy such as the physiological effects during different stages of their pregnancy, a more in-depth understanding of this high risk disease itself, and knowing their rights in terms of questioning their health care. They were anxious to learn the meaning of some medical terms they heard because the medical terminology communicated by doctors and nurses was foreign to them.

High risk pregnancy is defined as "one in which the life or health of the mother or infant is jeopardized by a disorder coincidental with or unique to pregnancy" (Perry et al., 2010, p. 189). Maternal conditions such as hypertension, hemorrhage, gestational diabetes, and premature labor are among a number of health conditions that can affect the health of the mother and/or baby (Perry et al., 2010) and which some participants experienced. Being high risk meant that the Mi’kmaq women had to be assessed more frequently than low risk patients whose pregnancy did not present any health problems. For example, Loretta explained that she was not cared for by a midwife because she was classified as high risk due to having GDM. This meant she received her prenatal care from an obstetrician, a doctor specialized in caring for women with obstetrical complications. When Anne was pregnant with her twins, she started bleeding at 32 weeks gestation. As a result she was transferred to a tertiary care center for closer observation in the event of complications.

The meaning of pregnancy.

The Mi’kmaq women looked forward to the experience of pregnancy and birthing their babies, as children are an integral part of their lives. The participants described this as a natural event in their lives with minimal anticipated medical interventions. However, being diagnosed with GDM unexpectedly changed their world and drained them of the anticipated joy of motherhood. Their bodies were not the same as they were before pregnancy. For example, Carol recalled two major symptoms, “tiredness and thirst” which were a major contrast from the way she felt prior to pregnancy. Veronica, Annette, and Kate commented on much weight they gained and it was hard to lose weight after they had their baby. Although some women were not entirely surprised by their diagnosis because diabetes was known to be higher in the Aboriginal population, the majority were caught off guard when having to deal with the reality of having GDM. Descriptions of individual feelings varied including feeling sick, miserable, awful, no way out, anxiety, uncertainty, fear, lacking energy, suffering, feeling out of control, and many others as described in the study. For instance the feeling of loss of control and diminished energy temporarily drained the women of their confidence to fully care for themselves and their children. This left them feeling apprehensive about what might happen to them and their families' health if they did not get their body in balance. Some described the experience as suffering. Suffering deprived them of the necessities of life such as the food they enjoyed and their leisurely life. Others described themselves as feeling sick which van Manen (1998) describes as the "world has become sick" meaning they recognized they were not feeling well because they were unable to carry out their maternal roles in the way they were used to doing (p. 5). As a result of feeling sick, their world became small.

There were times in the pregnancy when the women were consumed with GDM and did not have the space to think about other things in life. It "played" on their minds. Thus GDM determined the actions they could take and tended to take up a large part of their life in planning their daily activities, something they did not have to worry about in the past. They were vulnerable in the fact that insulin was a major factor in keeping them feeling healthy and their body in balance. It kept them alive. This medication controlled how they felt and how they functioned at home and in the community.

The Mi'kmaq women began to develop a new relationship with themselves (Evans, 2003). Solchany (2001) describes three components in transitioning from woman to mother in the following manner "re-evaluating ideas about motherhood and babies, re-evaluating and making role adjustments, and accepting body changes" (p. 31).

These components may or may not be obvious but they are important. The woman's self-identity changes to adapt to a maternal role. Accepting of body changes seemed to be the most difficult to endure because the Mi'kmaq women in most instances had to take insulin and their health had to be monitored closely during pregnancy.

This was also a time when they began to develop a relationship with their unborn baby (Evans, 2003) and their relationship with others such as their mothers and partners. In everyday life van Manen (1990) describes how we develop a relationship with our lived body. It is this relationship that prompts people to act as in his case, as a father to his children (van Manen, 1990). Similarly, it encourages Mi'kmaq women to act when they are pregnant to take care of their bodies during pregnancy to ensure safe passage for them and their babies in preparation for childbirth (Lothian, 2008; Mercer, 1995, Rubin, 1984). When people are ill, or when they need nursing care due to having a baby, sudden injury, or aging, they need to find a livable relationship with their bodies (van Manen, 1998). GDM disconnected them from their body and affected the way they felt as a woman before they became pregnant. The role of health care providers is to help them re-establish this relationship with their bodies.

Understanding what was happening to their body and being able to verbalize what GDM meant in their lives was important. The women were aware of their bodily changes and realized that GDM limited their activity and overall movement until they started on an insulin regime. In understanding the importance of the women's awareness of their body, I turned to Merleau-Ponty (1962/1992) who writes "My body itself I move directly, I do not find it at one point of objective space and transfer it to another, I have no need to look for it, it is already with me . . . The relationships between my decision and my body are, in movement" (p. 94). Similarly, the movements of the women were synchronous with their mind in wanting to carry out activities such as motherly duties. The knowledge attained from prenatal education, healthy eating, taking insulin, being physically active, minimizing stress, and other actions were not separate from their body movement. Because the Mi'kmaq women had a holistic view of health as a few of the women alluded to, this philosophy helped them understand that the emotions were connected to their bodily changes (Loppie Reading & Wein, 2009) which helped validate and increase their awareness (Koch & Kralik, 2006). It was needed to cope with GDM.

As painful as it was at times to discuss, one mother, Barbara, found it beneficial to talk about what happened. For instance, she shared that she wanted her family and community to remember just how ill her son was when he was born with respiratory distress. She called him her miracle baby. This made me wonder about the spaces that exist for women to retell or relive their experiences. I also wonder how much healing may be occurring with giving women a chance to tell their story.

I found that with each conversation with the women, they began to open up and explain more about their lived experiences with GDM and their lives. I began to see how these discussions were building capacity in the women. For instance, during the second conversation with Veronica, she came up with suggestions to make healthy changes in her community. She suggested it would be good to have prenatal classes twice a week as opposed to once every 1-2 weeks. She looked forward to attending these classes during her pregnancy. She described her experience as: "They should have more of it [flexible prenatal classes] because I was learning a lot and I liked it when I was sitting there with other pregnant people and the way we sat around, laughed, talked and learned stuff". As I listened to the women and as we talked I started to feel stronger myself, and feel a need to speak out concerning their barriers in daily life and I have a better understanding of what they need for support.

When conducting a phenomenological study, Bergum (1989) experienced similar feelings as a mother to other women in her study. Bergum (1989) refers to these feelings as a transformation. They were feelings that seemed common to her as well as her participants. I also experienced similar feelings to what Bergum (1989) described during my conversations with the women. For instance when Veronica described her miscarriage, something I had experienced in the past, it brought back vivid feelings of what the loss of the baby felt like. Not only does the experience of having the baby change their lives but also all the experiences that occur before or after the birth. I could relate to many women's experiences.

Transformation to motherhood is a major change in a woman's life with new goals and responsibilities (Mercer, 2004). In a meta-synthesis study by Nelson (2003) on transition to mother hood, " Engagement" was the main "social process . . . only through making a commitment to mothering, experiencing the presence of the child, and being actively involved in caring for her child does a mother open herself to the opportunity to grow and be transformed" (p. 467). I wonder if the women in my study felt transformed. Although they did not use this term, they were actively involved with their children and in this role took full responsibility for ensuring their children grew up healthy and safe. Similarly, they cared for their family and community members.

Bergum (1989) reminds us that there is no separation between the knowledge of one's experience and what the experience means to the other person (Bergum, 1989). Understanding the situation can only come from reflection on the context of what is presented. Therefore, I, the researcher, am connected to the questions I am asking around "What are the experiences of Mi'kmaq women with GDM?" It became apparent that the time before and during pregnancy, and after the birth are so intertwined. From this perspective, the Mi'kmaq women's knowledge of their experiences and what the experience actually means is no different. Moreover, this is not a case of looking inward but rather seeing ourselves as we see the world. Bergum (1989) writes there is no space between being a woman who is pregnant, "bearer of the child, and living as mother" (p. 45). Thus their experiences with GDM carry on into the postpartum period and "a search is for knowledge of women as mothers and of oneself as mother" (Bergum, 1989, p. 45).

The Mi'kmaq women struggled to get their lives back on track once the diagnosis of GDM was made. Irrespective of how they felt, the women knew they had to be strong for their children and families. They had to find a way to balance the impact of this health condition with their busy lives. It became a full-time job in some ways, just managing GDM and the worry that goes along with this condition. Similarly, Hunter, Logan, Goulet, and Barton (2006), in an ethnographic study, looked at healing traditions such as Elders, talking circle, and smudging. Their participants found that gaining balance was empowering and provided them with a source of hope.

Vulnerability of the pregnant body.

The Mi’kmaq women were vulnerable partly due to being Aboriginal, but also because they had GDM. Vulnerable means “exposed to the possibility of being attacked or harmed, either physically or emotionally” (Oxford Dictionaries, 2012, p. 1). From the perspective of marginalization and health, vulnerability is defined as a situation where people are exposed to or unshielded from unhealthy environments (Hall, Stevens, & Meleis, 1994). People can be vulnerable when faced with disease. Vulnerability can have negative and positive effects. For instance, it places people at risk of a specific illness which can create a negative effect on the person. Resilience, on the other hand means that individuals develop the capacity to deal with adversarial situations and survive/cope well with the illness resulting in a positive effect (Hall et al., 1994). During our conversations, the Mi’kmaq women conveyed significant strength and resilience in enduring GDM and managing to carry on their other roles as a women, mothers, and partners.

Vulnerability is best understood in this study under the umbrella of the SDOH that includes socio-economic issues, literacy, and social inclusion (Potter et al., 2010). Living in poverty, being unemployed, lacking food security, lack of health care services, and other barriers prevent Aboriginal people from having the basic needs for healthy living (NWAC, 2007b). Loppie Reading and Wein (2009) agree that the SDOH affect a broad range of health vulnerabilities and ways to manage health. Aboriginal people who experience inequalities in the SDOH bear a number of health problems and lack access to health care and other resources (Loppie Reading & Wein, 2009). Research has shown that people who have a number of vulnerabilities, such as Aboriginal people, have a higher incidence of illness and are less likely to receive appropriate health care (Browne, Smye, Rodney, Tang, Mussell, & O'Neil, 2011).

In understanding the body's experience, I evoked the work of Gadamer (1996) who states "The life of the body always seems to me to be something which is experienced as a constant movement between the loss of equilibrium and the search for a new point of stability" (p. 78). The balance in life and feeling in control the women once knew was gone, at least temporarily, but likely forever they thought. The disease also took some of the fun out of life by compelling them to keep track of their blood sugar levels, administering insulin, and being monitored closely for complications as mentioned earlier in the study, thus evolving into a new way of living (Perry et al., 2010). They had to take on a new self-care regime quickly and accurately to protect the baby.

When disease affects the body, it consumes the person until either the symptoms subside and the person's body returns to the normal functioning experienced prior to the illness or the condition worsens and either the person functions the best he/she can or the person never recovers. Van Manen (1998) describes how the person's overall functioning is affected and the disease cannot be glossed over. Moreover, van Manen (1998) states "Serious illness changes everything: our sense of time and priorities, our experience of space, our felt relations with others, and our sense of self and of the body" (p. 6). Attention to time became critical because the women had to check their blood sugar and prepare special meals. The women wondered how their body was going to function on insulin. Was insulin going to make them feel better and keep them safe? Starting on insulin for some mothers made a difference immediately while it took time for others to feel like they did before they were diagnosed with GDM. Their lived space (van Manen, 1998) became one of worry and fear. The women's relations with others changed. Their relationships with their mothers, husband/partners, and relatives and community including the health care providers became closer as they sought advice and support. However, there were instances of misunderstanding and disagreement with health care providers and others, as identified in this study. They experienced their self and body as the "object-like nature" when their body did not feel in unity, but rather torn apart until they began taking insulin (van Manen, 1998, p. 6). The social support they received helped to reassure them they were going to feel better and get through the pregnancy.

As I reflected on the women's stories, it was evident that health care providers still dichotomize people and their bodies. Van Manen (1998) describes this as "dichotomizing Cartesian blindness" (p. 9). The thought of the body, mind, and spirit interconnected is not always considered. The health care providers often saw the physical ailment of GDM as the main focus. Although there has been more attention drawn to the importance of holistic care where the physical, emotional, psychological, and spiritual components of life are all intertwined (Loppie Reading & Wein, 2009; Health Council of Canada, 2011), it was clearly lacking in many of the stories the participants shared. For instance, when Kate suffered pain from a broken ankle when she was 5 months pregnant, the doctors and nurses in the small community hospital did not think of the emotional trauma she was going through at the time. They only assessed her body and then sent her home without appropriate medical care and no recommendations for follow-up.

