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Wîcohkamakew ("S/he Helps Someone"): A Qualitative Description of Experiences with a Community-derived Elders Mentoring Program for Indigenous Parents-to-be

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Abstract

Background: Responding to concerns about perinatal health risks and adverse outcomes, we established a community-based participatory research (CBPR) partnership between a *Nêhiyawi* (Cree) community and university-based researchers. We designed and implemented a community-derived Elders Mentoring Program (EMP) to provide additional support for pregnant women and their partners. Our objective was to understand the collective experiences of those involved in the Program.

Methods: We conducted a qualitative description with the principles of CBPR as an overarching framework. We carried out 14 qualitative interviews with parents, perinatal clinic staff, and mentor Elders involved in the Program. We also used detailed notes from Community Advisory Committee (CAC) meetings as data. All qualitative data were analyzed with content analysis.

Results: The Program helped pregnant women and their partners by fostering enhanced and multi-generational support networks. It also improved cultural security within the clinical environment and learning among health care staff. A sense of intergenerational fulfillment and enjoyment among those involved was common and was underpinned by genuine, collaborative relationships.

Conclusions: A community-derived prenatal EMP, designed in partnership with those who have intimate knowledge of the community, is a major step toward ensuring multi-generational and culturally secure care in pregnancy for women and families.

Keywords

Community-based participatory research, Healthcare providers, Indigenous population, Mentoring, Prenatal care, Qualitative research

Inequities between Indigenous populations in Canada (constitutionally recognized as First Nations, Inuit, and Métis) and non-Indigenous populations are prominent in maternal and infant health.[1] Historical trauma and colonial policies of cultural genocide and domination (such as residential schools, the Sixties Scoop, the Millennial Scoop, imposed poverty, anti-Indigenous racism, and so on) are root causes of these inequities that continue to ravage Indigenous populations.[2,3] Unsurprisingly, Indigenous communities are developing and advocating for decolonizing initiatives to improve health and well-being. Key recent movements, such as the *Truth and Reconciliation Commission Calls to Action*[4] and the *United Nations Declaration on the Rights of Indigenous Peoples*,[5] substantiate the need for such initiatives. Research indicates that pregnant Indigenous women[a] and their partners may benefit from community-derived and culturally

[a] In this article, we refer to pregnant people as pregnant women. We recognize and respect that not all pregnant people identify as a woman.

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appropriate services, flexible prenatal care approaches that move beyond current standard mainstream care, traditional pregnancy knowledge and healing practices, and enhanced support networks.[3,6–8]

With this in mind, and with a community-voiced need for improved pregnancy health and outcomes, we developed and implemented a community-derived EMP as additional support beyond that what is typically provided in mainstream health care for pregnant women and their partners from a *Nêhiyawi* (Cree) community in Alberta. Our objective was to understand the collective experiences of people involved in the EMP. Elders from our research partnership community intentionally chose *wîcohkamakew* ("s/he helps someone") for this article's title. This fundamental *Nêhiyawi* cultural value captures the EMP intent and our findings.

METHODS

Research Partnership

This study was part of an ongoing CBPR project in partnership with the *Nêhiyawi* communities of Maskwacîs, Alberta and researchers from the University of Alberta. Maskwacîs is a rural community in central Alberta (Treaty 6 territory) with a registered population of 16,004. It comprises four distinct First Nations: Samson, Louis Bull, Montana, and Ermineskin Cree Nations. The inception of our partnership began with a community voiced desire to collaborate. Specifically, R.T.O. (first author) had developed relationships with a number of community members through involvement in previous research studies and was asked to work with the community to improve the health and wellness of pregnant women. Our partnership's goal is in-depth understanding of how to better support pregnant women, with the aim of improving perinatal-related health and pregnancy outcomes, and ultimately reducing the burden of non-communicable diseases. Our partnership intentionally concentrated efforts on highlighting and building upon the strengths within the community, rather than focusing on deficits.

Our CBPR partnership began in September 2013 with R.T.O. engaging the community, developing relationships and trust, hearing from community members, and grasping the living context for pregnant women in the community. Initial engagement by R.T.O. was facilitated by E.L.T. (second author), a physician who has worked with and in the community for more than a decade. Ongoing engagement was facilitated by several community members and Elders that R.T.O. had built relationships with, and led to a snowballing of relationships, invitations to community events, participation in community ceremonies, and so on. After approximately 1.5 years, a CAC was formed and a research partnership formalized.

