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Title

Conceptualizing cultural safety at an Indigenous-focused midwifery practice in Toronto, Canada: Qualitative interviews with Indigenous and non-Indigenous clients

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Author Contributions: The evaluation within which this study was nested was co-developed by midwives at Seventh Generation Midwives Toronto (Sara Wolfe, Cheryllee Bourgeois, Sadie Booth, Alanna Kibbe) in partnership with research staff at the Well Living House (Janet Smylie [Principal Investigator], Michelle Firestone, Conrad Prince, Marcie Snyder, Bernice Downey). The study was co-led by SW and CB in partnership with JS, MF, and CP. The interview guide was developed by SW, CB, JS, MF, and CP with minor comments from MC and HM. The interviews were conducted and transcribed by MC as a part of her Master's thesis. The transcripts were analyzed by MC, JS, and SS, with themes and linked quotes being confirmed on an iterative basis in partnership with SW and CB. MC, JS, and SW shared the role as primary author for this manuscript, receiving minor edits from CB, HM, and MF. All authors read and approved the final manuscript.

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Keywords: Indigenous; Cultural competency; Midwifery; Health services research; Qualitative research

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ABSTRACT

Objective: Efforts to improve health care services for Indigenous peoples in Canada have become increasingly centered around cultural safety. There is a need to better understand what cultural safety means, and how it can be evaluated. This study explored how Indigenous and non-Indigenous clients of an Indigenous-focused midwifery practice in Toronto, Canada conceptualized and experienced culturally safe care.

Design: Interviews were conducted with former clients as a part of a larger Indigenous health service evaluation of the practice. The interviews were transcribed and analyzed thematically using an iterative, consensus-based approach and a critical, naturalistic, and decolonizing lens.

Setting: An Indigenous-focused midwifery practice in Toronto, Canada.

Participants: Saturation was reached after interviewing twenty former clients (n=9 Indigenous participants, n=11 non-Indigenous participants). Participants were recruited via purposive sampling**.**

Results: The study found that, while having room to grow, this particular Indigenous-focused midwifery practice is a leader in delivering culturally safe care. The study also found that the Indigenous participants conceptualized cultural safety in distinct ways that reflect cross-cutting Indigenous social constructs and understandings – providing further evidence of the survival of Indigenous values and approaches in urban centres. Parallels were also identified between the Indigenous and racialized non-Indigenous participants' conceptualizations of cultural safety, and between all participants with regards to the anti-oppressive benefits of cultural safety.

Conclusion: By highlighting the uniqueness of Indigenous cultural safety; demonstrating the survival of Indigenous values, approaches, and resurgent practices in urban spaces; and introducing the relevance of cultural safety to diverse non-Indigenous communities, this study has broad implications for providers, educators, and evaluators committed to ensuring cultural safety achieves its full potential.

ARTICLE SUMMARY:

- This study centres the experiences of Indigenous and non-Indigenous clients who received care from the first urban Indigenous-focused midwifery practice in Canada; this adds to the limited but growing field of midwifery and Indigenous midwifery research.
- This study is one of the few that evaluates cultural safety from the perspective of clients – the only individuals who can truly define whether a service or experience was culturally safe.
- While we attempted to optimize diversity across our sample, participants tended to be older, more educated, and have more hospital births than the average client at the practice.
- There were no Inuit-identified participants among the Indigenous participants, and the majority of non-Indigenous participants were white/European, perhaps reflecting SGMT clientele.
- Focusing on a single midwifery practice with a unique approach, care must taken in interpreting the study's relevance across pregnancy, birth, and postpartum settings.

INTRODUCTION

Anti-Indigenous and anti-Black racism have been embedded within the Canadian health care system since its conception.[1 2 3 4] One of the most widely cited and disturbing examples of anti-Indigenous racism in health care is the death of Brian Sinclair. In 2008, Mr. Sinclair, a Cree Man, died in a Winnipeg

emergency department of complications from a treatable urinary tract infection following a 34-hour wait during which he was ignored and not triaged.[5] Unfortunately, Mr. Sinclair's story is not unique. There is a substantial body of evidence documenting the poor treatment of First Nations,[6 7] Inuit,[8] and Métis[9] people within the health care system, and the harms that have resulted from being denied or made to wait for treatment, being misdiagnosed based on stereotypes, and/or avoiding treatment until it is critically necessary to protect themselves from discrimination and/or child apprehension.[1 10-12]

Cultural safety

Cultural safety is a concept that was developed by Māori nurses in the 1990s to interrupt the mistreatment of Māori patients in the New Zealand healthcare system.[13] It was designed to go beyond conventional cultural awareness/sensitivity approaches that have been criticized from promoting stereotyping, reducing culture to dress and food, obscuring the influence of structural power dynamics, and failing to improve Indigenous health outcomes.[14-17] Although cultural safety has since been adapted to a wide range of contexts, its core tenets remain. Cultural safety rejects the view that culture is "static," understanding it as fluid, complex, and embedded within sociopolitical and historical landscapes; begins with providers engaging in critical self-reflection; and can only be defined by those who receive a service.[13]

Understanding cultural safety begins with an understanding of culturally "unsafe" care – that is, "any actions [or omissions] that demean, diminish, or disempower the cultural identity and well-being of the individual."[18 p5] Culturally unsafe care is enabled by systems of racism, colonialism, and sexism that, in Canada, gave/give rise to the Indian Act, residential schools, Métis land appropriations, the forced relocation and settlement of Inuit communities, and the Sixties and Millennial Scoops.[1 19 20] Culturally *safe* care, then, is inherently anti-colonial and anti-racist; it has the potential to transform how healthcare is delivered to Indigenous and non-Indigenous peoples. Although the literature on cultural safety is limited, emerging work establishes its role in healthcare professional education[21] and improving healthcare services in Canada and beyond.[22-24]

Indigenous and non-Indigenous midwifery in Canada

Indigenous midwives have been supporting the health and well-being of Indigenous families since time immemorial. Surviving attempted erasure and delegitimization, Indigenous and non-Indigenous midwives have recently re-emerged in mainstream Canadian contexts.[25] Today, in Ontario, Registered Midwives are primary care providers who care for pregnant people during pregnancy, labour, and up to six weeks post-partum.[26] Indigenous midwives are Indigenous-identified midwives who are either Registered Midwives or practicing under the Aboriginal Exemption Clause.[25] Indigenous midwives are unique, in that they bring a specific approach, knowledge base, and set of skills to their practice that enables them to support parents and families during the birth year and early life in a culturally safe way.

Although all midwives practicing in what is now known as Ontario are committed to cultural safety[27 28] little has been published about this type of work. The literature is largely based in Australia, centering the perspectives of providers rather than recipients,[29-31] or focus on rural, remote, and/or northern settings [32 33.] As the number of Indigenous people living in urban centres continues to grow[34], so too does the need for culturally safe care for pregnant and parenting people in cities. Seventh Generation Midwives Toronto [SGMT] is an Indigenous-focused midwifery practice in Toronto, Canada that strives to meet this need.[35] Toronto is one of the largest and most ethnically diverse cities in Canada.[36] It has the largest population of Indigenous people in Ontario, with recently confirmed estimates of at least 70,000 people.[37] Accordingly, SGMT welcomes both Indigenous and non-Indigenous clients into their practice. As an Indigenous-*focused* practice, SGMT reserves spaces for Indigenous clients with low- and

high-risk pregnancies; supports Indigenous student-midwives; creates opportunities for Indigenous clients to include Indigenous teachings, practices, and protocols in their care; and supports all families to reflect on the importance of culture and tradition in their birth year experience.[35 38]

In this study, we conducted interviews with twenty former clients of SGMT as a part of a larger evaluation of the practice to determine how Indigenous and non-Indigenous clients at SGMT conceptualize cultural safety, and the extent to which their experiences at SGMT aligned with these conceptualizations.

METHODS

Study Overview & Approach

This study was initiated as a part of a multi-phased Indigenous health service evaluation of SGMT, informed by Indigenous, utilization-focused, and realist methodologies.[39-41] The evaluation was co-led by Indigenous midwives at SGMT (SW, CB) and researchers at the Well Living House, based at St. Michael's Hospital in Toronto (JS, MF). The ultimate aim of the evaluation was to learn how, why, and for whom SGMT was working in order to develop a culturally relevant performance measurement system for the practice.

The evaluation design and implementation drew on the Well Living House's established methods and protocols for conducting rigorous, ethical, and high-quality Indigenous health research[42-45] and existing best practices for Indigenous health research.[46] These methods prioritize the balancing of tangible community benefits with research excellence, strong and reciprocal relationships, capacity building, Indigenous leadership, and Indigenous governance and management of Indigenous information.[47] This particular evaluation built on over ten years of pre-existing Indigenous community, clinical, and research collaboration between the community and academic leads (SW, CB, JS). A project-specific data sharing, research, and publication agreement between the Well Living House and SGMT delineated agreed-upon roles and responsibilities regarding study conduct, governance, data sharing, and SGMT data ownership. SGMT midwives were actively involved throughout the research process, co-leading the identification of key evaluation questions, the development of a logic model to guide the evaluation (available upon request), and subsequently the development of evaluation tools, training of data collectors, recruitment of study participants, and vetting of outputs. The final evaluation drew on three data sources: perinatal outcome data, pre/post client questionnaires, and interviews with midwives and former clients (i.e., the focus of this study).

Participant Recruitment & Data Collection

Potential participants were identified via purposive sampling[48] to best represent the diversity of needs, choices, identities, and experiences observed at SGMT. Clients were eligible to participate if they were ≥ 18 years old and gave birth in a period of 2014. The SGMT receptionist made first contact with potential participants. With permission, the interviewer (MC) contacted potential participants who had expressed interest to review study information, answer questions, and invite them to meet to discuss the study. During the initial meeting, MC provided potential participants with comprehensive study information, answered their questions, and obtained informed consent.

Interviews were conducted in-person by MC between October 2014 and March 2015. Interviews varied in length from twenty minutes to one hour and took place in quiet, private locations of the participants' choice (coffee shops, homes, SGMT office). The interviews were digitally recorded with participant consent. One participant requested that their interview be transcribed via laptop. Participants were asked whether they wished to review their transcripts prior to analysis to enhance the accuracy, validity,

and credibility of the study[49] and four requested this review. Participants were given a small gift and monetary compensation ($20) to acknowledge their contributions and cover any costs related to participation.

Questions focused on past experiences with perinatal care; specific needs during pregnancy, birth, and the post-partum period; experiences receiving care from SGMT; culturally safe care; and the role(s)/importance of identity and knowledge sharing. Cultural safety was explained to participants as "what makes you feel comfortable, respected, and able to be yourself." The interview guide is presented in Appendix A. The research team members from SGMT (SW, CB) and Well Living House (JS, MC) agreed that saturation had been reached after nine Indigenous participant interviews and eleven non-Indigenous participant interviews (N=20), as no new themes or ideas were emerging.[50]

Data Analysis

The recordings were transcribed verbatim by MC and verified by a second Well Living House researcher. Transcripts were analyzed thematically using an established consensus-based, iterative method[44] that involved both academic and community-situated peer researchers and applied a critical, naturalistic, and decolonizing interpretive lens. The aim of our methodological approach was to centre Indigenous perspectives and to understand and represent the gathered information in a way that was as true to the lived experiences of the Indigenous and non-Indigenous participants as possible.

Analysis began with a mixed academic-community team completing an in-depth review and preliminary theme-based coding of the transcripts. The team consisted of MC, a White settler researcher who at the time was completing a Master of Public Health; JS, a well-known Métis family physician and applied public health researcher; and SS, a First Nations woman who was invited to contribute based on her lived experience as a former SGMT client and experience in qualitative analysis. Each team member was tasked with independently identifying the major themes in the transcript along with key quotations that illustrated this them. After this preliminary independent thematic coding, the team met to reach consensus on major themes and develop a codebook with exemplar quotations. MC then conducted an in-depth analysis of the transcripts using a crystallization-immersion process[51] to further develop the coding. The resultant analysis was iteratively refined in a series of meetings with JS and SS and then presented to community research partners SW and CB for final review and approval.