Communal and Holistic Verses Individualism and Cartesianism

During this study, I could hear and sense the said and unsaid tensions between individualism and Cartesianism that still exists in health care today as opposed to communal and holistic thinking. It is surprising in this time of history based on the testimonies of these women in the study, that Cartesianism still underlies much of the health care providers' thoughts and subsequent actions. Therefore I provide a brief background on the above concepts to illustrate why there is difficulty in understanding the beliefs and traditions of Aboriginal people seeking health care. Aboriginal people hold a different philosophy from individualism and Cartesianism, where the body and mind are interconnected. This was evident all through their experiences of GDM.

The Cartesian view described by Rene Descartes is based on the premise that the mind and body are separate (Polifroni & Welch, 1999). This philosophy dominated the science field for many years, but in more recent years their ideas of the mind/body split has been challenged. Cassell (1982), like many others, contests the Cartesian view by saying "So long as the mind-body dichotomy is accepted, suffering is either subjective and not truly real—not within medicine's domain—or identified exclusively with bodily pain" (p. 640). Likewise, Watson's (1985) concept of the person is one of holism where the body, mind, spirit, and soul are all in one. Holism refers to viewing the individual as a “unitary whole in mutual process with the environment” (Zahourek, 2008, p. 33). According to Cowling, a unitary view of people is that they are whole and that the environment in which a person lives is not reducible. In other words everything is connected. Communal refers to connected to a community (Merriam Webster Dictionary, n.d.). Hobfoll, Schroder, Wells, and Malek (2002) suggest that communal refers to the idea that people can attain their goals by being connected with one another. Moreover Benner (1985) points out the absurdity of the Cartesian split meaning that the person’s symptoms are either subjective or objective. The enigma of this situation is that a person’s culture, history, or embodied way cannot be captured by Cartesian philosophy (Benner, 1985). Bowers, Vasquez, and Roaf (2000) associate individualism with Western thinking, opposing views of Indigenous people. Bowers et al. (2000) find this troublesome that the idea of individualism elevates individuals’ status whereby their opinion and analysis of a situation is considered the most credible source of knowledge. Likewise, Battiste (2000) believes this notion of individualism goes against Indigenous people’s beliefs. Autonomous decisions should not be made without involving other Indigenous people (Battiste, 2000; Bowers et al., 2000). Their world is determined by forces outside of which they live. Indigenous people view the world from a wider lens where situations/events that occur, happen at a wider societal level and require the input of their communities.

It was apparent through the stories of the participants and my observations in the communities that Aboriginal people see their community as a whole and their relationships with each other as interconnected. For instance, if someone is sick or dies everyone helps out with a generous community spirit. The participants are concerned not only for their immediate family but also for their extended family, friends, and the entire community. There were several examples of where they assisted their families in areas such as improving nutrition, increasing physical activity, becoming more knowledgeable about GDM and diabetes, and volunteering at the school breakfast program.

A holistic nursing perspective values the importance of seeing the patient from a broader perspective where the care of the patient takes in the physical, psychological, emotional, and spiritual dimensions of the person. I wonder how this concept can be better integrated in the health care system.

Mi'kmaq Women's Experiences Affected by SDOH

The Mi'kmaq women's experiences were affected by the SDOH in many instances such as income, employment, social support, education, discrimination, culture, self-determination, and resilience versus oppression. As is well known, their living conditions are worse than anywhere else in Canada (Office of the Auditor General of Canada, 2011). Loppie Reading and Wein (2009) identify the 1) proximal, 2) intermediate, and 3) distal determinants of health as key factors in understanding the impact of health on Aboriginal people. Proximal determinants of health pertain to the physical, emotional, mental, or spiritual aspects of health. In this study, for example, the participants were physically affected when they developed GDM and had to cope with the symptoms of this disease. This condition required changes in diet, exercise, and close monitoring of their health. It led to them feeling anxious and it became a stressor as they had to make lifestyle changes. Yet, this did not guarantee that they would not develop Type II diabetes later in life. The intermediate determinants of health refer to the community infrastructure and resources, abilities, and environmental factors that create barriers for Aboriginal people having access to health professionals (for example) who understand their culture such as dietitians, nurses, and doctors. They may lack the opportunity to hunt and fish as a result of their land being taken for urbanization and development. According to the participants, their infrastructure is lacking in both communities. Although they have resources such as a health center, school, church, gas station, a corner store, and other smaller resources, they have to travel for appointments to specialists, to grocery stores, to the Kids First Family Resource Program, and for other personal needs. The distal determinants of health have the greatest effect on their health because they are the socio-economic, historical trauma, and political areas that form the proximal and intermediate determinants of health. Examples such as the improper and discriminatory treatment of some of the participants by the health care professionals stemming back to colonialism, lack of opportunities for employment and education, and loss of Mi’kmaq language exemplify some of these barriers that affect the women in this study.

Income and employment.

The need for more specialized prenatal care when diagnosed with GDM opened the Mi’kmaq women’s eyes to seeing beyond the inequities of health care to the SDOH. Although they did not use this terminology, they discussed the barriers that prevented them from appropriate access to care. It became evident that every determinant of health such as Aboriginal status, early life, education, employment, access to food, housing, income, social safety net, social exclusion, and unemployment (NWAC, 2007b) affected one or more women in this study. Although the Canadian government put forth their pledge in 1994 for a "population health approach" (Federal, Provincial, and Territorial Advisory Committee on Population Health, 1994, p.1), they did not embrace the SDOH as being universal (NWAC, 2007b).

As mentioned earlier, income is the greatest factor in determining the quality of other SDOH such as food, housing, and other basic human needs (Mikkonen & Raphael, 2010). Several Mi'kmaq women identified low income as their greatest difficulty for maintaining good health. They lived on a low income when they were pregnant and the majority continued to live on a low income after pregnancy. According to Jane, they received \$185–\$200 every 2 weeks during pregnancy. Their limited income affected their access to transportation to appointments, their ability to buy nutritious foods, their ability to send their children to affordable daycares, and others as discussed earlier.

Although some of the women had full time employment or seasonal work, their salaries were low. This disadvantage affects them in managing their homes and all of the basic necessities of life. As Anne pointed out, she has ADI training now so she has the education that is needed to teach her community about GDM and diabetes. She wants to be employed.

Effectiveness of social support.

The study revealed that Mi’kmaq women valued social support. Support from their family, the community health nurse, the health center, the CHR, the Chief and Band Council, and health care professionals made a significant difference because they were able to cope with GDM and they had healthier outcomes than if support was inadequate. Thus their experiences with social support were affected by the SDOH.

The Mi’kmaq women deeply valued the camaraderie of getting together with family and friends for weddings, parties, visiting, and other occasions. Sharing their stories and seeking knowledge and guidance from their family helped bring them comfort and direction in life. Dobbelsteyn (2006) claims that Aboriginal people embrace the values of family, their community, and the contributions they make to the overall well-being of their culture. They maintain a balanced approach to health, to their culture, to their past history, and are connected to their Creator and to all living things around them (Dobbelsteyn, 2006). In a qualitative study by Razee et al. (2010) regarding the beliefs, attitudes, social support, barriers, and environmental concerns related to having GDM among Caucasian Australians, Arabic, and Chinese women, they report that social support from family and friends motivated the women to achieve a healthy lifestyle. Having someone to discuss their concerns with helped to lighten their burden (Razee et al.). They wanted to be a good wife/partner and take care of their children similar to the Mi’kmaq women. The majority of the women did not receive much support from partners or families who were working, leaving them feeling stressed (Razee et al., 2010). Likewise, some Mi’kmaq women wished they had more support from their partners and sometimes from other members of their families. However, in my study the majority of participants found their families and husbands/partners supportive through their experience with GDM. For instance, the family supported the women when they had to change their diets to healthier eating, accompanied them to the doctor when they had discomfort, assisted with childcare, and gave financial assistance and others. This is relevant to note because it demonstrates the Aboriginal ways of knowing where they recognize that social support encompasses more than attending to a physical need; they see the world from a holistic perspective (Battiste, 2000). For instance, if something affects a person physically, it also affects them psychologically, mentally, and spiritually which is different from other cultures where the focus may only be on the illness and not on how it affects the person holistically. Van Manen (1998) calls us to consider gestures such as explaining a situation "to resume or rebuild an unbroken relation with the body and thus with the world" (p. 6). Explaining and giving information can help lessen anxiety and promote healing (van Manen, 1998).

In Kate's situation, she relied on her mother and partner when she had a broken ankle during pregnancy as previously mentioned. They intervened and advocated for her well-being. Loretta valued the support from her boyfriend and parents when her child was sick in the hospital with idiopathic thrombocytopenia. Her boyfriend took care of one child while she stayed in the hospital with her sick baby. Her parents were also there to help out at home and the hospital as Loretta explained: "family members would be coming in [hospital], giving me a break." She was sincerely grateful for their kindness during this stressful time.

Likewise the care/support from the community health nurse was highly regarded. The community health nurse saw to all their health concerns and made sure they were assessed by family doctors or specialists as necessary. It is my sense that the community health nurses, whom the women trust, spend a good amount of individualized time with the women so perhaps a lot of their concerns were answered or addressed. Their high quality of knowledge and skill was valued.

A few of the participants remarked on the value of the CHR. Kate, for instance, described the value of the CHR's role as she stated "Our CHRs are really gonna be the avenue to helping people. I've visited a few other communities where I see the CHR is you know a very vibrant and vital person in the community." The CHR has a lot of political power in her community to make recommendations on health resources and policy changes needed to meet the needs of his/her Aboriginal community. Kate believes that there is sufficient money allocated from the federal government for health in her First Nations community but because it is not guaranteed to be used solely for health, other departments compete for a share of the money. I wonder how much of the health budget is sacrificed to give to education and other departments.

Education.

Similar to social support, the Mi'kmaq women received useful education from their family, friends, the health center, community health nurse, CHR, and others as described early in this study. However, it became quickly apparent that they longed for additional prenatal education to help them manage GDM. They also wanted ongoing education on diabetes and about staying healthy.

The women learned which foods were unhealthy on their own or through the community health nurse or other community members. Although the participants had varying degrees of knowledge about GDM and the health care system, they realized that they required health care that was individually designed to meet their needs.

The first step in understanding the need for education is to explore how Aboriginal people understand health and illness and what interventions work for them when they are ill (Reading, 2006). Fundamental to delivering prenatal education is determining how to approach where the mothers are starting from and what they hope to achieve (Smith, Edwards, Martens, & Varcoe, 2007). The potential is there for the women to use prenatal education as a way to achieve their goals of becoming healthy (Smith et al., 2007). Pregnancy can provide an opportunity for addressing more than prenatal education; it can provide a forum to learn more than women anticipated about health and other topics.

Little consideration is given to drawing on Indigenous people's knowledge to learn new ways of thinking about health (Stout, 2012). Planning interventions with the assumption that "one size fits all" will not meet the diverse needs of various Indigenous populations. For example having a gymnasium in the community where both men and women use the same facility sounds like a good idea. However, the participants pointed out that although they were grateful to have this facility, they were not comfortable exercising in the same room as men. They prefer to have their own place and space.

Aboriginal people are gradually trying to find a way forward that recognizes where they were living hundreds of year ago, flourishing and healthy. Stout (2012) suggests that there needs to be a shift in thinking about health and wellness in the Indigenous population. The effect of colonization on Indigenous people has been viewed from a homogeneous lens rather than from the perspective of diversity in Indigenous groups.

Discrimination and culture.

The RCAP (1996) does not recognize Aboriginal women as leaders or valuable members of their community. The report did not credit them as Canadian citizens which has further marginalized the women (Fiske & Browne, 2006). The problem lies not only in not giving them credit as knowledgeable women but the report focused on increasing the public's attention to the needs of Aboriginal people (Fiske & Browne, 2006). Cultural differences became the theme in the RACP report which led to the stigma of "Othering" and Aboriginal people's lifestyles were blamed for their poor health (RCAP, 2006). "By privileging cultural difference, the Commission did not name directly the relations of power and economic disparities that are recognized by social determinants of health" (Fiske & Browne, 2006, p. 96) thus narrowly conceptualizing what shapes Aboriginal people's lives and health. The notion of 'Othering' of Aboriginal people based on cultural differences creates a feeling of vulnerability (Fiske & Browne, 2006).

