BRIDGING THE GAP BETWEEN HEALTH COMMUNICATION AND INTERCULTURALITY: A CASE STUDY OF MATERNAL HEALTHCARE FOR INDIGENOUS CANADIAN WOMEN IN OTTAWA

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Short Summary / Abstract

Indigenous women in Canada face a severe lack of access to health care. These women often experience anti-Indigenous racism in healthcare facilities, a lack of cultural safety, and the non-recognition of Indigenous healing and health methods. Language hurdles, gender differences, and privacy concerns over medical records all contribute to intercultural communication problems between Indigenous women and health professionals. Intercultural Communication refers to the study and practice of communication across different cultural contexts. It involves understanding how people from different countries and cultures act, communicate and perceive the world around them. It also requires awareness of one's own cultural background, values and beliefs and how they may affect the communication process.

This study explores how intercultural communication could be used as a tool to improve information on access to healthcare to Indigenous women in Canada within Ottawa. This research investigated the challenges in health communication and in maternal healthcare access among Native Canadian mothers and mothers-to-be when seeking medical attention.

Various previous studies have demonstrated that there are intercultural obstacles to Indigenous Maternal healthcare in Canada, which makes treating different disorders and disseminating health information difficult.

The present research uses a mixed method, which combines quantitative (survey questionnaires) and qualitative methods (systematic literature review) to collect data. The final part of the thesis will provide in-depth findings and analysis to the research.

Keywords: Health Communication; Intercultural Communication Competence; Mixed Methods**;** Indigenous Canadian; Maternal Healthcare, Cultural Competence

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Chapter 1

Introduction

1.0 Introduction

In healthcare, communication serves as an essential medium through which patients and healthcare providers exchange information, facilitating mutual understanding and fostering improved health outcomes (Schiavo, 2013). Effective communication helps build trust, allowing patients to feel supported in their medical journeys, particularly in sensitive situations like maternal healthcare. However, diverse cultural backgrounds between patients and healthcare providers often create barriers to effective communication (Kourkouta & Papathanasiou, 2014). These challenges become especially pronounced in Indigenous populations, among which cultural misunderstandings, linguistic differences, and systemic biases significantly hinder healthcare interactions (Belasen & Belasen, 2018; Kourkouta & Papathanasiou, 2014).

Indigenous Canadian women, particularly those seeking maternal healthcare, often face a myriad of obstacles, including anti-Indigenous racism, lack of cultural safety, and limited access to healthcare services, particularly in rural and remote areas (Truth and Reconciliation Commission, 2015). The underrepresentation of Indigenous healthcare providers compounds these issues, as fewer than 1% of Canadian physicians identify as Indigenous, even though Indigenous peoples comprise approximately 4.5% of the population (Public Health Agency of Canada, 2023).

Gudykunst defines intercultural communication as the exchange of information and meaning between individuals or groups from different cultural backgrounds (Gudykunst, 2005) Furthermore, intercultural communication involves navigating and understanding the dynamics of

communication between people from different cultural backgrounds (Gudykunst, 2005). The study of intercultural communication as defined by Gudykunst, among others, is essential for addressing healthcare disparities, as it provides a framework for understanding how cultural factors influence health-seeking behaviours, communication preferences, and patient-provider interactions (Zhao, 2021).

As societies become increasingly multicultural, the need for effective communication across cultural boundaries has become more urgent. This growing complexity in interpersonal and institutional interactions has prompted further interest in the study and application of intercultural communication principles. In this light, Yakar & Alpar (2010) argues that the ongoing rise in cultural diversity and the necessity for individuals from various backgrounds to coexist points to the relevance of the concept of intercultural communication.

Chen and Starosta's model of intercultural communication competence identifies three key dimensions: cognitive, affective, and behavioural (Chen & Starosta, 1996). Chen and Starosta (1996, p. 366) argue that *intercultural communication competence consists of three dimensions: intercultural awareness (cognitive), intercultural sensitivity (affective), and intercultural adroitness (behavioural)*. The authors described that the objective of the model was to have individuals recognize other people's cultural differences, and approach them with tolerance and respect (Chen & Starosta 1996).