RESULTS

The demographic information of participants is presented in Table 1. Seven major themes emerged from analysis. The themes were organized into three domains: relationships and communication, sharing knowledge and practice, and culturally safe space. The themes are presented below, supported by quotations from the Indigenous and non-Indigenous participants. The Indigenous/ethnic identity of each quoted participant is coded following each quotation below using "I" for Indigenous and "N" for non-Indigenous, followed by a participant number and specific ancestry/ethnicity.

Relationships and Communication

Respect and support for choices

When describing cultural safety, many participants (n=13) emphasized the importance of feeling respected and supported in their choices:

> 'Culturally appropriate care would be something that is respectful of any practices that I would have that I would want to do, not judgmental about choices that I'm making, giving me informed

or information about a choice I made that they may not necessarily follow their model of care […] but respecting my choices regardless.' (I5, Métis)

"Choice" was broadly defined to include life choices, choices about pregnancy and birthing, and choices about client involvement in decision-making. Respect and support for choices, then, was made possible when the midwives withheld judgment, honoured the participant's decisions, and/or advocated on their client's behalf:

'When I first met [my primary midwife], I was feeling insecure and she made me feel really confident, like what I was doing, you know, choosing to be a single mom. She really helped me feel like it was a good choice instead of something to be afraid of.' (N13, White/European)

'[My midwife was] warm, easy to talk to, she didn't judge me for anything I said. She just... she understood, you know. She didn't, like even though, yes, she had to remind me "it's better to breastfeed," she never pushed the idea on me, you know what I mean?' (I4, First Nations)

'[My midwife] was able to like be in my corner and be like "no, she doesn't actually have to do this. […] There's nothing indicating that she needs to be in this position." So because of that, she kind of gave me the strength to continue to be my own advocate even when she wasn't in the [hospital] room.' (I7, First Nations)

One participant felt that her midwives could have been more supportive of their preference for a midwife-led approach:

'Just saying, "you can do it or you don't have to do it," to me, is not what I'm looking for. I still want to have the choice, but I'd like someone to explain the risks, the benefits, what most people do, why most people do what they do.' (N11, White/European)

Personalized, continuous relationships

Cultural safety was also conceptualized as having personalized, continuous relationships with midwives. Participants from both groups described these relationships as being treated like a human and peer rather than a number, not feeling rushed, and receiving individualized emotional and mental health support.

'You can feel when somebody actually cares, as opposed to making it a clinical situation. […] I mean sometimes we would just chit-chat and it was nice, you know?' (N14, Caribbean and European)

'Once I was in the room with the midwives... all the attention was on me. Just taking the time to ask any questions or, you know, not make me feel like I was being asked to get in and out as quickly as possible. […] I felt like I would be able to build a good relationship with the midwives there.' (I8, Métis)

'It was very important to have a little bit of the emotional support that just, kind of, buoys you when you're pregnant and feeling awful and overwhelmed. […] That's not something I have at home, so it was good to know that I had somebody to provide that, as well as that sort of physical and medical backup.' (N19, White/European)

However, for most of the Indigenous participants and one of the racialized non-Indigenous participants, these relationships were more specifically conceptualized as two-way, kin-based relationships built on shared understandings and experiences.

> 'I would like to imagine my childbirth experience to be, to feel like I'm amongst sisters and not with a medical professional. And with my sisters I know their story, and so I feel like I would like to know my midwives' story a little bit more.' […] I think that's important and it develops trust and well, really, a sense of community.' (I1, First Nations)

> 'It's nice when [the midwives] would share where they're from. [My midwife] said what reserve she's from […] and she shared her stories. It made me feel more comfortable in talking to her and sharing my story and going through the journey of giving birth, cuz it's a very personal, highly personal, thing.' (I6, First Nations)

> 'It was literally about bringing this new person into the world and welcoming her in this, kind of, almost like a sisterhood.' (N20, Black/Caribbean)

This sub-theme was also evident when some of the Indigenous participants explained why it was so important to have an Indigenous-identified midwife.

> 'The ideal is the Aboriginal midwife, just being Aboriginal herself. She understands what it means to be an Aboriginal woman because she's lived that life. […] She would know and understand and we'd have that connection. We'd understand each other.' (I6, First Nations)

> 'Throughout the pregnancy, the student was awesome because she was, for one, she was Aboriginal so she gets it. Secondly, she just had a calming effect on me. And so, I liked that. And she, she didn't make anybody feel lesser or higher than her. She was at the same level and that's what I loved about that.' (I9, First Nations)

Only one Indigenous participant (IP8, Métis) felt that her non-Indigenous midwife "practiced culture care as much as my Aboriginal one […] She might have been more sensitive because she wasn't [Indigenous]."

For some of the Indigenous participants, personalized and continuous relationships also meant the midwives facilitating the intergenerational transmission of knowledge and participation in care, and practicing beyond the scope set by the Ontario midwifery model of care or standards of practice.

> 'My daughter was there for my birth, so that was a big thing for me too. I was kind of hesitated about if she should come or if she couldn't come, but the midwives, were like, you know, "it's fine, she can come.' (I3, First Nations)

> 'I think for my mom, who isn't in touch with her Aboriginal culture, I think it was really nice for her to live through it through me. […] She came to one of my appointments with me and she made me a moss bag, so you know? Just really celebrating her culture where she felt safe to do it.' (I8, Métis)

> '[When] I was at [the children's hospital], my midwife actually gave me money to buy food because they don't feed people, they don't feed grown ups [there].' (I4, First Nations)

> 'There are ceremonies that you have for couples too, right? Like in parenting. I would've loved to have learned a little bit about that kind of stuff [at the practice].' (I9, First Nations)

For the non-Indigenous participants, personalized relationships were described in more client-centered terms; several participants spoke to the importance of the midwives "getting to know the patient and making sure that they're sort of doing everything they can to have a healthy pregnancy and maintain their own health emotionally and physically" (N16, White/European). Continuity of care was also understood as such, with participants identifying having the same midwife/group of midwives, being visited at home, and receiving comprehensive post-partum care as vital to feeling supported, respected, and able to be themselves.

> 'I think in terms of labour and delivery, I think having the actual person you developed a relationship with is hugely important. […] That made a huge difference, I think, in my comfort in that experience, 'cause they know you, they know how to keep you calm, and yeah, you feel better.' (N11, White/European)

> 'To have somebody tell you, "nope, everything's fine, everything's perfect, she's perfect; nope, she's progressing as she should be; no, this jaundice this nothing to worry about it's only a little bit." All of those things, it's just constant reassurance and it just allows you to just focus on what you should be focusing on, which is a newborn, getting a bit of sleep, all that kind of stuff.' (N12, White/European)

> 'It was great because they could come to the house and I had [my first child], she's quite [laughs]… she's not a handful, but especially after you've just given birth, they would come to the house and check up on the baby and they… seemed to really take time with the baby too and she wasn't just a number, like they actually cared about how she was doing.' (N10, White/European)

<u>The influence of past negative experiences</u>

Fourteen participants, nine of whom were Indigenous and one of whom was non-Indigenous and racialized, drew on their past negative experiences with hospital-based health care providers and systems to explain what cultural safety was *not.*

> 'I have a background of having doctors not listen to me. Or not respect my opinion. And so there was a fear that if I had to make some decisions […] that my options weren't gonna be considered. […] So that's what I mean by [not wanting to be in a] medical setting where everything's standardized – your individual concerns aren't really heard.' (I8, Métis)

> 'I had a rather bad experience with the obstetrician we started with - like I didn't feel she was taking our concerns serious. [...] [After I asked my] third question, she was like literally cutting me off, and she wasn't even sitting down for the appointment. She was just like standing in the doorway the whole time! So that's when I said to my [partner], "we need to find midwifery care!"' (N17, White/European)

Sharing Knowledge and Practice

<u>Learning about the logistics of pregnancy, birth, and the post-partum period</u>

All twenty participants made a connection between their comfort and being informed about the "logistics" (I9, First Nations) of the childbearing year/early life. Some participants reiterated the

importance of being informed in ways that are understandable and accessible to families of all genders, sexualities, situations, and literacy needs.

Having access to Indigenous knowledge and protocols

All of the Indigenous participants and three of the non-Indigenous participants conceptualized cultural safety as being able to access Indigenous knowledge, teachings, ceremony, and protocols ("Indigenous knowledge and protocols") during the perinatal period. For one Indigenous participant, cultural safety was about access and:

> 'Treating cultural things as "normal," so it's not a novelty thing that like I was seeing a healer and he was giving me teas to drink. […] Like [the midwives] just took it at value that, like, a traditional person gave those to me.' (I7, First Nations)

Indigenous knowledge and protocols did not only encompass more formal teachings, medicines, and ceremony, but also, everyday practices and protocols such as including family members, learning via storytelling, and sharing food and drink:

> 'Something that would make me feel more culturally rooted would be the chance to either accept or offer food or drinks. Not just water, but like if there was, I don't know, like a tea station or something. Something that makes me feel like I'm going to my granny's house, you know? Or to my auntie's house, or you know? Like where you're just a cup of tea.' (I1, First Nations)

Eight of the Indigenous participants sought care from SGMT to access Indigenous knowledge and protocols. All of the Indigenous participants who were given the opportunity to include Indigenous knowledge and protocols in their midwifery care reported benefits:

> 'You know how long it takes for your chest to go down [after labour]? It took me two days with that tecta [tea], so it was very helpful.' (I4, First Nations)
> '[My primary midwife] smudged with some tobacco that she got and that was quite sacred to her. So that was really special that we really got to smudge before her birth. […] It calmed me down because I wasn't ready for [my baby] to be born; she was too early.' (I2, First Nations)

> 'We could smudge when I was in labour, right? That was a big thing for me. Doing that meant a lot and especially giving my daughter a cedar bath when she was born, that meant a lot to me too, right? So it's impacted me a lot, my culture, in the last few years. And I'm happy to be giving my children that now because I understand it more and I know a little more about my culture, and now they can pass it on.' (I3, First Nations)

Six Indigenous participants felt that there was room for their midwives to better initiate conversations about Indigenous knowledge and protocols. Some participants did not know what to ask for, or how to ask for it.

> 'I remember that experience being told about the cedar bath […] I really have no clue how to do the ceremony. And so I think the assumption was, "no, just do a cedar bath, you know? Put cedar in a bath." So I think some things have to be spelled out so people feel comfortable doing it, cuz if it's not… you feel like you're misrepresenting the cultural practice and you're not passing it on properly.' (I8, Métis)

> 'My midwife just took it upon herself to say, "hey do you wanna smudge?" and we're like "yeah, that's great, like we didn't even know that was an option" because of, you know, you're in a hospital. […] She did it on her own and she asked me in the birthing room if it was something I wanted to do and… then she told me the story of the tobacco and how she got it and it was pretty special. So it made me feel quite, quite special about that.' (I3, First Nations)

The importance of the midwives asking/inviting became clear after one Indigenous participant was *not* asked, which made the participant feel "that I'm not Aboriginal, right? That I'm not Métis" (I5, Métis). She went on to share that she was hoping for "an experience where I would learn a little bit more. My grandparents passed away when I was fairly young and we moved to a very White community, which sort of segregated any teachings that I would've experienced from them." (I5, Métis)

All of the Indigenous participants wished that they had access to more Indigenous knowledge and protocols. Some Indigenous participants spoke to the challenges of this task, such as the impacts of colonial suppression:

> 'In the community that I was brought up in, we haven't really shared childbirth, traditional knowledge about childbirth. And so it's not something that my sisters and I carry with us today that we can share amongst others. So if they have anything that they could share related to traditional knowledge and childbirth, I would love to hear about it because I feel like it's something that's been lost' (I1, First Nations).