Some Mi'kmaq women were hesitant to seek information from health care providers because the information they gave them was inadequate, in error, or discriminatory in nature so they avoided communicating with them. For instance, the health care providers had an important role to play, but did not always give the care the women expected or were hoping for. Kate found that “there seems to be a little bit of a disconnect from the doctor, because you know they are so very busy.” Feeling rushed made them feel devalued and not important as people. The women wanted time to express their concerns and ask questions when they went to see health care providers. A similar situation of feeling devalued and the health care providers disregarding the health condition as not serious are exhibited in the following example. In a qualitative study conducted by Browne and Fiske (2001) First Nations women seeking health care in rural communities in Canada were dismissed by doctors and nurses because it was assumed that there was nothing seriously wrong with them and their symptoms were trivial. Some participants attributed the dismissal of their health concerns as being due to their Aboriginal descent (Browne & Fiske, 2001). Browne (2006) reminds us that we cannot separate the sociopolitical and historical situations that exist and the need to examine the power relations between patients and health care providers.

The mainstream health care system is rooted in a biomedical model that focuses on physical health of people (Meleis & Im, 2002). Diversity in culture and language can lead to miscommunication and inappropriate care (Browne, 2005; Browne & Fiske, 2001; Foster, 2006; Health Council of Canada, 2011; Whitty-Rogers, 2006). Blending Western and Indigenous worlds through the Two-Eyed Seeing approach as mentioned earlier in this study would be a helpful way to understand the Mi’kmaq language, culture, and traditions and restore relationships with each (Iwama et al., 2009, p. 3). This approach is not meant to blend two cultures, that is the Aboriginal and non-Aboriginal culture, but rather bring together each other's different ways of knowing to try to understand one another.

Gadow (1995) believes that nurses engage with patients in situations to help them through life's events safely. Where were nurses in the women's experiences with GDM. experience? Nurses and other health care providers need to help patients understand their conditions and help them find comfort and be content in their liveable bodies (van Manen, 1998).

Social, economic, and political factors contribute to keeping Aboriginal people living on the margins (Browne, 2007; Fiske & Browne, 2006; Gracey & King, 2009). As a result, Aboriginal women are prevented from receiving the same health care privileges/opportunities as the mainstream population (NWAC, 2007b). Aboriginal people have experienced discrimination for generations as a result of the social, cultural, political, and economic strain of colonization (Bartlett, 2004; Browne, 2006; Fiske & Browne, 2006). In addition to the burden of colonization, Mi'kmaq women in particular, like other minority women, experience marginalization as part of a hierarchical and patriarchal society. The health outcomes of being marginalized occur not only from feeling marginalized but also from the possibilities in one's environment (Hall et al., 1994). Inequalities in the SDOH such as low income, lack of employment, poor housing, and others can create conditions where diseases become prevalent (Raphael, 2004) and make people vulnerable to health problems (Hall et al., 1994). Hierarchal power from mainstream society pushes their ideas to the forefront, leaving others with having no voice. As a result, marginalized peoples' voices are not heard (Hall et al., 1994). People who are marginalized tend to be silenced by mainstream society as shown in the findings in my study. Some Mi'kmaq women did not feel the doctors or nurses listened to them and they sometimes felt misunderstood.

Hall et al. (1994) define marginalization as "the process through which persons are peripheralized on the basis of their identities, associations, experiences, and environments" (p. 25). This means that people are cast outside the so-called mainstream group in society (Hall et al., 1994). The results include situations like Mi'kmaq women experience such as having limited resources and opportunities that decrease their quality of life and inevitability lead to poorer health. For instance without knowing the needs of marginalized people, community health programs to address illness and to establish interventions will be inadequate to improve their health. People who are marginalized need to have adequate social, economic, and political resources to provide for their basic needs and to be a part of the decision-making process for their care (Hall et al., 1994). For instance there were inadequate resources for programs such as diabetic education and mental health in the participant communities. One property of marginalization is not having a voice and feeling silenced, experiences that some of the women experienced at different times during their experiences with GDM. Hierarchical power acknowledges the dominant group and encourages the language in that culture, thus devaluing other voices (Hall et al., 1994). Power, another property of marginalization, occurs when the center of the group or community exerts power over a peripheral group or reversal (Hall et al., 1994). Barbara felt powerless when she was told her baby was going to be sent to a high risk center because of his critical condition and she was not permitted to accompany him because she had only delivered the previous day. The doctors and nurses said that she was at risk of developing medical complications such as bleeding if she traveled too soon after delivery. Instead of listening to the mother’s concerns and looking for options such as transporting her by ambulance to the hospital to be with her son, the health care providers told her she could not go without much explanation, respect, or sensitivity to her concerns. Although Barbara did not listen to the health care providers and left the hospital without being discharged, the majority of participants did not always feel they could question the doctors’ and nurses’ decisions.

Providing culturally competent care is not an option as Meleis (1996) so eloquently emphasizes, but rather it needs to be the standard of care by which health care should be delivered. For instance, Kate did not feel supported when her doctor refused giving her the birth control pill when she was 17 years old, a year before she had her first baby. She felt her concerns were not acknowledged perhaps because she was young but possibly because she was Mi’kmaq. Kate did not think she was treated respectfully. Although she will never truly know, these comments still linger in her mind to this day. Therefore, developing and implementing cultural competency and culturally safe models in health care settings are needed.

Spitzer (2005) asserts that “marginalization, economic disadvantage and gender are closely related, and social exclusion engendered through low income, culture, gender, ability or geography can have deleterious health effects” (p. S85). Visible minorities, Aboriginal, immigrants, homeless people, individuals with disabilities, and others in

Canada experience marginalization. This sets up a class system where not everyone receives equitable opportunities. When structural inequities exist, racism becomes a concern. Racism as a result of structural societal problems can be considered a stressor to people with health problems (Spitzer, 2005). Racism is a method of discrimination that is enhanced by one group having power over another (McGibbon & Etowa, 2009; Price, 2010). Systematic racism refers to racism that is supported by power (McGibbon & Etowa, 2009). Discrimination occurs in multiple settings such as health care organizations, places of employment, neighbourhoods, colleges, and others. This study, my previous study on Childbirth Experiences of Mi’kmaq Women, and other research with Aboriginal peoples clearly highlight “the necessity for institutional and individual change” (McGibbon & Etowa, 2009, p. 77). This study shows some instances of discrimination, racism, and othering. I think this study on GDM helps to solidify that discrimination continues to seep in through the walls of hierarchal systems where the dominant group continues to house and control the power. If health care providers can understand how racism is connected to other societal barriers that influence health, then an antiracist framework is required. “Antiracism explores the dynamics of discriminatory practices that structure many aspects of oppressed people’s everyday lives” (McGibbon & Etowa, 2009, p. 78). It is important for health care providers to understand racism because it affects how Aboriginal people access health services. Patients are sometimes reluctant to seek health care if they do not feel properly treated. At times, they will wait until their condition is too far advanced to initiate treatment if they do not feel respected and worthy of care.

Health care providers need to recognize the barriers to health care for Aboriginal women. Health care improves when people are actively involved in their care (Barnett et al., 2002). If one has power over another and is truly committed to empowering the other, the most effective approach is to relinquish some power to that person (Zavis, 2003). Health care providers need to recognize the importance of listening to Aboriginal women's voices. Active participation in decision-making about their health care is paramount and until this happens, Aboriginal women will continue to experience marginalization.

Although there has been some work done on cultural awareness and cultural competence (CNA, CASN & ANAC, 2009), there is still a limited fundamental shift in ways that nurses and other health care providers practice. More in-depth work is needed in this area. According to Kumas-Tan, Beagan, Loppie, Macleod and Frank (2007) developing measures that address "cultural humility and/or assess actual practice" are required by health educators so they can understand and bring this information to the education and practice setting (Kumas-Tan et al., 2007). Helping nurses to expand their nursing knowledge and shift their thinking in caring for diverse populations such as Aboriginal women will go a long way in building relationships between Aboriginal and non-Aboriginal women. "Cultural traditions have their own focal practices that gather up the meanings of care and social responsibility" (Benner, Sutphen, Leonard & Day, 2010, p. 192).

McGibbon and Etowa (2009) provide a broad definition of culture as "beliefs, norms, and values" that people follow to guide their ways of living (p. 17). Culture provides community members with certain ideas and potential actions that help them see the world from their own lens (McGibbon & Etowa, 2009). With wide Canadian diversity, there is a need to provide culturally competent and culturally safe care in a way that represents the meaning of health and illness of patients and families. Meleis (1996) has defined culturally competent care to include "diversity, marginalization, and vulnerability due to culture, race, gender and sexual orientation" (p. 2) as mentioned earlier. This definition seems to be the best fit to use in ensuring Mi'kmaq women's cultural traditions, beliefs and values are upheld during pregnancy and post-partum. This definition encompasses the situation that Aboriginal women find themselves in when they become pregnant and need prenatal care. Cultural safety is defined as "the provision of quality care for people of ethnicities different than the mainstream" (McGibbon & Etowa, 2009, p. 212). Nurses are expected to try to understand how the care they provide affects patient care (Smye et al., 2006). Cultural safety helps nurses be aware of how power relations intersect with patient care (Smye et al., 2006).

Although extensive support and time will be needed, it will be beneficial to deliver educational programs on cultural competence and cultural safety to nurses and other health care providers. They need to prevent discriminatory practices and build relationships with Aboriginal people. However, I do not think that educational programs are all that is needed to change practice. This study demonstrates that nurses need to open their hearts and minds to listening to their patients, and create safe spaces.

Self-determination and resilience versus oppression.

The role of Aboriginal women must be acknowledged as they strive for self-determination (NWAC, 2007a). The NWAC (2007b) among others strongly recommends that the ‘Commission on Social Determinants of Health’ needs to explore why progress has not been made in addressing Aboriginal women’s health. Aboriginal women’s health is worse than Aboriginal men’s health illustrating that gender and race have negative consequences on their lives (NWAC, 2007b). Gender is an important determinant of health, which is a concern for Aboriginal women with GDM who already experience greater economic, social and political inequalities than Aboriginal men and mainstream society as mentioned earlier in Chapter II. Being disadvantaged, “creates unhealthy life and work experiences, continual instances of discrimination and huge gap in the health of Aboriginal women” (NWAC, 2007b, p. 5).

Although the Mi’kmaq women were vulnerable as they were exposed to physically and psychologically difficult situations, they showed resilience in coping with everyday pressures (Hall et al., 1994). Even though they had difficulty with transportation, they managed to attend their prenatal appointments. Resilience “includes not only genetic predispositions and learned abilities of persons, but also factors in their surroundings that enhance well-being” (Hall et al., 1994, p. 33). The love and support from families is likely the reason why they have the strength to manage their multiple roles. They also have wonderful support from their communities. The community cherishes their children and wants to keep them safe. **“**The concept of resilience has been a rallying emblem among Aboriginal communities and other oppressed populations because it inspires hope in the face of harsh adversity" (Tousignant & Sioui, 2009, p.45). They managed to cope with GDM despite the limited resources and sometimes support from others. The Mi'kmaq women showed incredible self-determination and resilience to carry on amidst the many trying and difficult situations they encountered in the health care system and in their community. Despite the impact from colonialism and Residential Schools and attempts to assimilate Aboriginal people (Kirmayer et al., 2011), the Mi'kmaq people are strong and continue to practice their traditions, and are trying to retain their language. Although they did not speak much about their traditions and beliefs during this study, they did emphasize the importance of family and community gatherings where everyone was included. They also valued the importance of the community health nurse and other health care providers who were kind and respectful to them.

We know that Mi'kmaq women are one of many marginalized groups who experience oppression. Oppression refers to one group having power over another (McGibbon, 2012). How do they overcome or manage to work through the "mechanisms of oppression" such as poverty associated with policies, and actions and inactions that continue to dominant their world (McGibbon, 2012, p. 24). Power in national and global organizations can do the greatest damage. Individual's physical, mental and spiritual suffering is rooted in the health care and legal system (McGibbon, 2012). It creates suffering and as a result increases inequities in people's lives. For example, denying Aboriginal people cultural competent care is an example of oppression (McGibbon & Etowa, 2009). The SDOH have been integral in making the connection between oppression and the poor health outcomes. Despite being an oppressed group, the Mi'kmaq women are becoming knowledgeable in how their health has become affected by the SDOH. They are pushing forward by raising concerns and pushing forward in their communities to address the inequities of poverty, unemployment, access to health care, social exclusion and other SDOH.

I believe as a nurse that I have an important role and responsibility to advocate for Aboriginal specific programs. Stout (2012) calls me "to be transformative for Indigenous people, the paradigm shift must focus on interventions that draw on nahi, fairness, rather than tipi, equal" (p. 12). I have learned that I must be an advocate for these women. I have read about and seen some of the benefits of Aboriginal women's programs. When programs get cut, the funding goes elsewhere and it takes that much longer to get things back in place when good programs are cancelled. When effective programs are cut, the Mi'kmaq women suffer.