To operationalize this concept in real-world contexts, scholars have introduced frameworks such as intercultural communication competence (ICC). While intercultural communication refers to the process of interacting with people from different cultural backgrounds, intercultural communication competence entails the ability to do so effectively and appropriately (Gudykunst, 2005). Intercultural communication competence (ICC) encompasses the capacity to engage in

communication that is both effective and appropriate across diverse cultural settings. Martin and Nakayama (2010) argue that some key components of intercultural communication competence include motivation, knowledge, and tolerance for uncertainty. Among these, motivation plays a foundational role, as it reflects an individual's willingness to initiate and sustain intercultural interactions. This drive may arise from internal factors, such as curiosity or a desire for personal growth, as well as external motivators like career advancement or social recognition. Without adequate motivation, the development and application of other aspects of ICC may be limited (Martin & Nakayama, 2010).

Yakar and Alpar (2018) claim that effective intercultural communication is fundamental to delivering culturally competent care. According to them, the ability to engage in effective intercultural communication constitutes a critical component of the provision of culturally competent healthcare, as it enables healthcare professionals to navigate cultural differences and respond appropriately to the diverse needs of patients from varying backgrounds. Findings form Yakar and Alpar's (2018) study examining intercultural training for nurses shows that "84.5% nurses said told that did not receive training on intercultural nursing" (p.1406). They also note that "Previous studies have reported that educational initiatives were effective in improving nurses' cultural competence" (ibid). In other words, Yakar and Alpar (2018) highlight the importance for healthcare professionals to be culturally sensitive and incorporate an awareness of cultural differences into their practice in order to provide holistic and high-quality care.

Scholars such as Crawford (2017), Hemberg and Vilander (2017) and Tanriverdi (2017) also argue that intercultural communication competence enhances the quality of care, promotes patient safety, fosters effective communication between patients and healthcare providers, reduces caregivers' work-related stress, strengthens their knowledge and skills, and increases patient

satisfaction. In other words, Crawford et al., (2017, p. 3) argues that cultural competence in healthcare is essential to reducing disparities and improving access to high-quality healthcare that is respectful of and responsive to the diverse needs of patients. They argue that "Good nursing practice is underpinned by effective communication, required to build trusting relationships and thus have the ability to accommodate, empathise and affiliate with patients" (Crawford et al., 2017, p.64).

Collectively, these scholars emphasize the critical contribution of ICC for improving healthcare outcomes. By fostering trust, minimizing misunderstandings, and supporting culturally safe practices, intercultural communication competence contributes to the creation of inclusive healthcare environments—particularly vital in diverse, multicultural settings such as Canada. The emphasis on communication not only supports individual patient-provider relationships but also informs broader systemic efforts to reduce health inequities.

In this context, the present thesis seeks to examine how health communication and intercultural communication competence (Gudykunst, 2005) intersect within the maternal healthcare experiences of Indigenous Canadian women in Ottawa. The primary aim is to identify communication-related barriers that may hinder Indigenous mothers' access to equitable and culturally safe maternal care services in the region.

This study draws on Intercultural Communication Competence (ICC), a concept further elaborated in Chapter 2 to investigate how cultural differences and biases shape healthcare communication between providers and Indigenous mothers. This theoretical framework is complemented by Critical Medical Anthropology (CMA), which is also discussed in Chapter 2, offering a broader perspective on how healthcare disparities are influenced by socio-political and economic factors (Corcoran, 2007). By integrating these frameworks, the study aims to provide a

nuanced understanding of how intercultural communication barriers contribute to the marginalization of Indigenous women within healthcare settings.

The research adopts a primarily qualitative approach, incorporating some quantitative data. The qualitative component involves surveys (including qualitative and demographic questions) and a systematic literature review employing thematic analysis to gather data. While the surveys also collect demographic data, the overall study remains predominantly qualitative, and is supported by thematic and descriptive analysis. Through this methodology, the study will address the following central research question: *How do Indigenous mothers in Ottawa experience marginalization in accessing maternal healthcare services?* This question will guide an exploration of the underlying reasons for the marginalization of Indigenous mothers in healthcare and examine how intercultural communication competence might serve as a critical tool for addressing these issues within Ottawa's maternal healthcare practices.