Through regular cooperative meetings, the CAC guided, oversaw, and made decisions about all aspects of the research through all stages of the research process. CAC meetings were a safe, respectful, ethical, and personal space for all members to contribute equally. The CAC meetings were also very personal, and a place for all members to discuss and receive support from one another. Decisions were shared and made by consensus. The CAC was a fluid group of up to 14 individuals at a given meeting and consisted of a core group of 4 dedicated *Nêhiyawi* Elders living in the community (including Elders who facilitated R.T.O.'s entry and engagement into the community), the local nurse manager (a *Nêhiyawi* woman originally from Saskatchewan), a graduate *Nêhiyawi* student from the community, and an academic researcher (R.T.O.; a Caucasian of mixed European descent). Additional Elders, staff from local health/social services departments, academic researchers, community research assistants, and community members contributed to meetings as needed. In addition to following principles of CBPR,[9] the CAC developed its own set of principles of how each member, whether a community member or an academic researcher, would work together in a good way: respect for all involved, building and maintaining strong relationships, using a strengths-based and positive focus, incorporating cultural teachings throughout, ensuring mutual benefits, and "acting now" to improve wellness in the community.

EMP Description

Part of the CAC "acting now" was to put in place a strength-based and community-derived solution to support expecting parents, and was an idea of the Elders on the CAC. Administrative data (requested by community partners) indicated that high-risk pregnancies and adverse pregnancy outcomes occurred significantly more frequently in the community than provincial averages (unpublished data provided by the Alberta Perinatal Health Program [APHP]). Also, CAC

members expressed serious concerns about health of pregnant women in the community. Many potential strategies were considered, and the CAC decided upon an EMP because it draws upon the strengths of the community (e.g., Elders, culture, language), touches upon all of our core CAC principles, and could potentially have a positive impact where "many people do not have a positive experience" (Elder referring to clinical care in the neighboring town). An EMP was conceptualized as Elders interacting with pregnant women and their partners in the clinical setting to offer support and ultimately to "protect every grandchild" (Elder). APHP data (unpublished) showed that most pregnant women from the community (approximately 70%) receive prenatal services off-reserve from the Primary Care Network (PCN) in a neighboring town. Care team members and staff at the PCN are non-Indigenous. The PCN employs staff that interact with both patients and Elders in the Program, including several full-time and casual registered nurses, licensed practical nurses, therapists, and a dietitian (all of whom are female). Also, a number of physicians and specialists provide care through the PCN, including several obstetrician/gynecologists providing prenatal care (male and female). Engagement with the PCN was initiated by R.T.O., which led to PCN managers and staff attending several CAC meetings to build relationships and discuss a possible EMP at the clinic. PCN managers identified a need for more culturally safe care for pregnant women at the clinic and invited Elders from the CAC to attend several PCN staff meetings. A verbal commitment to collaborate and develop the EMP was subsequently made.

In March 2016, Elders began attending the PCN for half-day sessions on one of two prenatal clinic days each week. Interactions between Elders and parents were not protocolled. Rather, interactions were intentionally 'organic' and meant to "meet parents where they are at in their life" (Elder). Mentorship approaches and strategies were discussed at length during CAC meetings and were specifically meant to be multi-generational and inclusive of fathers. For example, Elders engaged with parents and families in the waiting area by introducing themselves and their family/cultural roots, striking up conversations, offering support, listening, telling stories, providing healthy snacks and beverages, conducting cultural activities and displays, speaking about their experiences and traditional ways of pregnancy and childbirth, and initiating draws for free traditional moss bag infant carriers and gift cards to local stores.

After piloting our approach for 3 months, the EMP was expanded (with Elders attending one to two full prenatal clinic days each week), advertised, and re-launched. From the inception of the Program to the time of data collection, four Elder mentors have been involved (three female and one male) and all were also members of the CAC over that time. During each prenatal clinic day, one to two Elders were present. Elders were paid $200 for each visit as a mentor at the clinic, an amount the Elders decided was appropriate for their time, knowledge, experience, and mentorship. Elders wanted it to be non-invasive to women's privacy and therefore detailed information on participating women was deliberately not collected. In addition, the PCN does not collect information on ethnicity. However, Elders documented the number of interactions at each prenatal clinic day in a notebook, and based on APHP numbers we estimate roughly 30% of pregnant women from the community had interactions with an Elder in the Program each month at the PCN.