The NAHO (2007b) gives a clear message that the Commission on the SDOH must connect local and international human rights mechanisms using a legal and ethical thread to address issues with national policy-makers that are meaningful and get to the root of SDOH for Aboriginal women. Having Aboriginal women who are willing to begin this work on addressing the economic and social barriers that impinge on their lives with health care providers such as nurses is critical to beginning social changes in their communities. The participants raised several areas that need to be addressed in their communities such as getting a gymnasium for women, hiring a diabetic educator, more programs to address mental health issues, hire ADI workers and others which would address GDM and diabetes in their community.

Conclusion

Engaging Mi'kmaq women in this participatory research study on GDM was a meaningful and wonderful learning experience. The women unselfishly shared their inner thoughts and experiences demonstrating their self-determination and resilience. There was a continuous thread of hope and pride in their accomplishments such as parenting skills, advocating for better health care and reviving the Mi'kmaq language. The participants valued having someone to listen to their genuine concerns and opportunities for improved health and well-being for the women, families and communities. I shall never forget their honesty and straight forward sharing.

An intricate principle of PAR is a team approach where the planning, decisions and responsibilities are shared among the participants (Meyer, 2000) and the knowledge is owned by the Aboriginal communities. The PAR principles of collaboration, democratic, equitable, improved social practice and reciprocity minimized the hierarchical nature of research and it made me aware of how important and useful this process would be in clinical practice if nurses and other health care providers were more sensitive to thinking and working in a partnership relationship. PAR is an excellent approach for nurses who are concerned about marginalized people (Varcoe, 2006). This approach helped to address the racist nature of institutions that marginalize people like Aboriginal women by forcing researchers to look at the power structures and hierarchal organization setup up in health care and give back the power to those who have been disadvantaged (Varcoe, 2006). This study provided insight to the participants in areas where previously they did not have a voice, where they were inappropriately treated, misunderstood and not valued for their knowledge. The importance of developing and maintaining a trusting and respectful relationship was continually at the forefront of my thoughts and values.

Establishing prenatal and other health promotion educational programs in Aboriginal communities with their involvement from the ground level approach is paramount to success in healthier outcomes. By focusing on the importance of social support and self-determination of Aboriginal women, nurses and other health care providers can empower their communities to focus more on participatory actions to address inequities (Richmond, Ross & Egeland, 2007). Because of the women's experiences with GDM, they were able to implement actions for themselves and their families and communities that fit with their beliefs and worked to keep themselves healthy once diagnosed with GDM. The fear of developing diabetes in the future forced them to make lifestyle changes that they may not have taken if they were not faced with GDM.

Building a respecting and caring relationship where patients feel they can trust nurses and healthcare providers is first and foremost. To mitigate the difficulties that lead to relational difficulties, nurses need to develop a heightened awareness of class, gender and the power inequities that exist in institutions today (Browne, 2007; Smye et al.,2006). Nurses need to understand how culture shapes cultural situations and the benefit and necessity of providing culturally competent and culturally safe care to patients, families and communities (Smye et al., 2006). Nurses have a social responsibility to care for their patients and bearing witness to patients in families through being present for them. As the Mi'kmaq women told me over and over that they had to trust the health care providers or they would not come back for health care.

Chapter X

Implications and Conclusion

Implications for Policy Change

Nurses play an essential role in educating, caring and supporting Aboriginal women and families during the perinatal period. According to Sullivan and Benner (2005) “in today’s ascendant business model for institutions is so strong, the professions are vital reminders that the human welfare ultimately depends upon cultivation of values such as care and responsibility…” (p. 9). There are several actions that can be mobilized as a result of this study.

Nurses need to be able to articulate “their narrative understanding of patient-family illness experiences and concerns” (Benner et al., 2010, p. 28). Nurses are regarded as one of the most trusted professions according to public opinion (Boyle, 2006). Being highly regarded places nurses in a key role to take action to improve health care. This study shows that nurses are so close to the patients, yet they need to listen more and attend differently to the women. The Mi’kmaq women want a deeper trusting relationship with nurses. Nurses need to provide the space for the relationship to solidly develop (Bergum, 2002). There is more than ever a call for nurses to become leaders and transform the health care system (CNA, 2012).

In June 2012, I attended a presentation by Michael Villeneuve, a senior nurse consultant on the National Expert Commission Report (CNA, 2012). In his address to the School of Nursing at St. Francis Xavier University, he stated “we are not inclined to call for more doctors or nurses to fix the health care system” (M. Villeneuve, personal communication, June 2012). Instead, there is a need to “prepare the providers [meaning nurses and doctors] to be better leaders to influence policy change; integrate health into all policies [in reference to government and health care settings]” (M. Villeneuve, personal communication, June 2012). According to the CNA (2012), “Registered nurses are deeply engaged in system transformation because they care about human health and about delivering responsible health care. But…it is the professional and social responsibility of nurses to take a strong leadership stand on behalf of Canadians” (p. 1). The participants and I discussed collaboratively working together to propose some changes in their community to address access to care in particular transportation and affordable child daycare. Addressing prenatal care education that meets the needs of Aboriginal women that not only encompasses GDM education but diabetes was another area the women were interested in working on. They want to improve prenatal education that will address more questions about health. For instance they want to reduce fat and carbohydrate in their diet and learn about foods to buy that are healthy and within their budget. The Mi’kmaq women want to raise awareness around the limited welfare income they receive during pregnancy.

This study highlights the need for nurses and other health care providers to be leaders to bring about positive changes in order to meet the needs of Aboriginal people. Bringing the health care providers and the Aboriginal women together to discuss GDM, diabetes, and other related topics would be beneficial. The Mi’kmaq women want to discuss the importance of building better relationships between the health care providers and their communities. Often times the women had questions but they did not feel the health care providers were listening so they did not pursue or they felt dismissed by them. The aforementioned are several areas where advocacy could help to improve access and services for Aboriginal women and families. According to Rebeil and Walker (2010), “The literature suggests that policy and service delivery strategies are required to address the complex array of social and environmental determinants that contribute to major disparities in health status and outcomes for Aboriginal people” (p. 65). Nurses have an ethical responsibility to advocate for patients in situations where their care is inappropriate and/or disrespectful and to support them by speaking up in instances where they cannot do this for themselves (CNA, 2008).

Advocacy responsibility.

Advocating for policy changes to address the health inequities associated with access to care was a high priority for the Mi’kmaq women. The PAR approach used in this study provided a forum for the women to see where they could take some proactive steps and where we as a group could work together. Koch and Kralik (2006) maintain that “The participatory action process can lead to theoretical development and action can take place at individual or collective levels” (p. 92). Raising awareness around access helped the women to see that individual strategies regardless of how little or large they were could make a difference. Many participants had already undertaken actions on their own between our meetings and/or at the time of the situation. As Koch and Kralik (2006) assert trying alternative ways to manage a situation either individually or as a group such as lobbying an organization for improving health services is a helpful participatory action process. The women thought that addressing health services which are a major SDOH would be a beginning step in making economic and social changes in their communities. There were several areas that clearly limited these women from having equitable health services which were discussed throughout the study and will be discussed in the successive sections.

The geographic location of some First Nations communities creates challenges for access to perinatal care (National Aboriginal Health Organization, 2006). Lack of transportation was identified as a problem for Mi’kmaq women because many did not have vehicles or they were not mechanically working and they had to wait to have them repaired. Without public transportation, relying on taxi services did not always work because the women had to wait for drives and sometimes they did not have good relationships with the drivers so they refrained from using the service. In addition, some Mi’kmaq women want to have their prenatal care in a community close to their partner. However, the taxi service did not cover receiving care outside their First Nations communities. It is evident that some form of public transportation is needed to accommodate their medical appointments and access to other services such as grocery stores.

Funded daycare services are critical in the Aboriginal communities. Lobbying the federal government for funded daycare programs in First Nations communities would help to ensure that women have qualified child care workers caring for their children in their absence. Daycare facilities would also help families for short and long term services during instances when mothers need health care and/or require hospitalization related to their pregnancy or other medical reasons. The women would benefit from having dependable services so they can work outside the home and know their children are well taken care of. According to Aboriginal Affairs and Northern Canada Development (2012) daycare is intended to provide spaces for children in these facilities from low income families who work or are enrolled in educational programs. Instead of increasing spaces, daycares could choose to increase the operating costs and reduce the cost to parents who are working or taking courses. Although the majority of the women had jobs or worked seasonal jobs their annual salary was not high enough to afford daycare rates. Policies around how the money is decided to be allocated for each department within First Nations communities were also identified as a major concern. One participant was concerned about the health department having to compete with education and others for their amount needed to operate in their community.

Advocating for culturally competent and culturally safe care for First Nations women is needed in non-Aboriginal health care settings. In order for nurses and other health care providers to begin to understand Aboriginal women’s and their families’ beliefs about health, it is necessary to learn about what constitutes culturally competent and culturally safe care. Culturally competent content must be integrated in local, provincial and national health policies in Canada. Developing this care requires a collaborative effort between the Mi’kmaq and the non-Aboriginal health care providers to determine the guiding principles and core competences and an appropriate way to begin these conversations.

The Midwifery Legislation in Nova Scotia maybe helpful in assisting with developing culturally competent and culturally safe care. According to the NAHO (2004) “Aboriginal midwifery has the goal of providing safe and culturally appropriate birthing” (p. 9). Since midwives generally spend more time with women and families during the course of the prenatal, intrapartum and postpartum period than other health care providers, they may be able to help other health care groups in Nova Scotia with establishing culturally safe programs. Although the Mi’kmaq women did not identify this service as a priority, they acknowledged that non-Aboriginal midwives came to one community once a month to do assessments on low-risk pregnant women. This arrangement meant that the Mi’kmaq women who were low risk did not have to travel to the hospital outside their community to be seen by midwives. The mother and midwife had the opportunity to establish a trusting relationship before going to the hospital to have her baby. However, in instances where the mother was assessed as being high risk, she was cared for by an obstetrician. The Midwifery Regulatory Council of Nova Scotia regulates midwifery care in Nova Scotia (Nova Scotia Department of Health and Wellness, 2011). Midwives provide health care during the normal course of pregnancy, labour and the post-partum period. If complications arise, the care is transferred to physicians specialized in perinatal care. Midwifery care has been successful in northern Canada as well as Ontario and the western provinces.

Midwifery services were approved in November 2009 in Nova Scotia with a total of seven full time midwifery positions. There are three allocated to Isaac Walton Killam Hospital (IWK) and two each to South Shore District Health Authority (SSDHA) and

Guysborough/ Antigonish Strait Health Authority (GASHA) (Nova Scotia Department of Health and Wellness, 2011). There is a plan to expand the services to other districts in Nova Scotia by 2017 (Nova Scotia Department of Health and Wellness, 2011). The Nova Scotia Department of Health and Wellness does not mention anything about the Aboriginal population nor does it refer to other populations in the report. It is noteworthy that women in Nova Scotia can hire private midwives to have homebirths if they so choose. Since some Mi'kmaq women expressed interest in have midwives providing prenatal care, I think it may be an opportune time to develop collaborate partnerships with First Nations communities, nurse practitioners, midwives, nurses in clinical practice, nurse educators, physicians, diabetic educators and other stakeholders to further explore this topic.

Since the two modifiable risk factors for Type II diabetes are physical activity and obesity, primary prevention strategies such as increasing physical activity, healthy eating practices, and maintaining healthy body weight are needed (Health Canada, 2000; PHAC, 2011). Dietitians need to be located in First Nations communities where the location is more accessible and the programs delivered in an environment where Aboriginal people feel welcome and comfortable. Additionally, exercise facilities needed to be constructed to provide a place for these women and families to partake in physical activities. Mi'kmaq women want their private space to exercise away from men. Having a facility for women or constructing a women's room separate from the men's gym in the same building may be more economical and a workable solution. The women want privacy when they engage in this activity.

Reorientation of health services, one of the five major strategies for health promotion strategies (McMurray, 2007) requires that models of care are conducive to building and enhancing community capacity through focusing on developing leadership and competence at the local level (Fownes & Robinson Vollman, 2008). Women-centered approaches similar to primary health care services should be developed in partnership with the health care providers and the women in the community (McMurray, 2007). I could feel the energy in the room at the talking circles when the women discussed some realistic actions that they could advocate for. I listened as they talked about working with the health center as they found the health director very helpful and supportive. Barnett et al. (2002) believe that women-centered care does not support top-down decisions by professionals but instead the authors want women as full partners in health care decisions. Mi'kmaq participants strongly wanted to be part of decisions such as daycare issues, funding levels for women not working, transportation issues and educational sessions offered at the health center. During the talking circles, I observed how they spoke confidently about some strategies for changes in their communities. They wanted to be part of the decision-making process rather than have someone else institute changes that may not address their concerns.