This research is significant as it contributes to the expanding body of literature on the importance of culturally responsive healthcare (Betancourt et al., 2005). Furthermore, the findings of this study may provide useful insights for policymakers and healthcare providers interested in improving communication strategies and addressing healthcare access challenges for marginalized populations, particularly Indigenous women in Canada.

1.1 Background and Context

In healthcare, effective communication between patients and medical professionals is pivotal in ensuring the successful delivery of care. As highlighted by Schiavo (2013), clear, timely, and accurate communication fosters trust, enhances understanding, and improves health outcomes. This is particularly critical when considering marginalized populations such as Indigenous

Canadian women, who face multiple barriers in accessing healthcare, particularly maternal health services.

Studies have shown that Indigenous women often encounter specific challenges within healthcare settings. For example, Higginbottom et al. (2015) emphasize that, Indigenous women often experience racism, stereotyping, and cultural insensitivity in their interactions with healthcare providers, which undermines trust and creates significant barriers to accessing effective and culturally safe care. They argue that "These [Indigenous] women may not openly recall their negative or positive experiences or discuss their personal views on the procedure; nevertheless, special care and sensitivity are necessitated for this situation" (p. 302). This is further corroborated by the Truth and Reconciliation Commission of Canada report (2015), which asserts that, the health-care system has failed to adequately meet the needs of Aboriginal people, and Aboriginal women in particular, due to systemic racism, cultural insensitivity, and the lack of culturally appropriate services. The report states that "General Aboriginal health care was never a priority for the Canadian government" (p. 68).

These barriers highlight the urgent need for addressing intercultural communication challenges in maternal healthcare. The intersection of health communication and intercultural communication competence therefore carries interesting purchases for addressing these disparities, especially in maternal healthcare, because Indigenous women often face issues related to language barriers, gender norms, and cultural differences in medical settings (Higginbottom et al., 2015). This study aims to explore how improved health communication could help bridge these gaps, fostering better healthcare access and outcomes for Indigenous women in Ottawa. The focus on maternal healthcare is timely and significant, as maternal health is closely tied to broader public health concerns and social determinants of health (WHO, 2019).

Health communication is also a vital component of effective healthcare delivery, particularly in multicultural societies in which diverse populations may have varying health beliefs, practices, and needs. As highlighted by Kreps and Sparks (2008 p. 7), "Health communication is also an extremely broad research area, examining many different levels and channels of communication in a wide range of social contexts". In Canada, the significant barriers in accessing maternal healthcare services Indigenous women face can lead to adverse health outcomes for both mothers and infants (Browne et al., 2016, p. 8-15).

These barriers often stem from a lack of culturally competent care, systemic inequities, and historical mistrust of healthcare systems due to colonial legacies (Lavoie et al., 2010). Lavoie et al. (2010,) examine the systemic barriers faced by Indigenous peoples in accessing healthcare, arguing that the barriers Indigenous people have in accessing health care are structural, established through historical events, perpetuated in current policy, and expressed in behaviours that all interact in ways that inflict violence on Indigenous people.

For the purpose of this study and in line with its scope, we will focus on Indigenous Canadian women located in Ottawa, aiming to explore how health communication could benefit from a better awareness of effective and competent intercultural communication practices to meet Indigenous women's maternal healthcare needs in a urban setting.

Loyola-Sanchez et al. (2020) emphasize the importance of culturally relevant health messaging to enhance understanding and engagement in healthcare practices. They argue that by fostering an environment of mutual respect and understanding, healthcare providers can better address the specific needs of Indigenous women, ultimately leading to improved health promotion and outcomes (Loyola-Sanchez et al., 2020). In their study Loyola-Sanchez et al., (2020) argue that culturally safe health communication was seen as essential to improving trust, engagement,

and health outcomes among Indigenous populations, particularly when messages were adapted to reflect their lived experiences and values. They claim that "One way to move forward is to engage in meaningful collaborations with communities throughout the research process, including stages of identifying and addressing relevant health concerns, to data collection, interpretation of results and utilisation of results together with those that are impacted by it" (Loyola-Sanchez et al., 2020, p.2).