Three of the non-Indigenous participants were interested in accessing Indigenous knowledge and protocols at SGMT. Two of these participants had children whose biological fathers were Indigenous. One participant, who used an Indigenous sperm donor, felt that the cultural and spiritual aspects of her care "didn't get as developed as I would have liked" (N13, White/European). Another participant, who had a previous relationship with her child's father, was offered a smudge during labour but ran out of time. She was grateful for the sage because "it was like a little memento from the experience and everything and I think also, even though I'm not with [their] dad, that knowing that would've also gave him some level of peace […] 'cause he couldn't be here" (N20, Black/Caribbean). The third participant, after experiencing a perinatal loss, had her child honoured at a ceremony attended by her Indigenous midwife. She felt that this ceremony was key to her healing because afterwards, "it was just like I knew that some of the things I'd been feeling subconsciously but couldn't quite vocalize had been met" (N17, White/European).

Culturally Safe Spaces

Practice as home

Cultural safety was also conceptualized as being in a physical space that made participants feel "at home." Even though most participants (n=18) described this space as "less clinical" and more "homey," the ideals fell on a continuum ranging from the Toronto Birth Centre to their own home settings.

> 'I think the home environment would be my ideal place. […] I think the true privacy, that it really is your space. You know, no matter what you do to a hospital room or to a birthing centre room it never really becomes "your" space, but this [home] is always going to be your space. And it's just, you know, you can labour in any position you want, there's no… medical equipment just hanging in the corners waiting for you.' (I2, First Nations)

One of the non-Indigenous participants felt more at home in a "more medicalized space" (N11, White/European), whereas one of the Indigenous participants recalled the reserve where she grew up.

> 'The nature, the bush, the trees, freshwater; that is the ideal space I'd like to bring and raise my child into. […] It's just what I know, where I grew up, what I experienced. It makes me happy, relaxed, calm.' (I6, First Nations)

Family and community relationships shaping spaces

For many of the Indigenous participants and one of the racialized non-Indigenous participants, conceptualizations of culturally safe space were inseparable from relationships:

> 'It's almost like [primary midwife] came in and the energy changed in the [hospital] room again, and it was like calm, 'cuz I trusted her.' (I7, First Nations)

> '[Cultural safety is] pretty much what [the midwives] did, which was like give me enough space. So like, for example, I had a crap ton of visitors, right? And my visitors *[laughs]* are, you know, sometimes like very Caribbean and like wanna bring you food and tunes and stuff. […] It made all the difference in the world when, you know, my friends came and got me to laugh, and I just basically just was able to relax and, like you said, be myself and like quit freaking out. […] Just the fact that the space was given for me to be myself. Nobody made a big deal and said, "oh, you can only have this many people in the room.' (N20, Black/Caribbean)

The role of SGMT in the broader community also arose in discussions about culturally safe spaces. For one of the Indigenous participants, being and feeling connected to community was essential:

> 'In the summer I went to a pow wow and while I was there, I saw my midwife and her family. And then I didn't realize, but the [practice receptionist] was actually dancing and he was in regalia, and I didn't recognize him. When I came into the clinic just after the pow wow, he was telling me how he saw me there. So that makes me feel like, you know, being able to go to these Aboriginal events in the city and to see people who I know makes me feel more connected for sure.' (I1, First Nations)

SGMT also had varied but generally positive impacts on the non-Indigenous participants' attitudes towards Indigenous peoples. This mainly occurred through passive exposure and was met with varying degrees of reflexivity:

> '[My experience at the practice] has sort of has piqued my interest [in the Indigenous community] at a low level.' (N18, Chinese/European)

> '[My experience at the practice] made me read about [Indigenous communities] and get curious about it more. It's opened my mind towards this community more than before.' (N15, Middle Eastern)

> 'I absolutely have an interest [in engaging with the Indigenous community], but I also feel quite the opposite of entitled. In fact, like I shouldn't be given the privilege to know what other people do, especially Aboriginal people *[laughs]* given our history, the history of the country, the current state of the country.' (N19, White/European)

DISCUSSION

In this study, we found that while SGMT has room to grow, the practice is leader in delivering culturally safe care in their community. We also found that Indigenous participants conceptualize cultural safety in distinct ways that reflect cross-cutting Indigenous social constructs and understandings of the interwoven nature of relationships, spaces, knowledge, and practice.[53-55] This provides further evidence that Indigenous values and approaches to health, wellbeing, and society persist in urban spaces, despite the colonial imposition of Western biomedicine.[3 7-9 11 12] In this discussion, we will explore Indigenous cultural safety and its connections to cultural expression, cultural continuity, and Indigenous resurgence. We will also explore the parallels between the Indigenous and racialized non-Indigenous participants' conceptualizations, and between all participants in terms of the anti-oppressive benefits of cultural safety.

This discussion draws on Indigenous perspectives that understand "culture" as integral to social structuring and relationships, representing "the interconnected social totality of the distinct mode of life encompassing the economic, political, spiritual, and social."[4 p65] Cultural expression and continuity, then, are as much about ceremonial knowledge and protocols as they are about values, ethics of relation, knowledge systems, and social and political structure. Additionally, while we use the collective terms "Indigenous" and "Indigenous-specific," the diversity and richness of First Nations, Inuit, and Métis cultural heritage and expression as Indigenous peoples from many nations and backgrounds coming together in a large urban centre should not be underestimated. Support for self-determined and relationship-based cultural expression, cultural respect, and sharing across these diversities is a core premise of SGMT's practice,[52] and cultural safety in Toronto more generally.

Indigenous conceptualizations of cultural safety

Although the Indigenous participants were from different communities, there were several elements of cultural safety that emerged as "Indigenous-specific," or nearly so. For example, expressing a shared desire for **two-way, kin-based relationships**, the Indigenous participants described their ideals and their experiences at SGMT as being "amongst sisters" who "get it," creating feelings of trust, connection, and confidence in the care they receive. This sense that family is the "foundational relationship for pursuing any economic, political, social, or cultural activities and alliances"[57 p433] resonates with Indigenous social constructs such as Cree and Métis conceptualizations of *wahkootowin*. Métis elder and scholar Maria Campbell explains wahkootowin, or the "kinship or the state of being related" (Ermine as cited in 58 p5], as follows:

> "Today it is translated to mean kinship, relationship, and family as in human family. But at one time, from our place it meant the whole of creation. And our teachings taught us that all of creation is related and inter-connected to all things within it. Wahkootowin meant honouring and respecting those relationships. [It was] our stories, songs, ceremonies, and dances that taught us from birth to death our responsibilities and reciprocal obligations to each other. Human to human, human to plants, human to animals, to the water and especially to the earth. And in turn all of creation had responsibilities and reciprocal obligations to us." (as cited in 58 p6)

The Indigenous participants' desire to connect with their midwives as family for the process of childbearing may be interpreted as an expression of wahkootowin, and/or the diverse yet resonant ways in which familial or kinship relationships remain foundational to social order across Indigenous societies.

For some Indigenous peoples, there is the notion that if we relocate ourselves within the networks of kinship such as wahkootowin, we can heal the ruptures of multi-generational family disruption, abuse,

and forced displacement. However, kinship must be structured in contexts that are rooted in Indigenous knowledge and practice, and aligned with the diverse and specific personal, family, and community histories, experiences, and identities present. It is unsurprising, then, that the Indigenous participants valued **access to Indigenous knowledge, protocols, and/or ceremonies** in ways that respected autonomy of expression so highly when discussing cultural safety. It was also unsurprising that the Indigenous participants looked to their Indigenous midwives to receive this knowledge, given the rich cross-nation traditions of Indigenous midwives being vehicles for intergenerational knowledge transmission. This signals that these roles and expectations of Indigenous midwives are alive and well, and that the passing/receiving of knowledge to/from future and past generations are just as critical as ever. Cultural safety, then, is strongly linked to cultural continuity.[59 60]

The intergenerational transfer of knowledge that is needed to promote culturally continuous and safe care can be daunting in cities like Toronto. The Indigenous participants identified several challenges that have been previously reported[1 25 61 62] yet still need to be addressed: filling gaps in midwife and client knowledge created by colonial suppression; overcoming racist, institutional barriers in hospitals; navigated the forced politics of Indigenous identity; midwives lacking support/infrastructure to share knowledge and protocol in a good way; and the challenge of balancing sharing with protecting Indigenous knowledge and protocols from misrepresentation and appropriation. These challenges highlight the importance of Indigenous midwives being supported to engage in, expand upon, and identify the resources required to fulfill their knowledge-brokering roles.

The **intertwining of cultural safety and physical spaces** reflects the grounding of Indigenous ontologies and epistemologies within local ecosystems.[63 64] Relationships, responsibilities, Indigenous knowledge systems, and landscapes are foundationally interconnected across the diversities of Indigenous societies. Wahkootowin, for example, is inclusive of relationships with specific landscapes, waterways, plants, and animals, because these are considered kin. For many Indigenous peoples, these relationships and attached responsibilities are comparable in significance to those with our closest human relatives.

There is also a strong tradition of mobility among many Indigenous peoples that dates back to pre-colonial times.[3 65] Colonization brought new forms of mobility through forced relocations and the interruptions and undermining of traditional economics and food supplies. Still, the ability to build relationships with and adapt to new geographies is well documented.[66] Maria Campbell tells a story about how her grandmother, who was a traditional midwife, buried placentas from the babies she had delivered in a specific place to strengthen community ties to place at a time when there was high pressures of mobility due to European settlement. This story mirrors writings on the mutual constitution of land and body through Indigenous birthing practices, protocols, and language.[3 67 68]

This ability to build relationships with place and strengthen kinship networks have not been lost with urban Indigenous migrations and the urbanization of traditional Indigenous landscapes. The establishment of urban Indigenous friendship centres,[69] the assertion of traditional Indigenous land use in cities,[70 71] and the growth of vibrant city-based health, social, and education spaces such as SGMT are contemporary examples of how this ability to build relationships with physical spaces in ways that are mutually synergistic with the growth and strengthening of human relationships and the continuity of Indigenous knowledge and practice is thriving.

The survival of Indigenous values and approaches speaks more broadly to the notion of **Indigenous resurgence**. Indigenous resurgence involves “recreating the cultural and political flourishment of the

past to support the well-being of our contemporary citizens."[67 p51] It requires a reclaiming of "the very best practices of our traditional cultures, knowledge systems, and lifeways"[67 p17-18] but it is not about achieving cultural revitalization in a Western liberal sense.[4] Rather, it is about building stronger societies and it begins with the family.[57 72 76] In this study, culturally safe Indigenous midwifery care emerges as a form of Indigenous resurgence because it supports this reclamation and recreation process, and is concerned with the creation and nurturing of Indigenous life.[73] When health care services assert the inherent value of Indigenous infants, parents, families, communities and ways of life, and ground Indigenous peoples in their own culture and teachings, they are actively rejecting the dispossession of Indigenous peoples[4] and supporting the possibility of new, non-colonial political and social realities through birthing and family building.[74] We have shown in this study that this has many benefits for clients (e.g., reconnecting with families, communities and cultural identities; positive physical, mental, emotional, and spiritual health outcomes), yet recognize that, as with all resurgent practices, the full benefits of culturally safe Indigenous midwifery care will not be realized until many generations from now (Campbell as cited in 67).

Relevance of cultural safety to non-Indigenous peoples

In this study, we also noted commonalities between how the Indigenous participants and a few of the racialized non-Indigenous participants (i.e., specifically, the two participants who self-identified as Black) conceptualized cultural safety. Although the sample size was small, the common experiences of racism in the health care system and understandings of cultural safety in relational, kin-based, and community-specific terms are worth highlighting. Relationships between Black and Indigenous communities have existed for generations;[3] perhaps there have been/continue to be roles for Indigenous and Black midwives in strengthening solidarities and building cultural safety outside the confines of white colonial configurations.[75]

As for the additional non-Indigenous participants (the majority of whom self-identified as white/European), cultural safety was conceptualized as fitting more broadly anti-oppressive approaches to care. For example, the majority of the non-Indigenous participants felt less comfortable with the mainstream, hospital-based model of perinatal care and for that reason sought out midwifery care. Cultural safety was conceptualized as standing in juxtaposition to the highly medicalized, neoliberal, patriarchal, and heteronormative model of perinatal care that has come to dominate Canadian institutions.[25 76 77] Examples include: not being judged; not feeling rushed; being treated like a person and peer, rather than a passive, powerless recipient of care; being respected and supported in their choices, rather than losing control and their ability to choose especially during labour; receiving individualized, holistic, and client-centered support; and feeling more "at home" in a physically comfortable space (which was generally, but not always, understood as more homey and less clinical). Interestingly, many of these elements align with the Ontario[26] and Canadian[27] models of midwifery care. While it is certainly possible for other health care providers to deliver culturally safe care, other providers may be more constrained by the structures and systems in which they operate than midwives. Midwives thus has a unique opportunity to ensure that cultural safety becomes a core component of their clinical practices.