Advocating for more Aboriginal people to be educated would help in fostering healthier societies (Richmond, 2007). Some of the participants remarked on the benefits of CHRs as wonderful resources in their communities. Aboriginal communities need stable support and CHRs can provide that type of support by the nature of the relationship they generally have with the community. Likewise, they need other types of social support such as ADI workers that are specifically trained to educate women on GDM. According to Health Canada (2011), ADIs' role is to work on primary prevention, screening and treatment of people with diabetes as a partnership with First Nations communities, Tribal councils and government. The CHR's and the ADI's both know the social and economic issues in Aboriginal communities and have the connections to the communities to bring about change in collaboration with the Health Center and the Chief and Band Council.

Canada's health care services have failed to provide gender-sensitive inclusive health care programs and policies to Aboriginal women (NWAC, 2007b). There is however a gender-based analysis (GBA)[9] document on HIV/AIDS with recommendations including a culture and gender approach in Nova Scotia and consistent with the global world (Nova Scotia Advisory Council on the Status of Women, 2005). Having these guidelines helps the populations living with HIV/AIDS receive care that is based on gender, cultural differences and programs that meet their specific needs (Nova Scotia Advisory Council on the Status of Women, 2005). By using a GBA approach, the program identifies areas such as who is the most vulnerable to HIV, identifies and allocates sufficient funding sources, HIV/AIDS programs are more research focused because of using a population health approach, develop a research agenda as part of a national and global similar document explaining that gender matters when it comes to GDM and diabetes would help to raise awareness that this condition occurs in women.

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[9] GBA is "an analytical tool that systematically integrates a gender perspective into the development of policies, programs and legislation, as well as planning and interaction with, the health care system" (Health Canada, 2006, p. 1).

When women develop this condition it increases their chances significantly of developing diabetes (Canadian Diabetes Association, 2008). Establishing a similar GBA Report on diabetes would be helpful to address GDM and diabetes in Aboriginal people and to identify similar recommendations as put forth by the Nova Scotia Advisory Council on the Status of Women (2005). Having a similar program endorsed by the federal and provincial government would help provide additional funding for GDM, address inequality and power imbalances between men and women in Aboriginal communities.

Advocating for building knowledge around Mi'kmaq culture for health care providers would help to convey to Aboriginal women and families appreciation of the richness of their Indigenous knowledge and languages, worldviews, teachings, and experiences (Battiste, 2000). Sharing Indigenous knowledge could also provide a venue for developing insight into traditional food practices. Organizing activities where guest speakers knowledgeable in Aboriginal culture if possible are invited to conduct health education sessions and health promotion activities on such as healthy eating, physical activity and obesity are other strategies where Aboriginal women learn and exchange information about healthy lifestyles among themselves and with health care providers. Discussion on modifiable risk factors for GDM such as physical activity and dietary factors and avoidance of lifestyle factors that adversely influence insulin resistance, such as smoking and certain drugs (Dornhorst & Rossi, 1998) could be held. This exchange of information is also referred to as a back and forth conversation (Battiste, 2000; Bergum, 1999, 2002). Using health education sessions to develop collaborative approaches to reduce risk to health through clinical care, education and research would be helpful. A collaborative approach using a health promotion perspective could be organized by Aboriginal women and other community members as well as non-Aboriginal health care providers. Strategies to promote healthy eating, exercise and access to health services that address mental health issues as well as better health care for women with GDM and people with diabetes could be developed. As Koch and Kralik (2006) note, we are all involved in "life-long learning" and our role as health care providers is to support people to learn (p. 93). The women discussed ways to educate other people in their community on GDM and diabetes. Many recommended having workshops in the evening. A number of Aboriginal people cannot attend during the day if they work or have other commitments.

Advocating around increasing knowledge about alcohol and drug abuse in their community was raised. The Mi'kmaq women hoped that more education on substance abuse could benefit their community. Having someone hired in the community to address drugs and alcohol problems is a beginning step.

In addition to substance abuse, suicide in young Mi'kmaq people was identified as a serious concern by one participant. Addressing the concerns around suicide with the Chief and Band Council was recommended. Educational sessions on suicide prevention are sadly lacking and it is a topic that should be included in prenatal education according to Annette. Annette explained: that "suicides that are clustered in a family that are generational and how do you break that". Although there are programs beginning in her community, she says that more strategies are needed to address suicide. Since Aboriginal people embrace a holistic perspective on life (Battiste, 2000; Hunter et al., 2006; Loppie

Reading & Wein, 2009; NAHO, 2003; Reading, 2006), education needs to be considered in a broader perspective. Thus, nurses, physicians and other health care providers need to be aware that prenatal education can be as broad as necessary to help Aboriginal people get the most from this learning experience. Further discussion on how to include such a sensitive and important topic needs to be further explored with the health director, community health nurse and Chief and Band Council. Asking Aboriginal mothers which areas of health they want to discuss in addition to the standard prenatal topics such as nutrition, stages of pregnancy, labor and care of the baby would be helpful. Establishing a participatory approach where there is sharing of information helps individuals feel empowered and everyone learns from the knowledge exchange (Koch & Kralik, 2006). Developing treatment protocols and education programs need to include the social and economic situations and the cultural aspects of Aboriginal people (Reading, 2006). There must be broad community input from Aboriginal people, governments, health care providers, policy makers, and researchers, and recommendations put forward as part of the study (Reading, 2006).

Too often the mainstream health care system develops health promotion strategies and treatment and education programs without consultation with Aboriginal people (Bartlett, 2005). Little thought is put into understanding poverty and the conditions that are associated with it (Bartlett, 2005). Bartlett (2005) who conducted research in this area on the needs of Aboriginal women had some inspiring thoughts around the use of an Aboriginal Life Promoting Framework (ALPF). Bartlett’s (2005) framework was developed in 1994 for the purpose of gaining a better understanding of Métis women’s health in Manitoba. Bartlett (2005) developed the framework using the medicine wheels comprised of "determinants of life" with the overlying message centered on holism (p. S22). The results of this study revealed that Métis women have incredible strength in emotional, spiritual and mental health and these strengths may be applied to health promotions programs for Aboriginal women using the ALPF model. I wonder if this model might be relevant to the lives and contexts of the participants. Also, I wonder if it would it be worthwhile to explore if this could be implemented.

It became evident that some health care providers at times assume they know what type of education Aboriginal clients need. In a recent literature review, there is paucity in research on what Aboriginal women think would meet their educational needs on GDM and other prenatal health conditions? From the literature to date and my experiences with Aboriginal women, I think that it would be crucial to involve Aboriginal women in helping to develop culturally appropriate prenatal education programs for their communities.

Most participants were frustrated with the lack of concern and progress to date on equitable health care but were determined not to give up hope. The women wanted the federal government to put more money into restoring the Mi'kmaq language in schools, increasing welfare allowances, improve access to care such as transportation, affordable day cares, and increasing opportunities for employment. Furthermore, women wanted to increase resources in the community such as dietitians, programs for mental health, assistance with developing community gardens and others. Also, they know that when the money is transferred from the federal government, many decisions are made by the

Chief and Band Council. Some Mi'kmaq women thought that this governing body needs to further address the inequities as mentioned.

Registered nurses have a responsibility to establish professional and caring relationships with patients and to advocate for them, their families and communities (CRNNS, 2012). From speaking with the participants, they are ready to work with non-Aboriginal health care providers such as nurses to help them create healthier communities.

Implications for Education

Over the past number of years, Canada has grown as a multicultural society with an increase in immigrants and the growing Aboriginal population, making some changes and or raising awareness around changing the nursing curriculum to include cultural diversity, culturally competent and culturally safe care important (Astle & Barton, 2010). The ANAC, CASN and CNA (2009) have developed three documents including core competencies that will help educators develop a cultural competence framework in Nursing Education. Also, emphasis needs to continue to be placed on recruiting and retaining Aboriginal students in educational programs particularly in health care. As well, education programs in nursing must include threads of cultural safety and cultural competency pulled through each year of the program as students take on more difficult clinical areas of practice. Along with making curriculum more inclusive, Aboriginal students can bring their own lived experiences to the classroom where non-Aboriginal students and faculty and staff can have some rich discussions and learn about each other's cultures. For instance, some Mi’kmaq women preferred to have a Mi’kmaq nurse provide educational sessions in their health center. Anne for example said that her community would benefit from her knowledge as an ADI worker because she comes from the same culture. Although she is not a nurse, she is a Mi’kmaq woman and knows her community well, so she thinks they would be open to learning about diabetes from her.

Educators need to know that Aboriginal people want to learn more about their health. They find workshops a helpful way of learning. The Mi’kmaq women want more workshops on GDM and diabetes in their community. However, the workshops have to be scheduled at a time that is convenient for learning. Having educational sessions during midday with lunch provided works well for some while evening sessions work well for those working during the day. On a number of occasions the women said that they found ‘Face Book’ a good social media to keep current with the events happening in their community and elsewhere. During one of the talking circles, one of the staff at the health center sent out a reminder message about the gathering by posting a message on Face Book. As a result, a couple of additional women came, who likely would not have known without instant messaging. I wonder how much of a role social media plays in education.

This study illustrates that Aboriginal women value different sources of education. While some women learned from family and friends about GDM, others appreciated the CHRs and ADI workers. They also look for guidance from the health directors, doctors, nurses, dietitians and other people who have expertise in diabetes and other health conditions about healthy foods to eat, regulating blood sugar, taking insulin including adjusting insulin when they go to special events such as birthday parties, ways to prevent diabetes and others. They were receptive to receiving information and social support to improve their health from whoever had the knowledge and experience in the topic. This is an important finding for education because educators do not have to be university prepared to be the best educators/teachers, nor do they have to be from Aboriginal descent. Interprofessional and intraprofessional collaboration where different professionals and non-professionals play a role in educating Mi'kmaq women seemed to be what the women recognized as the best resources for learning. Appreciating that everyone brings a special gift is not surprising as Aboriginal people hold a special place for people who are sincere, genuinely caring, and respectful and provide social support to them (Browne, 1995; Browne, 2005; Browne, 2007; Browne et al. 2011; NWAC, 2007c).

Prenatal education is intended to help women understand their health and their babies' health during pregnancy, as well as to prevent or cope with prenatal complications (Reproductive Care Program, 2003) and prepare for parenthood. The Mi'kmaq women enjoyed the prenatal classes because they learned about their health, what foods to eat and foods to avoid, importance of physical activity and others. The community health nurses were knowledgeable in these topics and had a welcoming and informal group approach, so the women enjoyed attending the classes. Some women enjoyed the social gathering just as much as the educational session itself because often that is where the traditional knowledge and values are passed on.

Health care providers, in particular non-Aboriginal people need to be aware of how Aboriginal people view their health and experience illness (Reading, 2006). Their plan of care needs to be culturally sensitive and appropriate to their Aboriginal patients and families. According to the Health Council of Canada (2011), a number of Aboriginal women emphasized "that good-quality health care for expectant mothers and young children is not just prenatal care, delivery, postnatal care and checkups; it involves looking at the woman's life as a whole" (p. 5). They do not want to only discuss about having a baby but rather the dialogue must go further into exploring the women's mental status, relationships at home and other concerns that keeps them balanced and in harmony with life (Health Council of Canada, 2011). Similarly, the Mi'kmaq women wanted to discuss topics such as how people were doing in their community, talk about children and others. Keeping the conversations around what the women want to discuss was highly valued.

Implications for Clinical Practice

The knowledge gained from conducting this study revealed that Aboriginal women described their experiences with GDM from a holistic perspective and not solely from a physiologic viewpoint. The disease took hold of their bodies and instilled overwhelming fear that they will develop diabetes later in life. Knowing the fear that they endured, health care professionals need to acknowledge the complexity of GDM and learn how Aboriginal women feel when they are diagnosed with this condition. Developing culturally safe approaches and educational materials that addresses strategies to cope with GDM in a culturally safe manner is only the start to working with Aboriginal people to “access and safely move through health care systems and encounters with care providers” (ANAC, CASN & CNA, 2009, p. 3). Understanding the context of race and power within health care systems and how this creates inequities for Aboriginal women receiving care for GDM must be realized as evidenced by the incidences of Mi’kmaq women feeling discriminated against and feeling misunderstood.