The EMP was changed and adapted over time to better meet the needs of parents such as providing space for parents seeking additional and more in-depth Elder support privately in a separate room, and Elders volunteering their support 24 hours per day and were primarily accessible by telephone. Adaptations were made to build and maintain relationships between Elders and PCN staff including Elders and clinic staff members holding ongoing meetings and lunches together, and PCN staff being invited to community events and ceremonies. The Program was also adapted to ensure the Elders felt comfortable, safe, and cared for at the clinic by providing a space for Elders to rest, hanging Indigenous art from community in the clinic, bringing the Elders coffee and tea, and so on. The CAC meetings served as a platform for adaptations to the EMP to be implemented as they allowed a safe space for any and all issues to be raised and discussed.

Ethics

Ethical issues were addressed at several levels. We obtained ethical approval through the Human Research Ethics Board at the University of Alberta, which adheres to the *Tri-Council Policy Statement 2, Chapter 9: Research Involving the First Nations, Inuit and Métis Peoples of Canada*.[10] Community

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approval from key stakeholders, Elders, knowledge keepers, and community members was also obtained. The community of Maskwacîs is unique in that it is a collection of four individual First Nations. There is no formal review board/group for research for all four Nations. Thus, we sought approval from individuals specifically identified by the CAC as those whom approval was deemed necessary. Approval for the research consisted of both verbal and written approval. Those identified by the CAC were approached with community appropriate protocol and engaged in one-to-one meetings with R.T.O. to discuss the intent of the CBPR partnership, the EMP, and the planned research. Verbal approval was given in these meetings. Also, prior to the generation of data, a research agreement was collaboratively drafted by the CAC and signed by the Elders on the CAC as well as the CEO of Maskwacîs Health Services, whom liaises all research within the community to leaders of the four Nations. The research agreement outlined the collaboratively agreed upon purpose, approach, roles and responsibilities, methods, dissemination, ethical issues, and data ownership (including the principles of Ownership, Control, Access and Possession).[11] The research agreement described, at the behest of Maskwacîs Health Services and the Elders on the CAC, that all generated data would be co-owned between the community and researchers, which storage at the University of Alberta. The CAC was involved and made decisions at all stages of the project, providing ethical counsel and ensuring research moved forward in culturally and community appropriate ways. All research participants provided written informed consent.

Methodology

We used qualitative description to understand experiences of people in the EMP, with CBPR as the over-arching framework. Our CBPR approach relies on an experiential, participative-knowing epistemology.[9] Research developed from an outsider-expert standpoint is typically insufficient in addressing community issues.[9] CBPR recognizes that community members best realize and understand their own context and possess knowledge and expertise imperative to research that benefits communities.[12] Respectful, considerate CBPR with Indigenous communities can lead to community-owned, viable benefits.[13] In trusting genuine partnerships, CBPR approaches include community members as experts and ensure research is appropriate, culturally sensitive, relevant, and equitable.[12]

Qualitative description is frequently used within qualitative health research when an initial descriptive summary of a phenomenon is needed.[14] It stays close to participants' words to generate rich, straight descriptions with 'low-interference' data interpretation.[15] Qualitative description results in a portrayal of the experiences of participants in a language similar to their own.[14] Qualitative description fit specifically with the wishes of the CAC, who decided it was imperative for the direct and genuine voices of participants in the study to be portrayed. The CAC also felt that a descriptive summary of the participant's experiences with the Program could stimulate and provide a basis for future, more theory-based research and evaluation of our Program and similar Programs.

Data Generation

Data generation activities were decided upon by the CAC. Key sources of data were detailed CAC meeting notes and interviews with people connected to the EMP. Data were generated from our first CAC meeting (June 2014) to the last qualitative interview (October 2017). After the expanded EMP operated for more than a year, qualitative interviews were carried out between March and October 2017. Participants involved with the EMP were recruited with purposeful sampling to identify information-rich participants and capture perspectives of parents that had had more than one interaction with an Elder mentor in the Program, perinatal clinic staff that interact most often with Elder mentors, and the Elder mentors themselves. Participants received a $50 gift card for their interview. R.T.O. held one-on-one semi-structured interviews with participants. Parents were interviewed within 3 months of their last interaction with an Elder mentor. Interviews were in English, lasted up to 60 minutes, and were audio-recorded and transcribed verbatim. Participants were prompted to discuss their EMP experience and were encouraged to discuss other information they felt was relevant. The following are some of the prompting questions: Tell me about the health care you received for your pregnancy/tell me about the health care at the PCN. What was your experience like with the EMP at the PCN? Can you speak of some of the possible impacts the Program might have had? Were there any challenges/difficulties with the Program?