That said, where the Canadian and Ontarian midwifery models fall short is in articulating the distinctiveness of cultural safety for Indigenous and racialized clients and the specific roles of Indigenous midwives. These gaps raise questions about whose needs are being represented within existing models and whose are not – reiterating the importance of increasing the number of Indigenous and racialized midwives in practice and enhancing cultural safety training and accountability for everyone in health

care organizations. As more collaborative interprofessional perinatal care models emerge, we hope to see environments that are more conducive to cultural safety for staff, clients, and their families.

LIMITATIONS

This study involved a single midwifery practice with a unique focus; additional research is needed to better understand the relevance of these findings across different midwifery practice contexts. Furthermore, while we attempted to optimize diversity across our sample, participants tended to be older, more educated, and have more hospital births than the average SGMT client. Non-Indigenous participants were also more commonly white. This may be the result of older, more educated, white women being more likely to volunteer for the study and to choose or require hospital births or midwifery care compared to clients who were younger, had less education, and/or who were racialized. We also did not have any Inuit participants, which may be reflective of the small number of Inuit clients at SGMT.

CONCLUSION

By highlighting the uniqueness of Indigenous cultural safety; demonstrating the survival of Indigenous values, approaches, and resurgent practices in urban spaces; and introducing the relevance of cultural safety to diverse non-Indigenous communities, this study is rich in insight for providers, educators, and evaluators, who are committed to ensuring cultural safety reaches its full potential in health care. Offering a glimpse into the futures that can be made possible by culturally safe Indigenous midwifery care, we hope this study catalyzes the expansion of Indigenous midwifery in urban spaces and beyond; the pursuit of additional research on evaluating and holding people accountable for cultural safety in diverse settings; the provision of adequate support for Indigenous midwives to meet the needs of their communities; and the acceptance of cultural safety as a foundational component of clinical excellence.

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Table 1. Demographic characteristics of participants (N=20).

Characteristic	Indigenous participants	Non-Indigenous participants
Age (avg)	33.8	34.5
Education		
High school	2	0
College	2	1
University	3	5
Graduate/Professional	2	5
Parity		
Primiparous	4	8
Multiparous	5	4
Birth place		
Birth Centre	1	1
Hospital	8	7
Home	0	3
Indigenous/ethnic identity*		
	First Nations: 7 Métis: 2 Inuit: 0	European/White: 7 Racialized: 4

* Loosely based on participant self-identification.

Appendix A: SGMT Client Interview Guide

For all participants:

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

1. What number baby is this?
2. Did you have a midwife for prior pregnancy/birth?
3. Did you have an SGMT midwife for prior pregnancy/birth?
4. How old are you?
5. How far did you get in school? (no high school, some high school, graduated high school, some college/university, graduated college/university)
6. Who lives with you?
7.

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

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

These next questions focus on culturally safe care. Imagine a relationship with a caregiver in which you feel comfortable, respected and able to be yourself.

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

This final set of questions focus on identity.

For the Indigenous/Aboriginal participants:

1. Do you identify as Indigenous/Aboriginal? How do you identify?
2. Are there times you don't tell people you are Indigenous?
3. Did the midwife share any specific examples of Indigenous/Aboriginal teachings or stories during care? If yes, can you share some examples?
4. How did you feel about this (the sharing/not sharing teachings)?
5. What about ceremonies? If yes, can you share some examples?
6. How did you feel about this?
7. Would you have wanted the midwives to share more?
8. What are your suggestions for a good way for the midwives could share this type of knowledge and practice?

9. Has your understanding of being Indigenous changed since becoming a client at SGMT? If yes, how?
10. How or did or didn't your care at SGMT influence or change your family relationships?
11. Has your involvement in Indigenous community events, programs or services changed since becoming a client at SGMT? If yes, how?

For the non-Indigenous participants:

1. How do you identify?
2. Did the midwife share any specific examples of Indigenous/Aboriginal teachings or stories during care? If yes, can you share some examples?
3. How did you feel about this (the sharing/not sharing)?
4. What about ceremonies? If yes, can you share some examples?
5. How did you feel about this?
6. Would you have wanted the midwives to share more (Indigenous/Aboriginal teachings, stories, ceremonies; other cultural, spiritual knowledge and practice)?
7. What are your suggestions for a good way for the midwives to share this type of knowledge and practice?
8. Has your understanding of Indigenous people changed since becoming a client at SGMT? If yes, how?
9. Has your involvement or desire to be involved in Indigenous community events, programs, or services changed since becoming a client at SGMT?

Reporting checklist for qualitative study.

Based on the SRQR guidelines.

Instructions to authors

Complete this checklist by entering the page numbers from your manuscript where readers will find each of the items listed below.

Your article may not currently address all the items on the checklist. Please modify your text to include the missing information. If you are certain that an item does not apply, please write "n/a" and provide a short explanation.

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In your methods section, say that you used the SRQRreporting guidelines, and cite them as:

O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. Standards for reporting qualitative research: a synthesis of recommendations. Acad Med. 2014;89(9):1245-1251.

		Reporting Item	Page Number
Title			
	#1	Concise description of the nature and topic of the study identifying the study as qualitative or indicating the approach (e.g. ethnography, grounded theory) or data collection methods (e.g. interview, focus group) is recommended	1
Abstract			
	#2	Summary of the key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results and conclusions	3
Introduction			
Problem formulation	#3	Description and signifcance of the problem / phenomenon studied: review of relevant theory and	4

		empirical work; problem statement	
Purpose or research question	#4	Purpose of the study and specific objectives or questions	5
Methods			
Qualitative approach and research paradigm	#5	Qualitative approach (e.g. ethnography, grounded theory, case study, phenomenolgy, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g. postpositivist, constructivist / interpretivist) is also recommended; rationale. The rationale should briefly discuss the justification for choosing that theory, approach, method or technique rather than other options available; the assumptions and limitations implicit in those choices and how those choices influence study conclusions and transferability. As appropriate the rationale for several items might be discussed together.	5
Researcher characteristics and reflexivity	#6	Researchers' characteristics that may influence the research, including personal attributes, qualifications / experience, relationship with participants, assumptions and / or presuppositions; potential or actual interaction between researchers' characteristics and the research questions, approach, methods, results and / or transferability	6
Context	#7	Setting / site and salient contextual factors; rationale	4, 5
Sampling strategy	#8	How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g. sampling saturation); rationale	5
Ethical issues pertaining to human subjects	#9	Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues	2, 5
Data collection methods	#10	Types of data collected; details of data collection procedures including (as appropriate) start and stop	5, 6

		dates of data collection and analysis, iterative process, triangulation of sources / methods, and modification of procedures in response to evolving study findings; rationale	
Data collection instruments and technologies	#11	Description of instruments (e.g. interview guides, questionnaires) and devices (e.g. audio recorders) used for data collection; if / how the instruments(s) changed over the course of the study	6
Units of study	#12	Number and relevant characteristics of participants, documents, or events included in the study; level of participation (could be reported in results)	5, 21
Data processing	#13	Methods for processing data prior to and during analysis, including transcription, data entry, data management and security, verification of data integrity, data coding, and anonymisation / deidentification of excerpts	6
Data analysis	#14	Process by which inferences, themes, etc. were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale	6
Techniques to enhance trustworthiness	#15	Techniques to enhance trustworthiness and credibility of data analysis (e.g. member checking, audit trail, triangulation); rationale	6
Results/findings			
Syntheses and interpretation	#16	Main findings (e.g. interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory	6-13
Links to empirical data	#17	Evidence (e.g. quotes, field notes, text excerpts, photographs) to substantiate analytic findings	6-13
Discussion			
Intergration with prior work, implications, transferability and	#18	Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship;	13-16

contribution(s) to the field		discussion of scope of application / generalizability; identification of unique contributions(s) to scholarship in a discipline or field	
Limitations	#19	Trustworthiness and limitations of findings	16
Other			
Conflicts of interest	#20	Potential sources of influence of perceived influence on study conduct and conclusions; how these were managed	2
Funding	#21	Sources of funding and other support; role of funders in data collection, interpretation and reporting	1

BMJ Open

Conceptualizing cultural safety at an Indigenous-focused midwifery practice in Toronto, Canada: Qualitative interviews with Indigenous and non-Indigenous clients

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Title

Conceptualizing cultural safety at an Indigenous-focused midwifery practice in Toronto, Canada: Qualitative interviews with Indigenous and non-Indigenous clients

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Data Sharing Statement: As per the Research Agreement and the principles of OCAP®, the data that support the findings of this study (i.e. interviews) are owned by Seventh Generation Midwives Toronto. To protect participant privacy and confidentiality, the transcripts are not publicly available. The study interview guide is included in Appendix A.

Author Contributions: The evaluation within which this study was nested was co-developed by midwives at Seventh Generation Midwives Toronto (Sara Wolfe, Cheryllee Bourgeois, Sadie Booth, Alanna Kibbe) in partnership with research staff at the Well Living House [Janet Smylie (Principal Investigator), Michelle Firestone, Conrad Prince, Marcie Snyder, Bernice Downey]. The study was co-led by SW and CB in partnership with JS, MF, and CP. The interview guide was developed by SW, CB, JS, MF, and CP with minor comments from MC and HM. The interviews were conducted and transcribed by MC as a part of her Master's thesis. The transcripts were analyzed by MC, JS, and SS, with themes and linked quotes being confirmed on an iterative basis in partnership with SW and CB. MC, JS, and SW shared the role as primary author for this manuscript, receiving minor edits from CB, HM, and MF. All authors read and approved the final manuscript.

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Keywords: Indigenous; Cultural competency; Midwifery; Health services research; Qualitative research

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ABSTRACT

Objective: Cultural safety is an Indigenous concept that can improve how health care services are delivered to both Indigenous and non-Indigenous peoples in Canada. This study explored how Indigenous and non-Indigenous clients at an urban, Indigenous-focused midwifery practice in Toronto, Canada (Seventh Generation Midwives Toronto, SGMT) conceptualized and experienced culturally safe care.

Design and Setting: Interviews were conducted with former clients of SGMT as a part of a larger evaluation of the practice. Participants were purposefully recruited. Interviews were transcribed and analyzed thematically using an iterative, consensus-based approach and a critical, naturalistic, and decolonizing lens.

Participants: Saturation was reached after twenty interviews (n=9 Indigenous participants, n=11 non-Indigenous participants).

Results: Three domains of cultural safety emerged, with several themes in each domain, including: relationships and communication (respect and support for choices, personalized and continuous relationships with midwives, and being different from past experiences); sharing knowledge and practice (feeling informed about the basics of pregnancy, birth, and the postpartum period; having access to Indigenous knowledge and protocols), and culturally safe spaces (feeling at home in practice; having relationships interconnected with the physical space). While some ideas were shared across groups, the distinctions between the Indigenous and non-Indigenous participants were prominent.

Conclusion: The Indigenous participants conceptualized cultural safety in ways that highlight the survival and resurgence of Indigenous values, understandings, and approaches in cities like Toronto, and affirm the need for Indigenous midwives. The non-Indigenous participants conceptualized cultural safety with both congruence, illuminating Black-Indigenous community solidarities in cultural safety, and divergence, demonstrating the potential of Indigenous spaces and Indigenous-focused midwifery care to also benefit midwifery clients of white European descent. We hope that the positive impacts documented here motivate evaluators and health care providers to work towards a future where "cultural safety" becomes a standard of care.