Advocating for improving the family-centered care approach would help to address the way Aboriginal women are taught and cared for when they are diagnosed with GDM. Health care providers such as nurses view the health condition, GDM, as a series of varying episodes where the women may for example need adjustments in the nutritional and or insulin requirements, closer monitoring of their babies growth in utero or emotional support to cope with the changes in their life style during pregnancy. In a family-centered care approach “the emphasis is on defining and assessing the context in which the health occurs” (Locsin, 2003, p. 9). The approach would focus on assessing Aboriginal women’s educational, relational and personal needs and those of the family (Locsin, 2003). This holistic approach parallels First Nations traditional beliefs about health. Aboriginal women play a pivotal role in developing healthy communities whether it is caring for the families, maintaining cultural traditions, or taking on leadership roles, despite the current health outcomes (Stout, 2005). They view health from a holistic perspective, and therefore culture and social elements are central to the health of communities (Stout, 1996; Baker, 1998). When the participants are physically ill, it affects their entire wellbeing. Therefore, when the Mi’kmaq women did not have the energy to take care of their families prior to being diagnosed with GDM, it affected their physical, psychological emotional and spiritual health. Some women described feeling emotional, tired, fearful, depressed and frustrated because they initially did not know what was wrong with them and many found it hard to adjust their diets and taking insulin. It was a real life altering experience.

Health professionals working outside of Aboriginal communities need to know how invaluable community health nurses are to provide social support to women in their communities. Their approach is participatory in nature, a contrast from the traditional hierarchal nature of the health care system in Canada. They are highly respected by Aboriginal people through their participatory approach to learning where there are back and forth discussions between Aboriginal women and themselves. Because of their strong and respected relationships with the women, one Mi’kmaq community recommended that their role be expanded because the women believe that the community would use them as resources more than bringing in professionals from the outside (Richmond, 2007).

Some Mi’kmaq women spoke about the importance of setting up support groups so women can support each other during their pregnancy with GDM. Nurses working in the acute care settings could work with community health nurses in First Nations communities to help create culturally sensitive support groups where the women have an opportunity to share their concerns and learn from each other.

Nurses are in a unique position to help validate women’s concerns about GDM which helps to empower them and helps to gain more insight into their situation.

Encouraging women to share their stories, thus honoring Aboriginal ways of knowing, is paramount. Using a respectful and caring approach can build a trusting relationship and in turn can help Mi'kmaq focus more on setting realistic goals for themselves, similar to the participants in Evan's (2003) study.

Although there continues to be discussion and an agreement that providing culturally competent and culturally safe health care are needed, it still has not been given high priority (ANAC, CASN & CNA, 2009; Browne, 2005; Smye et al., 2006). According to the responses from some of the participants, they felt disrespected and in some instances received substandard perinatal care. Understanding the meaning of cultural competence and cultural safety and how it should be practiced is the responsibility of health care professionals such as the nursing regulatory groups, professional nursing and other groups, universities, governments and others (Astle & Barton, 2010). There are a number of cultural competent models in the literature such as 1) Leininger's Culture Care Theory and Sunrise Model, 2) Giger and Davidhizar Transcultural Assessment Model and 3) Campinha-Bacote Cultural Competence (Astle & Barton, 2010; ANAC, CASN & CNA, 2009) 4) Purnell Model for Cultural Competence (Purnell, 2005) that could be adopted in non-Aboriginal health care settings. Although I agree a cultural competent model is needed, I do not necessarily think that the above models are the absolute answer. They could provide a beginning dialogue, but I think the most important approach is to engage Aboriginal women in this dialogue as they can share their experiences in the context in which they live. The Mi'kmaq women need to be directly involved with determining and developing a culturally competent and culturally safe model that would work for their communities. Awareness around the importance of ethical and relational space, a respectful relationship, and reciprocity between the Mi’kmaq women and the health care providers is key (Kirkness & Barnhardt, 1991). Setting up a cultural competence model in health care settings with input from Mi’kmaq women and other community members including Elders would be a beginning point to improve Aboriginal people’s experience in health care settings. Once an appropriate cultural competent model is established, maintaining safety by assessing nurses and other health care providers on a regular basis to ensure they are knowledgeable and current to continue providing safe care to patients is needed (Omeri, 2006).

Communication is an important component of conveying messages in health care. Language differences are likely the greatest barrier to providing culturally sensitive health care (Spector, 2004). Aboriginal people’s epistemology is based on oral stories passed on through generations (Battiste, 2000; McKeough et al., 2008). Knowledgeable interpreters not only translate the language but also ensure that nonverbal messages are well understood (Astle & Barton, 2010). Helping Aboriginal women learn to be comfortable in communicating with non-Aboriginal health care providers and vice versa is essential. This study highlights the need for non-Aboriginal providers to communicate with Mi’kmaq women in a sensitive, respectful and non-judgmental manner

Social exclusion created hardship for the Mi’kmaq women. Some mothers did not think they received appropriate health care such as when they did not think anyone was listening, when they felt ignored, when they received inappropriate medical treatment among others, which left them feeling discriminated against and created feelings of marginalization. Learning more about the magnitude of how the SDOH affect Aboriginal women and families may assist nurses and other health care providers to understand their lived experiences and how they can assist Aboriginal women and families to find appropriate resources that can improve their health.

Implications for Research

Although the participants in this study were impacted by all the social determinants of health, further research is needed to determine how in particular poverty, food security, employment and social inclusion impacts on their Aboriginal communities' health. How do Aboriginal communities bring their issues to the level of government and policy makers to help bring more meaningful changes in their communities, as well as to help reduce the incidence of GDM and diabetes?

Further research is needed to explore which health promotion strategies would be effective in helping Aboriginal women and families design a healthy lifestyle program following their experience with GDM to prevent Type II diabetes. There is a paucity of research around how successful the interventions on changing eating habits and physical exercise during postpartum and months and years following their experience with GDM.

Some women identified the CHR and the ADI workers as being helpful to give advice and support to women with GDM as well as other health problems. Exploring the value of having these roles in Mi'kmaq communities could be a future research study. Also, it would be helpful to ask the Mi'kmaq women about what they think would be ways that non-Aboriginal professionals could help them during their experience with GDM in areas such as understanding the Mi’kmaq language, communication, prenatal resources and others. As Kumas-Tan et al. reports (2007) it is not enough to say that cultural competence is reached when health care providers attain knowledge and are aware of the ‘Other’. They must also be trained to identify and understand when certain actions are discriminatory or when acting results in people feeling discriminated and marginalized. A lack of culturally competent knowledge and cultural safety was evident in this study. Increasing individual’s consciousness of cultural diversity increases the chances that health care providers will provide culturally competent care resulting in improved health care (Purnell, 2005). A future research project could be to do an intervention study with some of the Mi’kmaq participants and other Aboriginal people as well as some non-Aboriginal health care providers to help health care providers understand the positive impact of non-discriminatory practices on Aboriginal women's health.

Another area for research could be identifying the prenatal needs of young pregnant Mi’kmaq mothers. The prenatal education is set up for all ages and does not specifically address the needs of teenage mothers. They may have complications but would not necessarily seek prenatal care.

Further research is needed to establish effective methods to evaluate cultural competence and cultural safety in clinical practice. Kumas-Tanis et al., (2007) found that despite the number of culturally competent models of care available, there are no valid methods for examining competent care across diverse social differences. If the measures are incomplete, how will health providers know if they are providing culturally competent care from the perspective of the patients and families' needs and expectations? Being knowledgeable about every culture is not possible, but having a basic understanding of the level of competence and being sensitive to the population you are caring for is expected (Willis, 1999).

Based on my reflections of this study, a number of future research questions came to mind. They include 1) How do we begin the conversation around developing culturally competent and culturally safe models in non-Aboriginal health setting? 2) Do non-Aboriginal health care providers understand the impact of the SDOH on Aboriginal women's and communities health? 3) What contributions do CHR's make to Aboriginal communities? and 4) Would Aboriginal midwifery make a difference in helping Mi'kmaq women have a better experience in pregnancy with GDM?

Conclusion

The Mi'kmaq women and I believe we have begun some important conversations about improving health and social practices in their communities as the research was coming to an end. Learning about their lived experiences from their perspective was a beginning step. It has given us further insight into health resources and health disparities from the Aboriginal women's perspective. They are receptive to getting together to continue to follow up on actions identified in the study and to build collaborative relationships. The Mi'kmaq women enjoyed exploring ways to improve their health and the health of their family and communities. As we discussed some of the initiatives they have undertaken either at the beginning of the study or as we ended the study helped them to feel proud of their endeavours and their actions have become a motivating factor for them in the future. Inviting some Mi'kmaq women to become members on maternal/child committees may help to give them a chance to share their knowledge with non-Aboriginal health care providers such as doctors and nurses, which is a start as we build partnerships between Aboriginal communities and health care settings.

My Final Reflections

Returning to Kincheloe (2006) and his notion of a critical ontology, I have worked to stay close to the women's words and to their decisions and hopes and dreams. Working with the 'Two- Eyed Seeing' umbrella encompassing Indigenous methodologies, PAR and critical hermeneutics enabled me to see how working with these knowledge systems and methodological approaches were both enlightening and cumbersome. PAR assisted with the process of speaking to the women about the research; what I wanted to find out and the tools I brought with me to do this. The women in turn discussed what they were willing and also able to do to participate. Being grounded in the Indigenous approaches of Battiste (2000); Loppie (2007); Marshall (2007, 2009); and Wilson (2001) assisted me in my role as a non-Indigenous researcher yet they also gave me the ability to undertake respectful and collaborative research. I often found myself imparting education, teachings, as something came up the women wanted to know. This was received well and the women were generous to me as well, sharing their experiences. In working with the data, critical hermeneutics as described by van Manen (1997) allowed me to bring to view, a different way of knowledge production most importantly as a way to understand and generate actions based on the lived experiences of the women.

I have been especially struck throughout this work with the notion of sacrum as introduced in the methodology chapter. Sacrum refers to the bone at the base of the spine and is of the same root as sacred. Sacrum or sacral is also related to the earth, often through what remains of an animal after a sacrifice (Skeat, 1963). Skeat (1963) traces the word sacrum from the root sacrer, meaning to consecrate, to make holy.

If we take the etymological meanings of the word as related to this work, it could be said that the women in articulating both difficult and positive past experiences of health care living with GDM and low social determinants of health are in the process of rooting themselves in a healing mode. It would be to say that through this work and other life events of course, they were trying to render their experiences sacred as a metaphor for what was experienced and what was learned through their participation in the research methods here. But most importantly, what needs to be done from their point of view is to make a turn, a turn to taking action now to address these things, to render them better for the women and families to come behind them as they often stated through the time of the study.

The other word that kept lingering in my mind is the lungs. They are a large organ that occupies most of the space in a person’s chest. The etymological meaning of this word is the light organ not heavy, agile (Harper, 2001-2012). The lungs took in oxygen to keep the mother and baby alive and healthy. As the heart pumped blood, it provided nourishment to all. The lungs represented the women's experiences as they breathed and shared breath together as they took actions to improve their lives.

While the document is perhaps too long, it was difficult to shift and shorten the women's stories given the 'Two -Eyed Seeing Approach'. I was committed to showing the action as it emerged in the PAR process, the data analysis, and subsequent documentation of this. As Kincheloe (2006) points out, "the line between knowledge production and being is blurred, as the epistemological and the ontological converge around questions of identity" (para, 3). Here, questions of ethics in action, morality of health care professionals and safe care, political events of the past and present including situated ones like the Chief and Band Council and its approachability, emotion from being ill yet also bringing a new life into the world poorly understood in the GDM discourse. And just plain gut feelings as Kincheloe (2006) writes, come together in a narrative, a "framework of principles with which we can negotiate" (Kincheloe, 2003, p. 49). Kincheloe (2006) admonishes us to respect difference and situatedness and to focus on better modes of listening and respecting diverse viewpoints. This work has been my attempt to respect diversity and different ways of listening to the women's lived experiences.

Bergum (1994) writes that times of multiple doubt, times of not knowing what right action is, need to be anchored in relation, relational space, and context. I shall never forget these women and hope to find research funding to work alongside the Mi'kmaq women to help them undertake their actions, as well as address additional research questions they have on health programming and policy outcomes. I am committed to continuing this work.

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Appendix A

Information Sheet (Readability level 7.9)

Study Title: Exploring Mi'kmaq Women's Experiences With Gestational Diabetes Mellitus.