Data Analysis

The data analysis approach was decided upon by the CAC. Data analysis was cyclical, iterative, and concurrent with data generation. R.T.O. conducted the initial analysis of all data with qualitative content analysis[16] and Atlas.ti qualitative software. Content analysis was used as this approach is suitable when conducting exploratory work in an area where little is known[17] and has roots in communication theory and focusing on the therapeutic processes that take place within the care provider–client relationship.[18] To code, the data transcripts were read and re-read separately, and persistent concepts and core patterns were highlighted and categorized. Highlighted sections were excised and grouped in categories in separate files. Categories were similarly read and re-read and subcategories were created. Emerging categories were compared together and in relation to the entire data set to identify common threads. Next, the CAC were presented with the initial findings and convened for a series of meetings aimed at refining categories, reducing redundancy, and ensuring accuracy and community appropriateness of the findings. Members of the CAC had access to raw data if need be. Data collection and analysis ended when no additional insights emerged and when categories were well defined and refined by the CAC. After homogeneity was made certain for each, the categories and subcategories were described in depth. Additional members of the academic research team reviewed the findings and contributed to refining the categories.

Notes from 23 CAC meetings were analyzed and 14 interviews were conducted. Six parents (five mothers and one father), four clinic staff, and four Elders took part in interviews. Average age of parents was 22 years (range, 17–34 years), of clinic staff was 39 years (range, 30–49 years), and of Elders was 66 years (range, 57–79 years). Average number of children per parent participant was three (range, 1–8 years).

Rigor

Strength and rigor were maintained by adhering to approaches of authenticity, credibility, criticality, and integrity of data collected.[19,20] Authenticity meant carefully considering participants' voices, and was reached by purposeful sampling, participant-driven data generation, and precise transcription. Credibility meant depicting a true insider point of view, and was reached by researcher reflection on believability of findings and by CAC review. Criticality meant questioning our work, and was reached by critical appraisal of decisions during research and inclusion of the CAC throughout. Integrity meant honesty in our work, and was reached by peer review and reflection on researcher bias. Rigor was further enhanced by the CBPR process and by frequently seeking CAC advice. The CAC and academic research team members had the opportunity to share their views regarding findings, particularly with respect to the potential influence of R.T.O.'s involvement in data generation and analysis, and the accuracy of the findings. Each participant received a copy of their transcript to review. Those that agreed to review verified the findings as an accurate portrayal of their collective experiences. Finally, the CAC recommended that R.T.O. kept a reflective personal journal throughout the research, with particular reflexivity on being a Caucasian father and researcher of mixed European descent collaborating with the CAC to interpret the voices of Indigenous parents, health care staff, and Indigenous Elders. The CAC felt reflexivity ensured reliance on CBPR principles and presentation of authentic participant voices.

RESULTS

Participants shared vivid personal reflections on their recent experiences with the EMP. Similarities emerged in their experiences and are detailed here in three categories: enhanced support networks, improved cultural security and learning, and intergenerational fulfillment and enjoyment.

Enhanced Support Networks

All participants acknowledged the EMP as an opportunity for parents to receive enhanced support through their pregnancy for those who need it, especially first-time, teenage, and younger parents. Some parents described having very little help and reassurance during their pregnancy and welcomed the opportunity for Elder support: "I know that maybe this EMP wouldn't benefit other people, but it did for sure benefit me" (Parent). Those who engaged less with the EMP cited already having strong support systems and good access to Elders in their family and community.

Enhanced support through the EMP was multilayered and tended to be specific to what parents were dealing with day to day. According to the participants Elder support was

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multi-faceted and meant connecting on a personal level, telling stories, providing a sense of hope, laughing, actively listening, empowering, encouraging, caring, being kind, validating, valuing parents as people, being non-judgmental, transferring cultural knowledge and values, healing historical traumas, teaching parenting skills and responsibility, being respectful, and "being on their side" (Clinic staff member). Parents expressed feeling comforted knowing they could call upon an Elder if necessary: "She would tell me that if I didn't have anybody to come with me to the labor room or if I needed her at any time that she would be there" (Parent). One parent explained how having the Elder in the clinic allowed her to feel safe and not judged:

> It is difficult [being pregnant] . . . because people just look at me and they'll be like, "Oh! Wow, she had a big mistake." Or, "someone didn't raise their kid right." When you're sitting in that clinic and it's full, like no chairs available, full, you feel judged . . . my boyfriend works and my mom works and my sister works. And my grandma has cancer so she goes to the Cancer Society. So, there's me, leaving school, coming there, and sitting there all by myself. And I don't feel judged anymore, because I'm confident in being a mom. It makes me confident to be a mom, for sure, and that's what I like most about the Program specifically . . . It really made me feel better. I love being there, because I didn't look alone. (Parent)

In many instances, health care providers cannot provide the support parents need and may not identify with the complexities faced by community members. Participants agreed the EMP filled a gap in the western care model, with Elders from the community who understand the issues faced by young parents offering culturally and community-relevant support and advice. One Elder described the context in which many women live and the need for encouragement and support from someone who parents can relate to:

> If I put myself in that position, and I was young, and unsure of myself, maybe my home is overcrowded, maybe I don't live in a very happy environment, because when you really face the facts there's a lot of family violence. There's alcoholism, there's drug addiction, and no one is untouched by those elements. And so, we have children becoming mothers in this milieu, what more important way is there then to go there when a mother is expecting and to say: "You know what? You're going to be okay. You're a very strong girl, and you're a good dad. You're right here and that says so much about you." (Elder)

A clinic staff member explained how having Elders in the clinical setting can help parents open up more about their support needs:

> I have seen a value in the Elder Program. I see that the patients are maybe more willing to speak to an Elder than say, ourselves or our therapist, or our nurses. Even in an open space, like the waiting room area, they'll still give more information than they might in a closed door to one of our nurses. So, I see that there's value there . . . and I think once they have that attention, then the Elder could—the sky's the limit. (Clinic staff member)

Lack of inclusion and acknowledgement of male partners during pregnancy was often identified as another gap in mainstream perinatal care that the EMP helped to fill, as one Elder explained:

> There's nothing there for a man . . . And I kind of think the Program has helped in that sense; helped the mothers and the fathers understand each other and their roles as parents now . . . Nobody thinks about the father and how it impacts his life. He does go through all of that stuff. "Holy I made a child". It hits him, it hits him hard, you know? But nobody recognizes it. Nobody acknowledges it . . . So, I think [the Program] helps to build a relationship that they can understand what each other is going through, and the feelings and emotions of being a parent. (Elder)

Improved Cultural Security and Learning

The EMP contributed positively to righting colonial and historical harms that have eroded culture, language, values, and responsibilities. It provided an opportunity to rebuild intergenerational connections and pass on traditional

teachings surrounding pregnancy, parenting, and family. Specifically, the EMP encouraged *Nêhiyawi* cultural practices such as smudging, wrapping infants in mossbags, singing traditional songs, speaking the *Nêhiyawi* language, using traditional medicines, adhering to longstanding protocols for pregnant women, attending sweatlodges, participating in ceremonies, and following cultural underpinnings of love, compassion, and generosity. Parents explained that their sense of identity and belonging was validated by talking with Elders in the EMP. Genuinely incorporating *Nêhiyawi* culture and ways of knowing into the clinical setting was thought to directly and indirectly foster healthier pregnancies, as one Elder expressed:

> The culture was eroded. The values were also eroded. And there was nothing strong for people to live by anymore . . . The girl that is the mother today, is very, very disconnected from her cultural values, from her identity. And she's very removed psychologically, emotionally, mentally, physically—in all aspects of her being, from her culture, her values, and her belief system . . . And so, this is why [the EMP] is good, to begin to mend. Many people go through a pregnancy very scared, alienated, and feeling lost. When they feel that way, the child within them feels that emotion and internalizes that emotion. And they are not born the same way physiologically, psychologically, as the child that was born 30 years ago, 40 years ago. So [the EMP], by what we're doing now, is beginning to go back to the way that—that it was a long time ago. Those forces will work, and babies will be born healthier. We are the facilitators of reconnecting them to the culture. I know that it is sacred and powerful work. There is no more important work on this earth than to be part of the journey of a spirit into this world. (Elder)

The EMP advanced mutual learning between clinic staff and Elders that in turn enhanced overall cultural safety at the clinic. Participants agreed that clinic staff members, from front-end employees to physicians, benefited from interacting with Elders. Elders spoke of the clinical setting as a predominately non-Indigenous space where racism and superiority over Indigenous people occurs often in both overt and discrete ways, and where Indigenous ways of knowing and healing are very rarely discussed. Clinic staff members were interested in learning more about the history, culture, and perspectives of the community, and felt the EMP offered the opportunity to do so in an experiential way. Participants described how the EMP allowed communication, trust, and relationships to develop authentically over time, ultimately creating a safe space for mutual learning and understanding.