STRENGTHS AND LIMITATIONS OF THIS STUDY

- To the best of our knowledge, this study is one of the few to evaluate cultural safety from the perspective of clients – the only people who can truly define whether a health service is culturally safe
- Qualitative interviews offered a glimpse into the unique ways in which Indigenous and non-Indigenous clients of an urban Indigenous-focused midwifery practice in Canada conceptualized and experienced culturally safe care
- Participants tended to be older, more educated, and have more hospital births than the average client at the practice; there were also no Inuit-identified participants among the Indigenous participants, and the majority of non-Indigenous participants were white/European
- Focusing on a single midwifery practice, care must taken in interpreting the study's relevance across pregnancy, birth, and postpartum settings and communities

INTRODUCTION

Background

Given the context of historical and ongoing settler colonialism, anti-Indigenous racism has been embedded in the Canadian health care system since its inception (1). Resulting harms to First Nations (2,3), Inuit (4), and Métis peoples (5) have been well-documented (6). One of the most disturbing examples is the death of Brian Sinclair, a Cree man who died from complications of a treatable urinary tract infection in a Winnipeg emergency room in 2008 after waiting for 34 hours without being triaged.(7) Unfortunately, Mr. Sinclair's story is not unique. Indigenous peoples are frequently ignored, shamed, and/or belittled by health care staff; misdiagnosed based on stereotypes; made to wait for long periods of time for services without explanation; denied health care services; and threatened with or face unfounded calls to child protection agencies across the spectrum of perinatal, infant, child, youth, adult, or senior care (2-6,8,9). As a result, many Indigenous peoples avoid health care services until they are critically necessary, or refuse care altogether. (6,8,9). Black patients have reported similar harms in health care rooted in systemic anti-Black racism (10,11).

Several approaches have been proposed to improve how Indigenous and racialized peoples are treated in the health care system. Common approaches include building the "cultural awareness," "cultural sensitivity," and/or "cultural competency" of health care providers. Although popular, these approaches have been criticized for drawing on narrow understandings of culture that promote stereotyping, reduce human interactions to check lists, normalize the "Othering" of racialized communities, and obscure the influence that structural forces have on health and wellbeing (12–17). These approaches have also failed to redress inequalities in health outcomes rooted in systems of oppression, such as racism, sexism, and settler colonialism (12).

Cultural safety

"Cultural safety" is a concept that was first developed by Indigenous (Māori) nurses in New Zealand to improve how services were being delivered to Māori patients (13). Cultural safety is distinct from previous approaches for several reasons. First, it is built on the understanding that "culture" is not a superficial, static concept. Rather, it is fluid, dynamic, complex, embedded within sociopolitical and historical contexts and integral to social structuring, knowledge systems, and relationships (13,17).

Second, cultural safety is both a process and an outcome; it encompasses the planning, delivery, evaluation, and outcomes of health care (12,18). While culturally *unsafe* care includes "any actions [or omissions] that demean, diminish, or disempower the cultural identity and well-being of the individual" (19, p.5) and is enabled by systems of oppression, culturally *safe* care is the outcome of feeling comfortable, respected, and safe in one's cultural identity.

Finally, and most importantly, cultural safety dictates that the only person who can define whether a service is truly culturally safe is the person receiving that service (13). By requiring feedback, cultural safety attends to and challenges patient-provider power imbalances that give few opportunities for patient experiences to drive change. Service providers, meanwhile, are required to engage in a lifelong process of critical self-reflection, learning, and growth related to their sociopolitical identities and locations (12). Confronting the realities of how settler colonialism and racism have impacted and continue to impact the care they and others deliver is a critical first step to this process.

Although cultural safety has gained interest and uptake across Canada (20,21), little has been published with regards to how best to assess, evaluate, and build accountability for cultural safety in health care, social services, and education. There is also room to explore what cultural safety means for non-Indigenous peoples (22,23).

Indigenous and non-Indigenous midwifery in Canada

In what is now known as Canada, Indigenous midwives are leaders in delivering culturally safe care. The National Aboriginal Council of Midwives (NACM) defines "cultural safety" as a core value; as Indigenous midwives "create and protect the sacred space in which each woman, in her uniqueness, can feel safe to express who she is and what she needs" (24, p.3). Even though Indigenous midwives have been supporting the health and well-being of Indigenous families since time immemorial, it was only recently that midwives – both Indigenous and non-Indigenous – returned to mainstream perinatal care in Canada (25). Colonial attempts to erase, suppress, and delegitimize midwifery were actively resisted and Ontario became the first province to regulate midwifery in 1994 (25).

Today, Registered Midwives are primary care providers who have the skills to care for people during pregnancy, birth, and up to six weeks post-partum (26) Midwives typically support clients with low-risk pregnancies and that center choice of birthplace (i.e., home, hospital, and/or birth centre), informed choice, and continuity of care as core philosophies (27). Respect for client dignity, autonomy, cultural safety, and experience as central to decision-making are core values of Ontario Midwives (28). Indigenous midwives are Indigenous self-identified individuals who are either Registered Midwives or practicing midwifery under the Aboriginal Exemption Clause (25). Indigenous midwives are unique because they bring a specific approach, knowledge base, set of skills and core competencies to their practice that enable them to support parents and families during the birth year and early life in a culturally safe way (24).

The literature exploring Indigenous midwifery and culturally safe perinatal care in general is still emerging. The majority of studies are from Australia and evaluate cultural safety from the perspectives of care providers, rather than recipients (29–31). There is also a gap in the cultural safety literature with regards to place; most studies focus on rural, remote, and/or northern communities (32,33). Considering that the majority of Indigenous peoples in Canada are now living in urban centres, and that anti-Indigenous racism persists, there is an urgent need to understand what culturally safe care looks like in urban settings to ensure quality services and interrupt ongoing harms.

Seventh Generation Midwives Toronto (SGMT) is an Indigenous-focused midwifery practice in Toronto, Canada that strives to meet this need (34). Toronto is one of the largest and most ethnically diverse cities in Canada (35). It has the largest population of Indigenous people in Ontario, with recently confirmed estimates of at least 70,000 people (36). Accordingly, SGMT welcomes both Indigenous and non-Indigenous clients into their practice, and has Indigenous and non-Indigenous midwives on staff. As an Indigenous-focused practice, SGMT reserves spaces for Indigenous clients with low- and high-risk pregnancies; trains student-midwives and is designated as a priority placement for Indigenous students; creates opportunities for Indigenous clients to include Indigenous teachings, practices, and protocols in their care; and supports all families to reflect on the importance of culture and tradition in their birth year experience.

SGMT initiated its first practice evaluation in 2014. In this qualitative study, we present findings from interviews with clients that were conducted as a part of this evaluation. The purpose of this study was to determine how Indigenous and non-Indigenous clients at SGMT conceptualized cultural safety, and the extent to which their experiences at SGMT aligned with these conceptualizations.

While we use the collective terms "Indigenous" throughout this article, the diversity and richness of First Nations, Inuit, and Métis cultural heritage and expression as Indigenous peoples from many nations and backgrounds coming together in a large urban centre should not be underestimated. Support for self-

determined and relationship-based cultural expression, cultural respect, and sharing across these diversities is a core premise of SGMT's practice(37), and cultural safety in Toronto more generally.

METHODS

Study Overview & Approach

This study was initiated as a part of a multi-phased Indigenous health service evaluation of SGMT that was informed by informed by Indigenous, utilization-focused, and realist methodologies (38–40). The aim of the evaluation was to learn how, why, and for whom SGMT works and to develop a culturally relevant performance measurement system for the practice. Evaluation questions included: (1) What are the maternal, child and family birth outcomes for SGMT clients? (2) What are the key prenatal, birthing and reproductive health needs of our clients and how are we meeting these needs? (3) How do our clients define culturally secure reproductive health care? And (4) Is SGMT contributing to changes in attitudes and behaviours regarding Aboriginal peoples, knowledge, and practice, and how? The evaluation consisted of: (A) key informant interviews with SGMT clients and SGMT midwives, (B) pre- and post-care questionnaires for SGMT clients, and (C) SGMT outcome legacy data from 2005-2012. This study reports on findings from the key informant interviews with SGMT clients.

The SGMT evaluation was co-led by Indigenous midwives at SGMT (SW, CB) in partnership with researchers at the Well Living House based at St. Michael's Hospital in Toronto (JS, MF). This evaluation built on over ten years of pre-existing Indigenous community, clinical, and research collaboration between the community and academic leads (SW, CB, JS).

The evaluation design and implementation drew on the Well Living House's established methods and protocols for conducting rigorous, ethical, and high-quality Indigenous health research (41–44) and published best practices (45). These methods balance tangible community benefits with research excellence, strong and reciprocal relationships, capacity building, Indigenous leadership, and Indigenous governance and management of Indigenous information (46).The roles and responsibilities of the evaluation partners (i.e., the Well Living House and SGMT) with study conduct, governance, data sharing, and SGMT data ownership were delineated in a project-specific data sharing, research, and publication agreement. The midwives were actively involved in the evaluation, co-leading the development of the evaluation questions, logic model, and evaluation tools (e.g., interview guide used for this study). The midwives were also involved in the training of data collectors, recruitment of participants for the interviews and questionnaires, and the vetting of evaluation outputs.

Participant Recruitment & Data Collection

Potential participants were identified using purposeful sampling (47) to best represent the diversity of needs, choices, and health care experiences observed at SGMT. SGMT midwives compiled a list of clients who were ≥ 18 years old, gave birth in 2014, and represented different social locations – including age, family structure, socio-economic status, education level, Indigenous/non-Indigenous identity, race, and birth outcomes – to be potential participants.

The SGMT receptionist made first contact with potential participants. Potential participants who expressed interest in the study and gave permission to be contacted were telephoned by MC. MC is a white settler cisgender woman who at the time of the study was a novice researcher completing her Master of Public Health. She had no previous relationship with SGMT, midwifery, childbirth, or the participants. MC received training and mentorship from the SGMT midwives and WLH researchers to prepare for participant contact and interviewing. Mentorship included conducting practice interviews with past Indigenous client volunteers

and receiving direct critical feedback from an Indigenous midwife on relational approaches to interviewing.

During the initial phone call, MC explained the study, answered questions, and if appropriate, scheduled an in-person meeting with the potential participant. During the subsequent meeting, MC reviewed the study in depth, assured them that their participation or lack thereof would have no impact on their future care with SGMT, answered questions, and obtained informed consent. All interviews were conducted in-person by MC between October 2014 and March 2015. Interviews varied in length from twenty minutes to one hour and took place in quiet, private locations of the participants' choice (e.g., coffee shops, homes, SGMT office). The interviews were digitally recorded with participant consent. One participant requested that their interview be transcribed via laptop. Participants were asked whether they wished to review their transcripts prior to analysis to enhance the accuracy, validity, and credibility of the study (48) and four requested this review. Participants were given a small gift and monetary compensation ($20) to acknowledge their contributions and cover any costs related to participation.

Questions focused on past experiences with perinatal care; specific needs during pregnancy, birth, and the post-partum period; experiences receiving care from SGMT; culturally safe care; and the role(s)/importance of identity and knowledge sharing. Cultural safety was explained to participants as "what makes you feel comfortable, respected, and able to be yourself." The interview guide is presented in Appendix A**.** The research team members from SGMT (SW, CB) and Well Living House (JS, MC) agreed that saturation had been reached after nine Indigenous participant interviews and eleven non-Indigenous participant interviews (N=20), as no new themes or ideas were emerging (49).

Data Analysis

The recordings were transcribed verbatim by MC and verified by a second Well Living House researcher. Transcripts were analyzed thematically using an established consensus-based, iterative method that involved both academic and community-situated peer researchers and applied a critical, naturalistic, and decolonizing interpretive lens (42,43). This lens is based on key assumptions that have been detailed elsewhere (41, p.437-438). The aim of our methodological approach was to centre Indigenous perspectives and to understand and represent the gathered information in a way that was as true to the lived experiences of the Indigenous and non-Indigenous participants as possible.