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(780) 492-6412
E-mail: brenda.cameron@ualberta.ca

Student's Co-Supervisor:
Dr. Vera Caine, RN, PhD
Faculty of Nursing
University of Alberta
3rd Floor Clinical Sciences Building
Edmonton, Alberta
T6G 2G3 Canada
(780) 248-1974
E-mail: vera.caine@ualberta.ca

Background: I invite you to take part in a research study titled: Exploring Mi'kmaq Women's Experiences with Gestational Diabetes Mellitus (GDM). This health condition is a form of diabetes that occurs when a woman is pregnant. This can lead to problems prior to having your baby for you and the baby and also after the baby is born. Your doctor or nurse will check each woman for this while she is pregnant. Some extra health care is required by other doctors and nurses.

Purpose: I would like to explore with Mi'kmaq women who have or had GDM their stories during and after being pregnant. We know very little about how this form of diabetes affects women, families and communities. I also hope that we can look at likely actions we can take to address some of the problems.

Procedures**:** You may take part in this study if you are a Mi'kmaq woman, 18 years or older, living in a Mi'kmaq community and have lived with GDM.

Your being in the study may involve:

1) I hope that we can meet three to four times to talk alone or in a talking circle. We will meet at a place and time that is best for you.
2) You may choose to verbally consent instead of giving a written consent.
3) I would like to audio-tape our talk. You may ask to have the tape recorder turned off at any time during the talks. They will last between one to two hours and it is up to us to decide when to stop.
4) You will have a chance to take part in a talking circle, to share your story with others and to see what possible actions can be taken. It is your choice if you want to take part.
5) The audio-taped talks will be typed according to what you said, which I will share with you and we can then talk about them again. It is OK if you do not want the talks to be tape recorded.
6) If you like, a Mi'kmaq interpreter will be present during our talks.
7) A copy of this study will be given to you.

Possible Benefits**:** This study may help you gain further insight into your story when you were pregnant with GDM. Your taking part in this research may help other Mi'kmaq women by adding knowledge about this form of diabetes. Coming up with some actions will also help the health center and other health care groups to help find better ways to provide health care.

Risks: There are no known risks to taking part in this study. If you do not feel at ease talking about your story, you can refuse to answer any questions or withdraw from the study anytime. Anything that is disclosed with me that suggests child abuse, I must report. If any feelings of distress or issues arise or problems occur, you can contact Andrea Currie at (902) 756-2139 or St. Martha's Hospital at (902) 863-2830 for help in your area. I will stay with you until this contact person comes to you.

Privacy: Your name will be kept private at all times and it will not be conveyed to anyone. You can choose a false name, rather than your real name when I report any findings from this study. No data that could single you out, your family, friends or the health center will be provided. Anything discussed with me or my supervisors for the purpose of this research will not be disclosed. Everything will be kept private, except when codes of ethics or the law requires that the data is reported. Your name will not be on any records. The transcriber and or interpreter will sign a privacy agreement to ensure that they keep the talks and data private. All data obtained during the study (documents, audio-tapes, field notes) will not name you. During the study, this data will be kept in a secure place in my home. You will be given a chance to read the tape-recorded notes and listen to the audio-tapes at any time. After the study is complete, you will be asked about storing, keeping and or disposing of the data. Information you provide is owned by you and you have the right to this information. Therefore, you have the right to decide what should be done with your data. The norm is that data is kept for at least five years after the study has been done.

Co-ownership of data: Once I have looked at the data, I will invite you to listen to the findings of the study. I will also invite you and other Mi'kmaq people from your area to a meeting to discuss the findings and to provide some likely actions. At the very end of this study, you will receive a copy of the final results.

Future use of data: I will present findings from this study at conferences. I may also publish some of the findings. Your name will not be named in any report.

Freedom to Withdraw: You are free to withdraw from the research study at any time, and your health care will not be affected in any way.

Gift for Taking Part**:** You will be given $20.00 for each visit to cover costs such as childcare and travel, as well as your time.

If you have concerns about your rights in the study, you may contact the Human Research Ethics Board at 780-492-0302. Collect calls will be accepted. This office has no affiliation with the persons doing the study. You can also contact my supervisors, Dr. Brenda Cameron or Dr. Vera Caine, who are listed at the front of this letter. Do you have any questions?

Please contact any of the individuals identified above if you have any questions or concerns:

If you agree to take part in this study, please sign the consent form attached to this letter.
Initials: Participant _______ Interviewer _______

Investigators must provide a phone number which can access an investigator or co-investigator 24 hours per day.

Appendix B

Statement of Participation in the Proposed Study

Thesis Title: Exploring Mi'kmaq Women's Experiences With Gestational Diabetes Mellitus

Researcher: Joanne Whitty-Rogers

If you wish to participate in this study, or talk further, please complete and sign this form.

My name is ________________________________

I can be contacted at

Address____

Phone Number____

If you do not have a phone, please indicate how I may reach you.

Appendix C

Participant Consent Form

Part 1 (to be completed by the Principal Investigator):

Title of Project: Exploring Mi’kmaq Women’s Experiences With Gestational Diabetes Mellitus

Student Researcher: Joanne Whitty-Rogers Phone Number(s): (902) 867-3629 or (902) 863-6797

Student’s Co-Supervisors(s): Dr. Brenda Cameron Phone Number(s): (780) 492-6412
Dr. Vera Caine Phone Number (780) 248-1974

Part 2 (to be completed by the research subject):

	Yes	No
Do you understand that you have been asked to be in a research study?	☐	☐
Have you read and received a copy of the attached Information Sheet?	☐	☐
Do you understand the benefits and risks involved in taking part in this research study?	☐	☐
Have you had an opportunity to ask questions and discuss this study?	☐	☐
Do you understand that you are free to withdraw from the study at any time, without having to give a reason and without affecting your future medical care?	☐	☐
Has the issue of confidentiality been explained to you?	☐	☐
Do you understand who will have access to the information you provide?	☐	☐
In consultation with you, do you agree that I may present the findings from this study in conferences and publish some of the findings?	☐	☐
Do you want the investigator(s) to inform your family doctor that you are participating in this research study? If so, give his/her name ___________________	☐	☐

Who explained this study to you?
____

I agree to take part in this study: YES ☐ NO ☐

Signature of Research Participant
____

(Printed Name)
____

Date:______________________________

Signature of Investigator or Designee
____

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

Signature of Investigator or Designee ________________________________
Date __________

THE INFORMATION SHEET MUST BE ATTACHED TO THIS CONSENT FORM AND A COPY GIVEN TO THE RESEARCH SUBJECT

Appendix D

Information Sheet (Readability level 7.9)

(Talking Circle)

Study Title: Exploring Mi'kmaq Women's Experiences With Gestational Diabetes Mellitus.

Student Researcher:
Joanne Whitty-Rogers, RN, MN
PhD Student, University of Alberta
4 Carter Crescent, Antigonish, NS
B2G 2S8 Canada
902-863-6797 (home) 902- 867-3629 (work)
E-mail: jrogers@stfx.ca

Student's Co-Supervisor**:**
Dr. Brenda Cameron, RN, PhD
Faculty of Nursing
University of Alberta
3rd Floor Clinical Sciences Building
Edmonton, Alberta
T6G 2G3 Canada
(780) 492-6412
E-mail: brenda.cameron@ualberta.ca

Student's Co-Supervisor**:**
Dr. Vera Caine, RN, PhD
Faculty of Nursing
University of Alberta
3rd Floor Clinical Sciences Building
Edmonton, Alberta
T6G 2G3 Canada
(780) 248-1974
E-mail: vera.caine@ualberta.ca

Background: I invite you to take part in a research study titled: Exploring Mi'kmaq Women's Experiences with Gestational Diabetes Mellitus (GDM). This health condition is a form of diabetes that occurs when a woman is pregnant. This can lead to problems prior to having your baby for the woman and the baby and also after the baby is born. Your doctor or nurse will check each woman for this while she is pregnant. Some extra health care is required by other doctors and nurses.

Purpose: I would like to explore with Mi'kmaq women who have or had GDM their stories during and after being pregnant. We know very little about how this form of diabetes affects women, families and areas. I also hope that we can look at likely actions we can take to address some of the problems.

Process**:** You may take part in this study if you are a Mi'kmaq woman, 18 years or older, living in a Mi'kmaq community and have lived with GDM.

Your being in the talking circle may involve:

1) I hope that you can meet in a talking circle with other Mi'kmaq women and other people from your area. We will meet at a place and time that is best for you.
2) You may choose to give verbal consent instead of giving a written consent.
3) I would like to audio-tape the talks during the talking circle. You may ask to have the tape recorder turned off at any time during this time. The talking circle will last between one to two hours and it is up to the group to decide when to stop.
4) You will have a chance to take part in this talking circle, to share your story with others and to see what actions can be taken. It is your choice if you want to take part.
5) The audio-taped talks in the talking circle will be typed based on what you said, which I will share with you and we can then talk about them again.
6) If you like, a Mi'kmaq interpreter will be present during the talking circle.
7) A copy of this study will be given to you.

Benefits**:** This study may help you gain further insight into your story when you were pregnant with this health condition. Your taking part in this research may benefit other Mi'kmaq women by adding knowledge about GDM. Coming up with some actions will also help the health center and other health care groups to help find better ways to provide health care.

Risks: There are no known risks to taking part in this study. If you do not feel at ease talking about your story, you can refuse to answer any questions or withdraw from the study anytime. Anything that is told to me that suggests child abuse, I must report. If any feelings of distress or issues arise or problems occur, you can contact Andrea Currie at (902) 756-2139 or St. Martha's Hospital at (902) 863-2830 for help in your area. I will stay with you until this contact person comes to you.

Privacy: Your name will be kept private at all times and it will not be told to anyone. You can choose a false name, rather than your real name when I report any findings from this study. No data that could single you out, your family, friends or the health center will be provided. Yet, I cannot promise that others in the talking circle will not tell anyone about what was said. Discussions with me or my supervisors for the purpose of this research will not be disclosed. All talks will be kept private, except when codes of ethics or the law requires that the data is reported. Your name will not appear on the records. The transcriber and or interpreter will sign a privacy agreement to ensure that they keep the talks and data private. All data used during the study (documents, audio-tapes, field notes) will not name you. During the study, this data will be kept in a secure place in my home. You will be given a chance to read the tape-recorded notes and listen to the audio-tapes at any time. After the study is complete, you will be asked about storing, keeping and or shredding the data. Information you provide is owned by you and you have the right to this data. Therefore, you have the right to decide what should be done with your data. The norm is that data is kept for at least five years after the study has been done.

Co-ownership of data: Once I have looked at the data, I will invite you to listen to the findings of the study. I will also invite you and other Mi'kmaq people from your area to a meeting to discuss the findings and to share likely actions. At the very end of this study, you will receive a copy of the final results.

Future use of data: I will present findings from this study at conferences. I may also publish some of the findings. Your name will not be named in any report.

Freedom to Withdraw: You are free to withdraw from the research study at any time, and your health care will not be affected in any way.

Gift for Taking Part: You will be given $20.00 for each visit to cover costs such as childcare and travel, as well as your time.

If you have concerns about your rights in the study, you may contact the Human Research Ethics Board at 780-492-0302. Collect calls will be received. This office has no affiliation with the persons doing the study. You can also contact my supervisors, Dr. Brenda Cameron or Dr. Vera Caine, who are listed at the front of this letter. Do you have any questions?

Please contact any of the individuals identified above if you have any questions or concerns:

If you agree to take part in this study, please sign the consent form attached to this letter.
Initials: Participant _______ Interviewer _______

Investigators must provide a phone number which can access an investigator or co-investigator 24 hours per day.

Appendix E

Research Participants Verbal Consent

My name is ______________________ I have discussed with Joanne Whitty-Rogers the study titled: Exploring Mi'kmaq women's Experiences With Gestational Diabetes Mellitus

I have read or listened to the Information Letter. I have been able to ask questions about the study. I agree to participate in this study.

I hereby give my verbal consent to this study.

I believe that the person who hereby has verbally consented to the study understands what is involved in the study and voluntarily agrees to participate.

________________________	___________	_____________________
Signature of Witness	Date	Print name

__________________________	___________
Signature of Investigator or Designee	Date

Appendix F

Confidentiality Agreement for Interpreter

Thesis Title: Exploring Mi'kmaq Women's Experiences with Gestational Diabetes Mellitus Researcher**:** Joanne Whitty-Rogers

I_________________________ have agreed to keep the information for the above research strictly confidential. I will not relate any segment of this information to another person, nor will I discuss the information with anyone other than the researcher for the purposes of clarification in the interview(s).