Parents differed in their receptiveness to cultural support. Some parents hoped the EMP would grow to involve more cultural activities (such as sewing, beading, and smudging) and add younger people from the community who understand the culture to work with Elders in supporting parents. Not all parents were open to learning more about *Nêhiyawi* culture during the pregnancy, and Elders and clinic staff were mindful to not impose cultural beliefs on those not interested in learning. One Elder described how support is not limited to cultural support:

> Once you have your child, it's a life changer. I try and explain . . . The goal of this Program is to support the young moms with whatever support they need and that doesn't necessarily mean cultural support . . . I don't try and preach to somebody. I just ask them well, how they feel. (Elder)

Elders also discussed participation in the EMP contributing to their own continued healing from historical traumas they experienced with colonization. Several Elders gave in-depth, detailed accounts of their own experiences related to colonization, including residential schools, foster homes, racism, discrimination, and poverty. They described how these experiences have, in many ways, hindered their ability to carry out their roles as Elders in the community during certain times of their lives. Elders shared how the EMP contributed to restoring their roles and compelling them to look self-examine their behaviors more honestly, to open up more to others, and to make positive changes so they could better care for or help others.

Intergenerational Fulfillment, Enjoyment, and Collaboration

When asked about their personal experience of the EMP, all participants repeatedly described feelings of fulfillment and

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satisfaction. Clinic staff members described an enhanced sense of accomplishment in their work. Parents were content after visiting with Elders and were often grateful for the opportunity to learn about pregnancy and parenting in a way they felt was relevant. Elders described at length the fulfillment they felt through EMP participation. Being involved in the prenatal journey of parents to "help bring life into the world" (Elder) offered especially strong pleasure through giving back to their community in a meaningful way.

Participants' personal experiences also included feelings of happiness and enjoyment, and optimism about the future of the EMP. The EMP brought more laughter and fun into the clinic. Participants felt that the EMP's laid-back, personal approach gave them more enjoyable clinic experiences. Having Elders in the clinic arrival area and including all families, Indigenous or non-Indigenous, led to a more cheerful and welcoming environment, as expressed by one clinic staff member and one parent:

> I think we're at a point where it's really running well. It's always good to see them [Elders] when they're here. They're really good people . . . The Elders enjoy their time here and so do we. It just reflects when they come in and they're just so eager and ready to help and it's nice for everyone. We like it, it's really good for our clinic. (Clinic staff member)

> She was a really, really nice lady though. It was nice to be able to just, you know, to laugh in that place. And that really made me - me the most happy . . . Yeah. I really enjoyed it. She actually just came and sat down with—and I mean, just started a nice conversation. (Parent)

Participants' stories clearly indicated that fulfillment and enjoyment arose from authentic relationships developed through the EMP and from enhanced collaboration between Elders, health care staff, and parents. This meant relationships that are built upon genuine and deep connection rather than those of a more paternalistic and surface level provider-patient nature. Coming together and evolving to a teamwork environment took time. Long-seated rifts between Indigenous and non-Indigenous communities were described, as were initial feelings of trepidation at EMP implementation. The continued, consistent presence of Elders through the EMP ultimately allowed participants to feel comfortable with each other, for stereotypes to be deflected, and for genuine and trusting relationships to emerge. These relationships were crucial to successful functioning of the EMP. Sincere collaboration supported the positive impacts described in the themes above.

DISCUSSION

The *Truth and Reconciliation Commission of Canada*[4] Call to Action 22 states "We call upon those who can effect change within the Canadian health care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients." This study provides rich qualitative evidence supporting this Call to Action and substantiates the need for reconciliation in health care through involving Indigenous Elders. Western science and medicine rarely formally acknowledge and appreciate Elders' expertise within health care systems and organizations. However, Elders are respected and esteemed for their lived experience, cultural connectedness, leadership, knowledge, wisdom, benevolence, humility, perseverance, commitment, helpfulness, and so on. They accordingly are vital in the health of Indigenous populations.[21]