Analysis began with a mixed academic-community team completing an in-depth review and preliminary theme-based coding of the transcripts. The team consisted of MC, a White settler researcher who at the time was completing a Master of Public Health; JS, a well-known Métis family physician and applied public health researcher; and SS, a First Nations woman who was invited to independently contribute based on her lived experience as a former SGMT client and experience in qualitative analysis. Each team member was tasked with individually identifying the major themes in the transcript along with key quotations that illustrated this them. After this preliminary independent thematic coding, the team met to reach consensus on major themes and develop a codebook with exemplar quotations. MC then conducted an in-depth analysis of the transcripts using a crystallization-immersion process (50) to further develop the coding. The resultant analysis was iteratively refined in a series of meetings with JS and SS and then presented to community research partners SW and CB for final review and approval.

Patient & Public Involvement

An advantage of our Indigenous community-partnered research approach and Indigenous leadership of both the academic and community research team is that "patient and public involvement" are built into the research process. Collectively, the three Indigenous authors (JS, SW, CB) have more than 65 years of

experience providing Indigenous-focused maternity care and they have all also personally experienced Indigenous midwifery care. Further, the larger evaluation of SGMT was informed by a number of focus groups that involved Indigenous Elders, Indigenous community members, and SGMT midwives. Indigenous experiences, priorities, and preferences of clients were therefore central throughout the evaluation, including the development of research questions, outcome measures, study design, and recruitment of participants. This specific study, in addition to being focused on client informants, included former SGMT clients for community context in the data analysis to ensure the results would be as true to the lived experiences of community members as possible. These aspects included data collection (i.e., participant interviews) and analysis (i.e., opportunities for member checking, and inclusion of the independent research analyst who was a former client of SGMT). Results from this study will be shared at conferences, in publications, and/or in community-friendly fact sheets distributed to SGMT clientele and study participants. Because SGMT owns the data, all materials must be reviewed and approved by SGMT before distributing.

RESULTS

Three domains of cultural safety emerged from the analysis: (1) Relationships and communication, (2) Sharing knowledge and practice, and (3) Culturally safe space. Several themes were identified in each domain. The themes are presented below, supported by quotes from the Indigenous and non-Indigenous participants. The Indigenous/ethnic identity of each quoted participant is coded following each quotation below using "I" for Indigenous and "N" for non-Indigenous, followed by a participant number and specific ancestry/ethnicity. The demographic information of participants is presented in Table 1.

Relationships and Communication

Respect and support for choices

When describing cultural safety, many participants (n=13) emphasized the importance of feeling respected and supported in their choices:

> 'Culturally appropriate care would be something that is respectful of any practices that I would have that I would want to do, not judgmental about choices that I'm making, giving me informed or information about a choice I made that they may not necessarily follow their model of care […] but respecting my choices regardless.' (I5, Métis)

"Choice" was broadly defined to include life choices, choices about pregnancy and birthing, and choices about client involvement in decision-making. Respect and support for choices, then, was made possible when the midwives withheld judgment, honoured the participant's decisions, and/or advocated on their client's behalf:

> 'When I first met [my primary midwife], I was feeling insecure and she made me feel really confident, like what I was doing, you know, choosing to be a single mom. She really helped me feel like it was a good choice instead of something to be afraid of.' (N13, White/European)

> '[My midwife was] warm, easy to talk to, she didn't judge me for anything I said. She just... she understood, you know. She didn't, like even though, yes, she had to remind me "it's better to breastfeed," she never pushed the idea on me, you know what I mean?' (I4, First Nations)

> '[My midwife] was able to like be in my corner and be like "no, she doesn't actually have to do this. […] There's nothing indicating that she needs to be in this position." So because of that, she

> kind of gave me the strength to continue to be my own advocate even when she wasn't in the [hospital] room.' (I7, First Nations)

One participant felt that her midwives could have been more supportive of their preference for a midwife-led approach:

> 'Just saying, "you can do it or you don't have to do it," to me, is not what I'm looking for. I still want to have the choice, but I'd like someone to explain the risks, the benefits, what most people do, why most people do what they do.' (N11, White/European)

Personalized, continuous relationships with midwives

Cultural safety was also conceptualized as having personalized, continuous relationships with midwives. Participants from both groups described these relationships as being treated like a human and peer rather than a number, not feeling rushed, and receiving individualized emotional and mental health support.

> 'You can feel when somebody actually cares, as opposed to making it a clinical situation. […] I mean sometimes we would just chit-chat and it was nice, you know?' (N14, Caribbean and European)

> 'Once I was in the room with the midwives... all the attention was on me. Just taking the time to ask any questions or, you know, not make me feel like I was being asked to get in and out as quickly as possible. […] I felt like I would be able to build a good relationship with the midwives there.' (I8, Métis)

> 'It was very important to have a little bit of the emotional support that just, kind of, buoys you when you're pregnant and feeling awful and overwhelmed. […] That's not something I have at home, so it was good to know that I had somebody to provide that, as well as that sort of physical and medical backup.' (N19, White/European)

However, for most of the Indigenous participants and one of the racialized non-Indigenous participants, these relationships were more specifically conceptualized as two-way, kin-based relationships built on shared understandings and experiences.

> 'I would like to imagine my childbirth experience to be, to feel like I'm amongst sisters and not with a medical professional. And with my sisters I know their story, and so I feel like I would like to know my midwives' story a little bit more.' […] I think that's important and it develops trust and well, really, a sense of community.' (I1, First Nations)

> 'It's nice when [the midwives] would share where they're from. [My midwife] said what reserve she's from […] and she shared her stories. It made me feel more comfortable in talking to her and sharing my story and going through the journey of giving birth, cuz it's a very personal, highly personal, thing.' (I6, First Nations)

> 'It was literally about bringing this new person into the world and welcoming her in this, kind of, almost like a sisterhood.' (N20, Black/Caribbean)

This was also evident when some of the Indigenous participants explained why it was so important to

have an Indigenous-identified midwife.

> 'The ideal is the Aboriginal midwife, just being Aboriginal herself. She understands what it means to be an Aboriginal woman because she's lived that life. […] She would know and understand and we'd have that connection. We'd understand each other.' (I6, First Nations)

> 'Throughout the pregnancy, the student was awesome because she was, for one, she was Aboriginal so she gets it. Secondly, she just had a calming effect on me. And so, I liked that. And she, she didn't make anybody feel lesser or higher than her. She was at the same level and that's what I loved about that.' (I9, First Nations)

Only one Indigenous participant (IP8, Métis) felt that her non-Indigenous midwife "practiced culture care as much as my Aboriginal one […] She might have been more sensitive because she wasn't [Indigenous]."

For some of the Indigenous participants, personalized and continuous relationships also meant the midwives facilitating the intergenerational transmission of knowledge and participation in care, and practicing beyond the scope set by the Ontario midwifery model of care or standards of practice.

> 'My daughter was there for my birth, so that was a big thing for me too. I was kind of hesitated about if she should come or if she couldn't come, but the midwives, were like, you know, "it's fine, she can come.' (I3, First Nations)

> 'I think for my mom, who isn't in touch with her Aboriginal culture, I think it was really nice for her to live through it through me. […] She came to one of my appointments with me and she made me a moss bag, so you know? Just really celebrating her culture where she felt safe to do it.' (I8, Métis)

> '[When] I was at [the children's hospital], my midwife actually gave me money to buy food because they don't feed people, they don't feed grown ups [there].' (I4, First Nations)

> 'There are ceremonies that you have for couples too, right? Like in parenting. I would've loved to have learned a little bit about that kind of stuff [at the practice].' (I9, First Nations)

For the non-Indigenous participants, personalized relationships were described in more client-centered terms; several participants spoke to the importance of the midwives "getting to know the patient and making sure that they're sort of doing everything they can to have a healthy pregnancy and maintain their own health emotionally and physically" (N16, White/European). Continuity of care was also understood as such, with participants identifying having the same midwife/group of midwives, being visited at home, and receiving comprehensive post-partum care as vital to feeling supported, respected, and able to be themselves.

> 'I think in terms of labour and delivery, I think having the actual person you developed a relationship with is hugely important. […] That made a huge difference, I think, in my comfort in that experience, 'cause they know you, they know how to keep you calm, and yeah, you feel better.' (N11, White/European)

> 'To have somebody tell you, "nope, everything's fine, everything's perfect, she's perfect; nope, she's progressing as she should be; no, this jaundice this nothing to worry about it's only a little bit." All of those things, it's just constant reassurance and it just allows you to just focus on what you should be focusing on, which is a newborn, getting a bit of sleep, all that kind of stuff.' (N12, White/European)

> 'It was great because they could come to the house and I had [my first child], she's quite [laughs]… she's not a handful, but especially after you've just given birth, they would come to the house and check up on the baby and they… seemed to really take time with the baby too and she wasn't just a number, like they actually cared about how she was doing.' (N10, White/European)

Being different from past negative experiences

Fourteen participants, nine of whom were Indigenous and one of whom was non-Indigenous and racialized, drew on their past negative experiences with hospital-based health care providers and systems to explain what cultural safety was *not.*

> 'I have a background of having doctors not listen to me. Or not respect my opinion. And so there was a fear that if I had to make some decisions […] that my options weren't gonna be considered. […] So that's what I mean by [not wanting to be in a] medical setting where everything's standardized – your individual concerns aren't really heard.' (I8, Métis)

> 'I had a rather bad experience with the obstetrician we started with - like I didn't feel she was taking our concerns serious. [...] [After I asked my] third question, she was like literally cutting me off, and she wasn't even sitting down for the appointment. She was just like standing in the doorway the whole time! So that's when I said to my [partner], "we need to find midwifery care!"' (N17, White/European)

Sharing Knowledge and Practice

Feeling informed about the basics about pregnancy, birth, and the post-partum period

All twenty participants valued the clinical information they received from their midwives, feeling supported and safe when they knew what to expect physiologically and what options were available.

> "Having [the midwives] talk to me, and really provide me with information so I can make an informed consent, an informed decision, and that would be where I felt respected." (I2, First Nations)

> "I needed information, mainly because it was my first pregnancy, so like everything is new. And as much as you read online, you need someone to guide you or answer your questions. So information was the main [support I needed], I would say." (N15, Middle Eastern)

> "I didn't know anything about pregnancy. I think the last time I was around anyone that was pregnant was my sister… [and] it's been awhile. Anything that came out of [the midwife's] mouth could help me!" (I9, First Nations)

There was also some discussion about *how* information was and could be communicated, with participants emphasizing the importance of using accessible language and welcoming families of all identities.

> "I was looking for, sort of the medical side of the pregnancy information to be delivered in a non-medical setting. That was very important to me. I didn't feel like it was a medical process to be pregnant, nor was childbirth a medical emergency. […] The midwives' approach was informative, calm. All the information was delivered in such a consumable way for me, an understandable way for me." (NA19, White/European)

> "They do the home birth class and have a question and answer night just for dads. […] Let's change that language and make sure that it's accessible to all partners and not just male partners. I think that the other piece was just watching the language on some of their intake forms and paying attention to pronouns, and making it a little more accessible to the LGBTQ population, given that Two-Spirited is something that is part of the Aboriginal culture and it's not on any of their paperwork." (I5, Métis)

Having access to Indigenous knowledge and protocols

All of the Indigenous participants and three of the non-Indigenous participants conceptualized cultural safety as being able to access Indigenous knowledge, teachings, ceremony, and protocols ("Indigenous knowledge and protocols") during the perinatal period. For one Indigenous participant, cultural safety was about access and:

> 'Treating cultural things as "normal," so it's not a novelty thing that like I was seeing a healer and he was giving me teas to drink. […] Like [the midwives] just took it at value that, like, a traditional person gave those to me.' (I7, First Nations)

Indigenous knowledge and protocols did not only encompass more formal teachings, medicines, and ceremony, but also, everyday practices and protocols such as including family members, learning via storytelling, and sharing food and drink:

> 'Something that would make me feel more culturally rooted would be the chance to either accept or offer food or drinks. Not just water, but like if there was, I don't know, like a tea station or something. Something that makes me feel like I'm going to my granny's house, you know? Or to my auntie's house, or you know? Like where you're just a cup of tea.' (I1, First Nations)

Eight of the Indigenous participants sought care from SGMT to access Indigenous knowledge and protocols. All of the Indigenous participants who were given the opportunity to include Indigenous knowledge and protocols in their midwifery care reported benefits:

> 'You know how long it takes for your chest to go down [after labour]? It took me two days with that tecta [tea], so it was very helpful.' (I4, First Nations)

> '[My primary midwife] smudged with some tobacco that she got and that was quite sacred to her. So that was really special that we really got to smudge before her birth. […] It calmed me down because I wasn't ready for [my baby] to be born; she was too early.' (I2, First Nations)

> 'We could smudge when I was in labour, right? That was a big thing for me. Doing that meant a lot and especially giving my daughter a cedar bath when she was born, that meant a lot to me too, right? So it's impacted me a lot, my culture, in the last few years. And I'm happy to be giving my children that now because I understand it more and I know a little more about my culture, and now they can pass it on.' (I3, First Nations)

Six Indigenous participants felt that there was room for their midwives to better initiate conversations about Indigenous knowledge and protocols. Some participants did not know what to ask for, or how to ask for it.