The present study aligns with Loyola-Sanchez et al.'s argument and will intend to demonstrate how effective health communication is crucial in promoting healthcare among Indigenous Canadian women, particularly in the context of marginalization. It will do so suggesting that the unique cultural perspectives and experiences of Indigenous populations necessitate tailored communication strategies that resonate with their values and beliefs.

1.2 Theoretical Framework overview

This thesis draws upon several theoretical perspectives to analyse the relationship between health communication and marginalization, which are discussed in more depth in chapter 2. This study will use some aspect of Intercultural Communication Competence (ICC) as central framework. ICC examines how communication is affected by cultural differences and how these can be navigated to improve mutual understanding in healthcare settings (Corcoran, 2007). This theory is particularly relevant to Indigenous women, as it considers the cultural dynamics, power relations, and communication barriers that often exist in intercultural healthcare interactions and this will be emphasized in the discussion part of the results.

Alongside ICC, Critical Medical Anthropology (CMA) provides an insight lens for understanding how health disparities among Indigenous populations are shaped by broader socio-political and economic factors. By combining the deployment of these theories with the Social Determinants of Health (SDH) framework, this study will also intend to examine how factors such as education, income, and geographic location may influence Indigenous women's access to healthcare.

This research is thus also grounded in the theoretical frameworks of intercultural communication and cultural safety. While intercultural communication theory emphasizes the importance of understanding and respecting cultural differences in communication styles, beliefs, and practices (Gudykunst, 2004), cultural safety is a concept developed in the context of Indigenous health and advocates for healthcare practices that recognize and respect the cultural identities of patients (Williams, 1999). By applying these frameworks, this study seeks to analyse the communication dynamics between healthcare providers and Indigenous women, aiming to identify strategies that promote culturally safe maternal healthcare.

Additionally, while this study is primarily grounded in the theoretical frameworks of Intercultural Communication Competence (ICC), Critical Medical Anthropology (CMA), and the Social Determinants of Health (SDH), it also recognizes the relevance of intersectionality as an important conceptual lens, but this study will not be making use of intersectionality theory. Originally introduced by Kimberlé Crenshaw (1989), intersectionality emphasizes the ways in which multiple and overlapping social identities—such as race, gender, class, and indigeneity—converge to produce distinct and often compounded experiences of marginalization or privilege. This said, intersectionality is not employed as a primary analytical framework in this study. While insights from this theory would be significant to understanding the complex realities Indigenous

women face in navigating healthcare systems and the scope of this study does not justify its deployment.

For instance, Indigenous women's maternal healthcare experiences are not shaped by cultural identity alone but are also mediated by the intersecting effects of systemic racism, colonial histories, gender-based violence, and socioeconomic disparities (Clark, 2016; Hankivsky & Grace, 2015). As such, while the analysis does not engage with intersectionality in the same depth as with ICC, CMA, or SDH, the study remains attentive to the multiple and interacting factors that influence Indigenous women's access to and experiences within maternal healthcare.

1.3 Research Questions

The main research question guiding this study is as follow:

How do Indigenous mothers in Ottawa experience marginalization within the context of accessing maternal healthcare services?

1.3.1 Hypothesis Overview

This study puts forward three key hypotheses to examine the relationship between intercultural communication and maternal healthcare experiences among Indigenous Canadian women. These hypotheses, articulated later in this thesis, are formulated drawing from a review of the existing relevant literature on Indigenous maternal healthcare, intercultural communication and barriers Indigenous women face during access to healthcare. The hypotheses are also structured to be empirically tested through a mixed-methods approach, combining quantitative survey data and qualitative insights.

The first hypothesis explores the link between healthcare providers' intercultural communication skills and Indigenous women's satisfaction with maternal healthcare services. The second hypothesis examines how systemic barriers—such as geographic accessibility, socioeconomic status, and cultural biases—affect Indigenous women's ability to access maternal healthcare. The third hypothesis advances that cultural safety training for healthcare providers enhances trust and healthcare engagement among Indigenous patients.