To our knowledge, ours is one of two studies examining inclusion of Elders specifically in perinatal care of Indigenous patients. The Strong Women, Strong Babies, Strong Culture Program in northern Australia has shown that senior women within Aboriginal communities providing support, encouragement, and advice to younger Aboriginal women in preparation for pregnancy led to a reduction in low birthweight babies.[22] A few other published studies explore Indigenous Elder programs for other health conditions and settings, and results are consistent with the positive impacts noted in our study. For example, Elder-facilitated health circles that focus on traditional health teachings can increase patient ownership of their health care and ease barriers to both mainstream and traditional health care, according to urban Indigenous participants in qualitative research.[23] Involving Elders in psychiatric care for Indigenous patients has led to statistically significant decreases in self-reported rates of domestic violence.[24] Qualitative interviews with Indigenous patients at

a mental health program in an inner-city primary care clinic suggest that including Elders in direct care has wide benefits to mental well-being.[25]

Indigenous families face multiple challenges during pregnancy from continued impacts of colonization, such as intergenerational trauma, poverty, discrimination, disempowerment, crowded living conditions, ongoing grief, and domestic violence.[2] These issues certainly do not have simplistic fixes, but our EMP seems to be a step in the right direction. Parents in our study expressed feeling more likely to trust, connect with, and talk to Elders about these issues than to a health professional. Mistrust and disconnection between pregnant Indigenous women and health care providers is thoroughly described in other qualitative research.[8,26–28] Including Elders in our study had meaningful impacts on sense of patients' context by clinic staff members and on providing culturally safe care. There is no shortage of research calling for improved cultural safety for Indigenous patients in health care settings, particularly perinatal settings.[6,26,29] Our findings suggest that consistent Elder presence in perinatal care offers another novel opportunity for ongoing experiential and reflective cultural safety learning for staff, rather than typical one-time, limited, and unidirectional cultural sensitivity trainings that tend to focus on cultural differences.[30]

Interacting with Elders allowed patients ongoing opportunities to connect and re-connect to traditional *Nêhiyawi* cultural principles and philosophies pertinent to pregnancy and raising children. An accumulating body of research indicates that Indigenous patients, including pregnant women and their partners, want and need Indigenous culture and language incorporated into health care practices in a meaningful way.[6,26,29,31] Our findings add to those of others suggesting positive associations between cultural connectedness and Indigenous health, healing, belonging, knowledge, identity, and wholistic wellness.[23,25,32,33]

Our findings suggest that the EMP can be one tactic to help fill other gaps noted in perinatal care. It proved particularly helpful in supporting younger and first-time mothers through their pregnancies that may feel more vulnerable, judged, and scared. In our study, opportunities to engage with Elders in the perinatal setting were believed to increase inclusion and acknowledgement of male partners during pregnancy. Our previous qualitative work[7] and that of others[34] highlights the importance of including fathers more in perinatal care. Finally, the EMP brought a sense of intergenerational fulfillment and enjoyment to all involved, stemming from relationships that developed through the EMP. This emphasizes the need for collaboration and partnership in improving Indigenous health, as suggested repeatedly through recent research.[9,10,13,35] It is not enough to simply conduct research or provide health care in a culturally sensitive way.

Our study has limitations. Each community is distinctive, so transferring our findings to other Indigenous populations must be approached with caution. Our intervention and study were carried out in a rural PCN, so suitability and usefulness in more urban care settings was not considered. This was our first attempt to understand the impact of a novel community-based intervention, and the findings are formative. Evaluations with context-specific indicators of impact are needed to compare Elder- and culture-based interventions with mainstream perinatal and clinical care. At the time of writing this manuscript, the EMP is in the process of expanding its reach within the Maskwacîs area and to other interested Indigenous communities in Alberta, and a protocol for more robust and in-depth qualitative and quantitative evaluation is in development with the communities. Finally, only one of the participating parents was a father, and thus the perspective of more fathers is needed to fully describe the extent to which the Program supports fathers.

CONCLUSION

Our qualitative analysis has important implications for those involved in perinatal and maternal care of Indigenous women. Our study suggests that an EMP that is community-derived, context-specific, and culturally appropriate within the perinatal clinical environment offers one way to potentially enhance support networks and improve cultural security for Indigenous women and families. The EMP is also one approach to offer meaningful cultural awareness among perinatal health care staff and a sense of intergenerational fulfillment and enjoyment among those involved in the EMP. Genuine collaboration and relationship building are crucial to EMP success.

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