> 'I remember that experience being told about the cedar bath […] I really have no clue how to do the ceremony. And so I think the assumption was, "no, just do a cedar bath, you know? Put cedar in a bath." So I think some things have to be spelled out so people feel comfortable doing it, cuz if it's not… you feel like you're misrepresenting the cultural practice and you're not passing it on properly.' (I8, Métis)

> 'My midwife just took it upon herself to say, "hey do you wanna smudge?" and we're like "yeah, that's great, like we didn't even know that was an option" because of, you know, you're in a hospital. […] She did it on her own and she asked me in the birthing room if it was something I wanted to do and… then she told me the story of the tobacco and how she got it and it was pretty special. So it made me feel quite, quite special about that.' (I3, First Nations)

The importance of the midwives asking/inviting became clear after one Indigenous participant was *not* asked, which made the participant feel "that I'm not Aboriginal, right? That I'm not Métis" (I5, Métis). She went on to share that she was hoping for "an experience where I would learn a little bit more. My grandparents passed away when I was fairly young and we moved to a very White community, which sort of segregated any teachings that I would've experienced from them." (I5, Métis)

All of the Indigenous participants wished that they had access to more Indigenous knowledge and protocols. Some Indigenous participants spoke to the challenges of this task, such as the impacts of colonial suppression:

> 'In the community that I was brought up in, we haven't really shared childbirth, traditional knowledge about childbirth. And so it's not something that my sisters and I carry with us today that we can share amongst others. So if they have anything that they could share related to traditional knowledge and childbirth, I would love to hear about it because I feel like it's something that's been lost' (I1, First Nations).

Three of the non-Indigenous participants were interested in accessing Indigenous knowledge and protocols at SGMT. Two of these participants had children whose biological fathers were Indigenous. One participant, who used an Indigenous sperm donor, felt that the cultural and spiritual aspects of her care "didn't get as developed as I would have liked" (N13, White/European). Another participant, who had a previous relationship with her child's father, was offered a smudge during labour but ran out of time. She was grateful for the sage because "it was like a little memento from the experience and everything and I think also, even though I'm not with [their] dad, that knowing that would've also gave him some level of peace […] 'cause he couldn't be here" (N20, Black/Caribbean). The third participant, after experiencing a perinatal loss, had her child honoured at a ceremony attended by her Indigenous midwife. She felt that this ceremony was key to her healing because afterwards, "it was just like I knew that some of the things I'd been feeling subconsciously but couldn't quite vocalize had been met" (N17, White/European).

Culturally Safe Spaces

Feeling "at home" in practice

Cultural safety was also conceptualized as being in a physical space that made participants feel "at home." Even though most participants (n=18) described this space as "less clinical" and more "homey," the ideals fell on a continuum ranging from the Toronto Birth Centre to their own home settings.

> 'I think the home environment would be my ideal place. […] I think the true privacy, that it really is your space. You know, no matter what you do to a hospital room or to a birthing centre room it never really becomes "your" space, but this [home] is always going to be your space. And it's just, you know, you can labour in any position you want, there's no… medical equipment just hanging in the corners waiting for you.' (I2, First Nations)

One of the non-Indigenous participants felt more at home in a "more medicalized space" (N11, White/European), whereas one of the Indigenous participants recalled the reserve where she grew up.

> 'The nature, the bush, the trees, freshwater; that is the ideal space I'd like to bring and raise my child into. […] It's just what I know, where I grew up, what I experienced. It makes me happy, relaxed, calm.' (I6, First Nations)

Relationships interconnected with physical spaces

For many of the Indigenous participants and one of the racialized non-Indigenous participants, conceptualizations of culturally safe space were inseparable from relationships:

> 'It's almost like [primary midwife] came in and the energy changed in the [hospital] room again, and it was like calm, 'cuz I trusted her.' (I7, First Nations)

> '[Cultural safety is] pretty much what [the midwives] did, which was like give me enough space. So like, for example, I had a crap ton of visitors, right? And my visitors *[laughs]* are, you know, sometimes like very Caribbean and like wanna bring you food and tunes and stuff. […] It made all the difference in the world when, you know, my friends came and got me to laugh, and I just basically just was able to relax and, like you said, be myself and like quit freaking out. […] Just the fact that the space was given for me to be myself. Nobody made a big deal and said, "oh, you can only have this many people in the room.' (N20, Black/Caribbean)

The role of SGMT in the broader community also arose in discussions about culturally safe spaces. For one of the Indigenous participants, being and feeling connected to community was essential:

> 'In the summer I went to a pow wow and while I was there, I saw my midwife and her family. And then I didn't realize, but the [practice receptionist] was actually dancing and he was in regalia, and I didn't recognize him. When I came into the clinic just after the pow wow, he was telling me how he saw me there. So that makes me feel like, you know, being able to go to these Aboriginal events in the city and to see people who I know makes me feel more connected for sure.' (I1, First Nations)

SGMT also had varied but generally positive impacts on the non-Indigenous participants' attitudes towards Indigenous peoples. This mainly occurred through passive exposure and was met with varying degrees of reflexivity:

> '[My experience at the practice] has sort of has piqued my interest [in the Indigenous community] at a low level.' (N18, Chinese/European)

> '[My experience at the practice] made me read about [Indigenous communities] and get curious about it more. It's opened my mind towards this community more than before.' (N15, Middle Eastern)

> 'I absolutely have an interest [in engaging with the Indigenous community], but I also feel quite the opposite of entitled. In fact, like I shouldn't be given the privilege to know what other people do, especially Aboriginal people *[laughs]* given our history, the history of the country, the current state of the country.' (N19, White/European)

DISCUSSION

This study found that Indigenous and non-Indigenous midwifery clients conceptualized and experienced cultural safety at SGMT in different ways. While some ideas were shared across groups (i.e., the three domains: Relationships and Communication, Sharing Knowledge and Practice, and Culturally Safe Space), the more prominent finding was the unique and distinct ways in which the Indigenous participants conceptualized cultural safety. In this discussion, we use a critical and decolonizing lens to explore the significance of the Indigenous participants' conceptualizations and their implications for health care practice. We then explore the non-Indigenous participants' conceptualizations and their implications – taking care to highlight the parallels that emerged between the Black and Indigenous participants.

Indigenous conceptualizations of cultural safety

Coming from diverse backgrounds, each Indigenous participant had their own conceptualizations of cultural safety – of what would make them feel comfortable, respected, and able to be themselves. However, there were aspects of cultural safety that were almost exclusively identified by the Indigenous participants. The conceptualization of cultural safety as having reciprocal kin-based relationships with midwives, access to Indigenous knowledge protocols, and relationships being connected to the space suggests that the Indigenous participants shared a distinct understanding of relationships, knowledge, and space. These conceptualizations resonate with overarching Indigenous social constructs that exist and have always existed across Indigenous communities (51–55).

For example, the desire to connect with midwives as family for the process of childbearing could align with the Cree and Métis concepts of *wahkootowin*. Métis elder and scholar Maria Campbell explains wahkootowin, or the "kinship or the state of being related" (Ermine as cited in 54, p.5), as follows:

> "Today it is translated to mean kinship, relationship, and family as in human family. But at one time, from our place it meant the whole of creation. And our teachings taught us that all of creation is related and inter-connected to all things within it. Wahkootowin meant honouring and respecting those relationships. [It was] our stories, songs, ceremonies, and dances that taught us from birth to death our responsibilities and reciprocal obligations to each other. Human to human, human to plants, human to animals, to the water and especially to the earth. And in turn all of creation had responsibilities and reciprocal obligations to us." (54, p.6)

For some Indigenous peoples, relocating within networks of kinship like wahkootowin can heal the ruptures of multi-generational family disruption, abuse, and forced displacement from colonialism. However, kinship must be structured in contexts that are rooted in Indigenous knowledge and practice,

and aligned with the diverse and specific personal, family, and community histories, experiences, and identities present. Here, we recall how important it was for the Indigenous participants to have access to Indigenous knowledge, protocols, ceremonies, and medicines through SGMT – regardless of their pre-existing level of knowledge or desire to use them. It was also expected that the Indigenous midwives would receive and share this knowledge with Indigenous participants. The ability to pass this knowledge to/from future and past generations was powerful and healing for some of the Indigenous participants. Given the rich cross-nation traditions of Indigenous midwifery (25) these findings signal that the roles and expectations of Indigenous midwives as intergenerational knowledge carriers remain alive and well.

Wahkootowin is inclusive of relationships with specific landscapes, waterways, plants, and animals because these are considered kin. Relationships, responsibilities, knowledge systems, and landscapes are foundationally interconnected across the diversities of Indigenous societies, and reflect a grounding of Indigenous ontologies and epistemologies in local ecosystems (56,57). Through this lens, it is not surprising that the Indigenous participants conceptualized relationships and physical spaces in cultural safety as intertwined.

The presence of Indigenous understandings and approaches to childbearing in large urban centres such as Toronto is significant for several reasons. As reported previously, and discussed by the Indigenous participants, cultural expression and intergenerational knowledge transmission can be daunting in this context. Systemic anti-Indigenous racism in hospitals (3,6); intergenerational gaps in Indigenous childbearing and midwifery knowledge linked to purposeful colonial disruption (25,58); the need to balance knowledge sharing with knowledge protection and preservation; and externally imposed politicizations of Indigenous identities (59,60) are only some of the challenges many Indigenous peoples living in cities must face. However, this study demonstrates that Indigenous values and social constructs – including the ability and desire to strengthen kinship networks and build relationships with place – have not been lost with urban Indigenous migrations and the urbanization of traditional Indigenous landscapes. Despite forced relocations and interruptions by colonial powers, Indigenous peoples have a long and well-documented history of adapting to and building relationship with places (61). The establishment of urban Indigenous Friendship Centres (62), the assertion of traditional Indigenous land use in cities (63,64) and the growth of vibrant city-based health, social, and education spaces such as SGMT are contemporary examples of how this ability to build relationships with physical spaces in ways that are mutually synergistic with the growth and strengthening of human relationships and the continuity of Indigenous knowledge and practice is thriving.

Reflecting on the diverse and resonant ways in which familial and kinship relationships remain foundational to urban Indigenous communities, this study affirms the importance of Indigenous midwifery and the need for culturally safe services in urban areas like Toronto. The Indigenous participants cherished the existence of SGMT and Indigenous midwifery, describing the unique sense of trust, comfort, connection, and shared understandings they could have with Indigenous midwives. The results show that, while non-Indigenous midwives and providers can provide culturally safe care, Indigenous midwives bring a shared understanding and approach that can have uniquely powerful and positive impacts on the health and wellbeing of Indigenous clients.

This study also highlights the role that Indigenous midwives play in Indigenous resurgence. Indigenous resurgence involves “recreating the cultural and political flourishment of the past to support the well-being of our contemporary citizens”(65, p.51) and requires a reclaiming of “the very best practices of our traditional cultures, knowledge systems, and lifeways” (65, p.17-18). Recall that “culture” is understood broadly through an Indigenous lens. Illuminating the power of Indigenous midwives and the

survival of Indigenous understandings of relationships, knowledge, and space, this study offers a glimpse into the Indigenous resurgence that is occurring in Toronto. When health care services assert the inherent value of Indigenous infants, parents, families, communities and ways of life, and ground Indigenous peoples in their own culture and teachings, they are actively rejecting the dispossession of Indigenous peoples and supporting the possibility of new, non-colonial political and social realities through birthing and family building (66–69). In other words, when health care services are provided in a culturally safe way to Indigenous peoples – whether by an Indigenous or non-Indigenous provider – it is a political act of care in support of Indigenous resurgence.