Each hypothesis is operationalized with measurable indicators, ensuring that survey responses and interview data can be analysed to test their validity. The results intend to provide a comprehensive understanding of how marginalization shapes certain healthcare interactions, and to offer evidence-based recommendations for improving maternal healthcare services for Indigenous women. A detailed discussion of these hypotheses, their theoretical foundation, and supporting literature will follow in Chapter 2.

1.4 Research Objectives

The study proposes to investigate the underlying causes of marginalization faced by Indigenous mothers within healthcare settings in Ottawa, focusing on cultural, systemic, and logistical barriers and to assess the pertinence of intercultural communication in addressing healthcare challenges.

1.5 Methodology

As explained in more depth in Chapter 3, this study will adopt a qualitative approach, (although it uses some quantitative data) and will involve a systematic literature review and the use of structured survey questionnaires administered to Indigenous Canadian mothers and mothers-to-be in Ottawa. The systematic literature review will provide deeper insights into the

communication barriers and cultural dynamics at play. The surveys will collect data on the experiences and challenges Indigenous women in Ottawa face when interacting with maternal healthcare providers. By combining these methods, the study aims to identify patterns and themes in the data, offering a comprehensive understanding of how issues of intercultural communication impact maternal healthcare access for Indigenous women.

Based on the dataset, thematic analysis and descriptive statistics were used to analyse data and interpret the responses and dataset. This involved summarizing the data using measures such as frequencies, percentages, means, and standard deviations to identify patterns, trends, and general characteristics of the participants' responses. The analysis provided a clear overview of the demographic information, as well as key themes related to participants' experiences and perspectives. Also, Thematic analysis is a qualitative research method used to identify, analyze, and interpret patterns or themes within data. It provides a systematic approach to organizing and describing data in rich detail, allowing researchers to explore meanings across a dataset. This method is flexible and can be applied across various theoretical frameworks.

Participants in this study were recruited in community organizations (The Christian Fellowship of the Indigenous community and The Wabano Centre for Aboriginal Health) that serve Indigenous populations in Ottawa. These institutions both served as the main source to recruit participants for this research, as they are strongly connected to other Indigenous groups and people. However, it is important to note that the experiences shared by the respondents and discussed are not relating to their experiences with the centres mentioned above (as they are committed in addressing the needs of Indigenous communities); rather, in this research, the participants reflected on their experience with mainstream maternal healthcare providers.

1.6 Structure of the Thesis

The remainder of this thesis is organized as follows:

Chapter 2: Literature review and Theoretical Framework

In this chapter, a thorough review of the existing and relevant literature will delve into the specific challenges faced by Indigenous women in accessing maternal healthcare. Drawing on the Truth and Reconciliation Commission's findings (on Indigenous people in Canada the need for a consultative approach in addressing the needs of the Indigenous people's key to the development of their society) and other studies (e.g., Fariba et al., 2016; Wright, Wahoush, and Jack's (2019); Bacciaglia, et al., (2023); Deborah et al., 2024; Schouten and Meeuwesen (2006); Schiavo (2013); Allan and Smylie's (2015); Higginbottom et al. (2015); Gudykunst's (2005); Zhao (2021); Ramsden (1993); Cakir (2010); among others) this chapter will highlight systemic barriers, including geographical isolation, cultural misunderstandings, and healthcare providers' biases faced by these women. This chapter will include a section on the problematization of this study, which will also offer a rationale for the articulation of the research questions and hypotheses.

Chapter 3: Methodology

In this chapter, the research design and methods will be outlined in detail. This includes the rationale for using a mixed-methods approach, a description of the survey protocols and an explanation of the data analysis techniques. It will also discuss the theoretical frameworks used in this study, as well as the rationale behind the study, addressing the key thematic areas explored.

Chapter 4: Results and Discussion

The results from the survey and interviews will be presented in this chapter, followed by a discussion of the key findings. The discussion will focus on how intercultural communication can be improved to reduce healthcare disparities for Indigenous women based on an analysis of participants' responses, and how these findings contribute to the broader literature on health communication and Indigenous women's marginalization in mainstream maternal healthcare.

Chapter 5: Conclusion

The concluding chapter will summarize the key findings of the study and provide recommendations for policy and practice. It will also reflect on the limitations of the study and suggest directions for future research. This chapter will also address the research hypotheses and question highlighting the implications of the findings.