Interpreter (Print name)______ ______________
Interpreter (signature)_______________
Date _____________________________

Researcher (print name) ____
Researcher (signature) ____
Date _____________________________

Appendix G

Confidentiality Agreement for Transcriber

Thesis Title: Exploring Mi'kmaq Women's Experiences with Gestational Diabetes Mellitus
Researcher: Joanne Whitty-Rogers

I, ________________________ have agreed to keep the information contained within the tapes for the above research strictly confidential. I will not relate any segment of this information to another person, nor will I discuss the contents with anyone other than the researcher, for purposes of clarification in transcription.

I agree to return all research information to the researcher, Joanne Whitty-Rogers once I have completed transcription.

I agree that after consulting with the researcher, to erase or destroy all information stored on the hard drive of my computer regarding this research project that is not returnable to the researcher.

Transcriber (print name)____
Transcriber (signature)____
Date ____________________________

Researcher (print name) ____
Researcher (signature) ____
Date ____________________________

Appendix H

Application to Conduct Research

Mi'kmaq Ethics Watch

1. Name of researcher(s) and/or supervisor(s) and related department(s). Name of contact person(s) and contact address (indicate summer addresses if pertinent).

Student Researcher: Joanne Whitty-Rogers, RN, MN
PhD Student, University of Alberta
4 Carter Crescent, Antigonish, NS
B2G 2S8, Canada
902-863-6797 (home) 902- 867-3629 (work)
E-mail: jrogers@stfx.ca

Student's Co-Supervior**:** Dr. Brenda Cameron, RN, PhD
Faculty of Nursing
University of Alberta
3rd Floor Clinical Sciences Building
Edmonton, Alberta
T6G 2G3 Canada
(780) 492-6412
E-mail: brenda.cameron@ualberta.ca

Student's Co-Supervior: Dr. Vera Caine, RN, PhD
Faculty of Nursing
University of Alberta
3rd Floor Clinical Sciences Building
Edmonton, Alberta
T6G 2G3 Canada
(780) 248-1974
E-mail: vera.caine@ualberta.ca

2. Anticipated start date of the research study and expected completion date. Include anticipated field research dates.

Response-I anticipate starting my research study after ethics approval in November 2009, where I plan to introduce the study on Gestational Diabetes Mellitus to the First Nations communities. I have already made brief contact with two communities. Following this introduction, I hope to begin data collection in November 2009 and anticipate the process will be completed by October 2010. However, I am aware that this process can take longer and therefore will allow for additional time if necessary. The expected date for completion of my research study is April 2011.

3. Title of study
Response: Exploring Mi'kmaq Women's Experiences with Gestational Diabetes Mellitus

4. Abstract (100-250 words), giving a brief statement of the hypotheses (or brief statement of research questions and significant proposed research) to be examined.

Response: Gestational diabetes mellitus (GDM) is characterized by a carbohydrate intolerance that is first diagnosed in pregnancy. In recent years, the incidence of diabetes has increased with one in eight First Nations women reporting the development of this condition. Diabetes is three to five times more common among First Nations people than the general population. Women diagnosed with GDM are at an increased risk of developing glucose intolerance later in life, with approximately 50% going on to develop Type II diabetes within 15 years. Hypertensive disorders, higher caesarean section rates, higher rates of spontaneous preterm delivery, pre-eclampsia, hypoglycemia are some of the major complications associated with condition. In addition to the physiological complications, there are a number of social and political conditions, which affect Aboriginal women and their families during pregnancy. Since there is a paucity of research on First Nations women's experiences with GDM, a qualitative study will be conducted for the purpose of providing new knowledge about First Nations women's experiences with this condition. Participant Action Research and Indigenous principles will inform and guide the study. My sincere hope is that this research process will facilitate Mi'kmaq women gaining more knowledge and in-depth understanding of their health and build capacity so that they can develop ways to improve their health and maintain their Mi'kmaq culture. It is anticipated that results of the study will also be used to develop appropriate actions in collaboration with these women to address GDM, thereby possibly minimizing complications in pregnancy and at birth, and improving health outcomes for Mi'kmaq women, infants and families.

5. Funding source: indicate the source of research or study funds, and whether grant funds have already been provided.

Response: I have received funding from the following sources:

- Atlantic Aboriginal Health Research Program (AAHRP). CIHR-IAPH July, 2008. PhD Funding received $ 7,876.00 x 2 years.
- Aztra Zeneca Urban Scholarship-Canadian Nurses Foundation July /08-January/09 $6,000.00

6. Participants: describe the procedures for recruiting, selecting, and assigning participants.

Response: The participants will be invited to participate through purposive and snowball sampling on the basis of the following criteria: Mi'kmaq women, 18 years or older living in one of the three Mi'kmaq communities I have been in touch with, who have or had GDM. Purposive sampling refers to observing and interviewing people who have experienced the topic of interest. Snowball sampling is used when you ask if there is anyone else that maybe interested in participating in the research. It is anticipated that 4 to 6 Mi'kmaq women will form the core group of participants.

Gaining Entrance to the First Nations Communities
It is important for me to build relationships with the three communities before beginning the research. I will contact the health director or executive director depending upon their title in the community and consult with them about my research. At that time, I will ask the health directors who they see as setting up an initial information session. Once this person is named from each of the communities, I will ask him/her to organize an information session. Although I will initially lead the information session, I will follow PAR principles where by the Mi'kmaq women will be given an opportunity to pose questions, provide comments and have a back and forth conversation with me. I will begin by meeting some potential participants, elders, community health nurses, dietitians and whomever else they would like to invite to explore health issues around prenatal care and GDM. During the information session, I will explain my proposed research. At this time, potential participants and other community members in attendance will be given a short presentation about the proposed study and a letter of introduction explaining the study. I will clarify that there is no obligation to participate in the study.

7. Consent: describe process by which participants consent to participate in the research project; that is, how will participants be informed of their rights as participants, and by what means they will signify their understanding of those rights and consent to participate. Any research involving children shall require parental informed consent.

Response: Once a participant expresses interest in participating in the study, a time and place convenient for her and I will be arranged to discuss the purpose of the study in more detail and to answer any questions or concerns. If a Mi'kmaq woman agrees to participate, a participation consent form (Appendix C) will be signed. I anticipate that three to four conversations with each participant will be conducted. This may be conducted in a talking circle format or one-on-one with each participant. The participation consent form will be signed at the time of the first conversation. An information letter asking the women to participate in a talking circle will be provided to each participant (Appendix D). Participants will also be asked to sign a participant consent form for the talking circle (Appendix C). The participants will be informed that anonymity and confidentiality will be protected to the best extent possible. The participants may choose to verbally consent instead of giving a written consent (Appendix E). Discussing possible actions, as part of the presentation of findings are other components of the PAR approach that are necessary for this study.

8. Language: describe how language and cultural differences of Mi'kmaw people will be accommodated in communicating or deriving consent. Describe process for determining and using appropriate protocols and traditions for entering into Mi'kmaq territory and homes.

Response: I will ask those community members in attendance of an information session whom they see as informing potential participants about the study. The role of the community member will be to work closely with the participants and will organize the talking circles, assist with recruitment of participants and act as a community liaison. This person will approach the Mi’kmaq women in person and or contact them by telephone. In either instance, she/he will hand out or mail potential participants a copy of a letter of introduction (Appendix A) for the study. The community member will verbally clarify information in the letter to ensure that potential participants understand the purpose of the study and the nature of participation. The letter will include a request for the potential participants to contact me if they would like more information or want to participate in the study (Appendix B). My phone number will be provided and the women are encouraged to call collect, so that cost is not a barrier to their participation.

Participants will be informed prior to the interview and or talking circle that they have the option of having a Mi’kmaq interpreter present to assist with interpretation if necessary (Appendix F).
The participants will be informed that they will have a choice to participate in talking circles, interviews (conversations) or both. My hope is that an Elder will be present during the talking circles to open with prayer and to safe guard the women. Some Aboriginal women may be reluctant to participate in a talking circle and may prefer to be interviewed one-on-one with the researcher. The latter preference may be due to wanting private time or not wanting to share an intimate part of their life. If one-on-one interviewing is preferred, participants will be interviewed in an area mutually agreed upon by the participant and researcher. If a participant expresses a desire to be accompanied by a friend or family member, he/she also will also be asked to sign a confidentiality agreement.

The conversations with the participants will be audio-taped and transcribed verbatim to ensure accuracy of the data. Confirmation of confidentiality will be obtained from the transcriber prior to transcribing the data (Appendix G). If the participants do not wish to be audio-taped, I will write detailed notes during and after the interview. I will write field notes after the conversation(s) with the participants have been completed. I anticipate that I will be using interviews (conversations) and talking circles but I await the unfolding of my research and will honor what the participants and other First Nations community members believe to be appropriate for this research.

If the participants choose to be interviewed in their home, I will arrange a time that is convenient for them. I will call the women prior to arriving at their home. If they have to reschedule, I will be most flexible and considerate of their time. I will introduce myself to all members of the family and or friends present. As the Mi'kmaq language tends to be low tone, I will provide amble time for them to respond. I also will be aware of special events in their communities such as pow wows and will try to attend if possible. Wakes and funerals are equally important so if there is a death in the community, I will respect their time and honor their loved on by not engaging in research until the community members feel it is appropriate for me to return.

9. Methods/Procedures: indicate if any aspects of the study involve risk to the participants or to the Mi'kmaw people collectively. Describe any risk to the person/persons as a result of the findings being reported or published.
Response: Possible Risks: There are no anticipated risks to being a participant in this study. If you do not feel comfortable discussing your experiences during the conversations you can refuse to answer any questions or withdraw from the study anytime without being penalized. If any feelings of discomfort or issues arise or problems occur, I can provide names and contact information for help in your area. Any information that is disclosed to me that suggests child abuse, I must report.

10. Risk or deception: indicate if any aspects of the study involve risk to the participants or to the Mi'kmaw people collectively. Describe any risk to the person/persons as a result of the findings being reported or published.
Response: Same response as # 9

11. Usefulness and Benefits: describe any benefit(s) for the individual Mi'kmaq person or to the Mi'kmaq Nation as a whole as a result of this study or its published report or findings.

Response: Possible Benefits**:** This study may help you gain further insight into your experiences during pregnancy with Gestational Diabetes. Participation in this research may benefit other Mi'kmaq women by contributing to knowledge about this form of diabetes. Identifying possible actions will also help the health center and other government agencies to help develop solutions or better ways to provide health care. Published report of the findings may help to educate health care providers and others about GDM in Aboriginal people and provide knowledge that will help them to better care for this population.

12. Interpretation of Results: explain how the data will be analyzed and whether any Mi'kmaq people will be involved in, consulted with, or informed about, the interpretation process of analyzing the data or in its presentation of its findings and conclusions.

Response: Participants will be recognized and treated as being equal in this research. Once I have done the data analysis, I will invite them to talk about the findings of this study. I will also invite you and other community members to a meeting to discuss the findings and to share possible actions. At the very end of this study, they will receive a copy of the final results.

13. Storage of data: detail how the data will be stored to ensure safety and confidentiality of the participants in the study. How long will the data be kept? Will the data be used again in another aspect of the study? Will the participants have the right to consent to this next phase of study?

Response: All materials collected during the study (documents, audio-tapes, field notes) will be kept in la secure place in my home. The participants will be given a chance to read the tape-recorded notes and listen to the audio-tapes at any time. After the study is complete, they will be asked about storing, keeping and or disposing of the data. Information they provide is owned by the women and they have the right to this information. Therefore, they have the right to decide what should be done with your data. All potential identifiers will be removed and participants will be identified by pseudonyms. These materials will be kept for at least five years as per protocol of the Health Research Ethics Board, Panel B (HREB) Review Committee, University of Alberta after the study is completed.
I am not certain at this point if there will be another aspect of this study, however the participants will have the right to consent to the next phase of study should this occur.

14. Confidentiality: describe what measures will be taken to protect Mi'kmaq participants and third party privacy (confidentiality and anonymity).

Response: Confidentiality and Anonymity: Your identity will be protected at all times and it will not be reported to anyone. The participants can choose a false name, rather than their real name when I report any findings from this study. No information that could identify the woman, her family, friends or the health center will be provided. Any information discussed with me or my supervisors for the purpose of this research will not have any identifying factors. All information will be kept private, except when professional codes of ethics or the law requires that the information is reported. The participants' names will be deleted from all records. The transcriber, and or interpreter will sign a confidentiality agreement to ensure they keep the data private.

15. Publication and royalties: describe anticipated publications or plans for publication from this research and how any royalties from book sales will be shared with participants of the study.

Response: I will present findings from this study at conferences and through journals with the participants’ permission. Their name will not be disclosed in any report. Information that is collected in this study may be used in future studies.