Non-Indigenous conceptualizations of cultural safety

As a relatively heterogenous group, the non-Indigenous participants' conceptualizations of cultural safety varied. Even though further research is needed to better understand these conceptualizations, patterns did emerge that distinguished the white/European participants' conceptualizations from the racialized participants' conceptualizations. One significant finding was the similarities between how the two participants with Black/Caribbean ancestry and the Indigenous participants conceptualized cultural safety. Although the sample size was small, the common experiences of racism in the health care system and understandings of cultural safety in relational, kin-based, and community-specific terms are notable; we are reminded of interconnections between Black and Indigenous communities, including historic and current acts of solidarity in the face of anti-Black and anti-Indigenous racism. These important relationships warrant further attention and exploration and present an opportunity to better understand intersections between Indigenous and Black constructions of cultural safety outside the confines of white colonial configurations (70).

While cultural safety may not have been specifically designed for white/European clients, this study shows that the Indigenous concept of culturally safe care resonated with and benefited participants with white/European ancestry. For example, several non-Indigenous participants, many of whom were white, spoke to how SGMT itself, given its Indigenous focus and commitment to cultural safety, motivated them to think more broadly about their own cultural needs and identities and in some cases learn more about Indigenous communities. Because dominant Canadian understandings of "culture" are still narrowly equated with "racialized communities"(17) it is promising that being asked by midwives to reflect on culture and tradition and actively exposed to Indigenous peoples and Indigenous spaces can help shift thinking.

With regards to white/European participants' conceptualizations of cultural safety, common themes emerged. In general, cultural safety was conceptualized as relationships, knowledge, and spaces that were client-centered and anti-oppressive. The notion that culturally safe care stood in juxtaposition to the highly medicalized, hospitalized, cisheteronormative, physician- and male-dominated mainstream model of perinatal care that has been critiqued elsewhere (71,72) was widely shared. Themes related to control over choices and spaces were especially prevalent. Upon reflection, it appears that white participants conceptualized cultural safety in ways that were resonant and at times identical to the core principles in the Ontario midwifery model of care (i.e., informed choice, continuity of care, and choice of birthplace; (27)). While it is likely that all participants valued these principles (hence their choice of a midwife), the white participants were more precise in their articulations of culturally safe care meaning Ontario midwifery care. This finding is significant because it suggests that Ontario midwives are well-positioned, by virtue of their philosophy, approach, and model of care, to provide what is considered to be culturally safe care to clients who are white/European. It also raises critical questions about whose understandings of midwifery and culturally safe care are taken into consideration when designing and delivering Ontario midwifery care. For example, the concept of client-centered care and "getting to

know the individual" may not foster cultural safety for Indigenous and racialized clients who understand relationships, knowledge, and space as interconnected manifestations of family, kinship-based societies. Here we are reminded of the necessity of increasing the number of Indigenous and racialized midwives and perinatal care providers and the need to ensure that cultural safety standards, initiatives, and appraisal become a core part of health service functioning and health service provider training. This in turn must draw on understandings of cultural safety that are meaningful and relevant to Indigenous and racialized peoples.

LIMITATIONS

This study involved a single midwifery practice with a unique focus. Additional research is needed to better understand the relevance of these findings across different midwifery practice contexts. Furthermore, while we attempted to optimize diversity across our sample, participants tended to be older, more educated, and have more hospital births than the average SGMT client. Non-Indigenous participants were also more commonly white. This may be the result of older, more educated, white women being more likely to volunteer for the study and to choose or require hospital births or midwifery care compared to clients who were younger, had less education, and/or who were racialized. We also did not have any Inuit participants, which may be reflective of the small number of Inuit clients at SGMT. We acknowledge that this study is very community-specific and hope it will motivate further exploration of the ways Indigenous and non-Indigenous communities conceptualize and experience culturally safe care across diverse gender identities, sexualities, identities, family situations, income levels, locations, and abilities.

CONCLUSION

In this study, we interviewed former clients of an urban Indigenous-focused midwifery practice to determine how Indigenous and non-Indigenous clients conceptualized cultural safety, and the extent to which their experiences at the practice aligned with these conceptualizations. Three core domains of cultural safety emerged: relationships and communication; sharing knowledge and practice; and culturally safe space. Several themes were identified in each domain, some shared across Indigenous, and/or non-Indigenous racialized, and/or non-Indigenous white/European groups, and some distinct to Indigenous participants. Indigenous participants' unique conceptualizations of cultural safety reflected longstanding Indigenous understandings of relationships, knowledge, and space. The survival of Indigenous values and approaches to childbearing affirms the value of Indigenous midwives, the need for culturally safe care in urban centres, and the resilience and resurgence of urban Indigenous communities.

Assessing cultural safety from the perspective of clients, this study offers new insights to the emerging fields of Indigenous midwifery and cultural safety research. Our results illuminate the unique needs of Indigenous clients, the resilience and resurgence of Indigenous communities in Toronto, and the vital role of Indigenous midwives. We have also demonstrated the positive impacts that culturally safe care can have for clients of all backgrounds. These findings highlight the desire of midwifery clients to see an expansion of Indigenous midwifery services and culturally safe services in urban spaces and beyond and the need to include "cultural safety" as an indicator in future evaluations of health care services and organizations. Making culturally safe care the standard of care is a key first step in interrupting the harms of anti-Indigenous racism and oppression in health care, and in supporting families and communities to not only be healthy and well but to thrive.

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Table 1. Demographic characteristics of participants (N=20).

Characteristic	**Indigenous participants**	**Non-Indigenous participants**
Age (avg)	33.8	34.5
Education		
High school	2	0
College	2	1
University	3	5
Graduate/Professional	2	5
Parity		
Primiparous	4	8
Multiparous	5	4
Birth place		
Birth Centre	1	1
Hospital	8	7
Home	0	3
Indigenous/ethnic identity*		
	First Nations: 7 Métis: 2 Inuit: 0	European/White: 7 Racialized: 4

* Loosely based on participant self-identification.

Appendix A: SGMT Client Interview Guide

For all participants:

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

1. What number baby is this?
2. Did you have a midwife for prior pregnancy/birth?
3. Did you have an SGMT midwife for prior pregnancy/birth?
4. How old are you?
5. How far did you get in school? (no high school, some high school, graduated high school, some college/university, graduated college/university)
6. Who lives with you?
7.

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

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

These next questions focus on culturally safe care. Imagine a relationship with a caregiver in which you feel comfortable, respected and able to be yourself.

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

This final set of questions focus on identity.

For the Indigenous/Aboriginal participants:

1. Do you identify as Indigenous/Aboriginal? How do you identify?
2. Are there times you don't tell people you are Indigenous?
3. Did the midwife share any specific examples of Indigenous/Aboriginal teachings or stories during care? If yes, can you share some examples?
4. How did you feel about this (the sharing/not sharing teachings)?
5. What about ceremonies? If yes, can you share some examples?
6. How did you feel about this?
7. Would you have wanted the midwives to share more?
8. What are your suggestions for a good way for the midwives could share this type of knowledge and practice?

9. Has your understanding of being Indigenous changed since becoming a client at SGMT? If yes, how?
10. How or did or didn't your care at SGMT influence or change your family relationships?
11. Has your involvement in Indigenous community events, programs or services changed since becoming a client at SGMT? If yes, how?

For the non-Indigenous participants:

1. How do you identify?
2. Did the midwife share any specific examples of Indigenous/Aboriginal teachings or stories during care? If yes, can you share some examples?
3. How did you feel about this (the sharing/not sharing)?
4. What about ceremonies? If yes, can you share some examples?
5. How did you feel about this?
6. Would you have wanted the midwives to share more (Indigenous/Aboriginal teachings, stories, ceremonies; other cultural, spiritual knowledge and practice)?
7. What are your suggestions for a good way for the midwives to share this type of knowledge and practice?
8. Has your understanding of Indigenous people changed since becoming a client at SGMT? If yes, how?
9. Has your involvement or desire to be involved in Indigenous community events, programs, or services changed since becoming a client at SGMT?

Reporting checklist for qualitative study.

Based on the SRQR guidelines.

Instructions to authors

Complete this checklist by entering the page numbers from your manuscript where readers will find each of the items listed below.

Your article may not currently address all the items on the checklist. Please modify your text to include the missing information. If you are certain that an item does not apply, please write "n/a" and provide a short explanation.

Upload your completed checklist as an extra file when you submit to a journal.

In your methods section, say that you used the SRQRreporting guidelines, and cite them as:

O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. Standards for reporting qualitative research: a synthesis of recommendations. Acad Med. 2014;89(9):1245-1251.

		Reporting Item	Page Number
Title			
	#1	Concise description of the nature and topic of the study identifying the study as qualitative or indicating the approach (e.g. ethnography, grounded theory) or data collection methods (e.g. interview, focus group) is recommended	1
Abstract			
	#2	Summary of the key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results and conclusions	3
Introduction			
Problem formulation	#3	Description and signifcance of the problem / phenomenon studied: review of relevant theory and	4

		empirical work; problem statement	
Purpose or research question	#4	Purpose of the study and specific objectives or questions	5
Methods			
Qualitative approach and research paradigm	#5	Qualitative approach (e.g. ethnography, grounded theory, case study, phenomenolgy, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g. postpositivist, constructivist / interpretivist) is also recommended; rationale. The rationale should briefly discuss the justification for choosing that theory, approach, method or technique rather than other options available; the assumptions and limitations implicit in those choices and how those choices influence study conclusions and transferability. As appropriate the rationale for several items might be discussed together.	5
Researcher characteristics and reflexivity	#6	Researchers' characteristics that may influence the research, including personal attributes, qualifications / experience, relationship with participants, assumptions and / or presuppositions; potential or actual interaction between researchers' characteristics and the research questions, approach, methods, results and / or transferability	6
Context	#7	Setting / site and salient contextual factors; rationale	4, 5
Sampling strategy	#8	How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g. sampling saturation); rationale	5
Ethical issues pertaining to human subjects	#9	Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues	2, 5
Data collection methods	#10	Types of data collected; details of data collection procedures including (as appropriate) start and stop	5, 6

		dates of data collection and analysis, iterative process, triangulation of sources / methods, and modification of procedures in response to evolving study findings; rationale	
Data collection instruments and technologies	#11	Description of instruments (e.g. interview guides, questionnaires) and devices (e.g. audio recorders) used for data collection; if / how the instruments(s) changed over the course of the study	6
Units of study	#12	Number and relevant characteristics of participants, documents, or events included in the study; level of participation (could be reported in results)	5, 21
Data processing	#13	Methods for processing data prior to and during analysis, including transcription, data entry, data management and security, verification of data integrity, data coding, and anonymisation / deidentification of excerpts	6
Data analysis	#14	Process by which inferences, themes, etc. were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale	6
Techniques to enhance trustworthiness	#15	Techniques to enhance trustworthiness and credibility of data analysis (e.g. member checking, audit trail, triangulation); rationale	6
Results/findings			
Syntheses and interpretation	#16	Main findings (e.g. interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory	6-13
Links to empirical data	#17	Evidence (e.g. quotes, field notes, text excerpts, photographs) to substantiate analytic findings	6-13
Discussion			
Intergration with prior work, implications, transferability and	#18	Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship;	13-16

contribution(s) to the field		discussion of scope of application / generalizability; identification of unique contributions(s) to scholarship in a discipline or field	
Limitations	#19	Trustworthiness and limitations of findings	16
Other			
Conflicts of interest	#20	Potential sources of influence of perceived influence on study conduct and conclusions; how these were managed	2
Funding	#21	Sources of funding and other support; role of funders in data collection, interpretation and reporting	1