1.7 Summary

Chapter 1 has established the foundational context, rationale, and objectives of this study, emphasizing the critical need to investigate how Indigenous mothers in Ottawa experience marginalization in their access to maternal healthcare services. Anchored in selected aspects of Intercultural Communication Competence (ICC) and Critical Medical Anthropology (CMA), this research foregrounds the importance of effective communication and culturally safe care in addressing persistent systemic inequities within the healthcare system. The chapter has articulated the central research question, outlined the theoretical and methodological orientation of the study, and introduced the frameworks that will guide subsequent analysis. These include the interplay of cultural, historical, and structural factors that shape Indigenous women's maternal healthcare experiences. While ICC and CMA are employed as the primary analytical tools, the relevance of

intersectionality and the Social Determinants of Health (SDH) are also acknowledged and will be further contextualized in Chapter 2. Through this integrative approach, the study seeks to contribute to a more nuanced understanding of how communication-related barriers reinforce healthcare marginalization, with the broader goal of informing more inclusive, respectful, and responsive maternal healthcare practices that affirm Indigenous identities and rights.

Chapter 2

Literature Review and Theoretical Framework

The literature on intercultural communication in healthcare, especially in maternal healthcare for Indigenous populations, reveals significant disparities and challenges are faced by Indigenous people accessing healthcare, often because of cultural differences, systemic biases, and socio-economic factors. This section provides a comprehensive analysis of the existing research in key areas relevant to this study: (1) Interculturality in Health Communication, (2) Cultural Competence in Healthcare, and (3) Barriers to Healthcare for Indigenous Women. Each subsection addresses a specific aspect of the research question, forming a basis for the hypotheses and contextualizing this study within broader theoretical frameworks.

Maternal health care for Indigenous women in Canada has garnered increasing scholarly attention in recent years, reflecting growing recognition of systemic inequities, cultural dissonance, and barriers to care. Wright, Wahoush, and Jack's (2019) qualitative systematic review offers an essential synthesis of Indigenous women's experiences across Canada, highlighting common themes and structural challenges. However, much of the existing research draws on rural or regionally dispersed populations, leaving critical gaps in understanding if and how these issues manifest in specific urban settings. Ottawa, as the nation's capital and home to a diverse and growing Indigenous population—including First Nations, Inuit, and Métis communities—presents a unique context where urban healthcare systems, federal institutions, and Indigenous services intersect. Exploring maternal health access in this setting offers the opportunity to examine how broader systemic issues play out on the ground, and how urban-specific factors—such as service

fragmentation, institutional proximity, and intercultural healthcare dynamics—affect Indigenous women's care experiences. By focusing on Ottawa, this study addresses a significant empirical gap and contributes to more place-specific, actionable insights for policy and practice in urban Indigenous maternal health.

2.0 Overview of Prior Research

This section focuses on two of the most recent and comprehensive systematic reviews examining Indigenous women's experiences with maternal healthcare in Canada, highlighting persistent structural and cultural barriers within the healthcare system and the potential of community-based, culturally safe models of care to improve access and outcomes. Wright et al. (2019) analysed 13 qualitative studies to understand Indigenous women's experiences with maternal healthcare in Canada, revealing persistent themes of racism, cultural insensitivity, disempowerment, and logistical barriers such as relocation for birth and inadequate postpartum care. The findings of the study also found out that "Several mothers expressed that the availability of numerous services within the same facility would improve their experience. Two mothers had accessed primary care clinics that provided a nutritionist, paediatrician and other health providers within the same building as their Primary Care Provider.

Their perceptions of care at these facilities were that they offered better access to specialty services than relying on referrals from their PCPs to other services in the community. Another mother described the ideal primary health service as one that combined early childhood development services with access to PCPs" (Wright et al., 2019, p. 5). Their review demonstrates how health systems often fail to integrate Indigenous knowledge systems, language, and relational approaches to care, resulting in alienation and negative health outcomes for Indigenous mothers. Bacciaglia, et al., (2023) found that Indigenous women accessing health services reported

experiences of disrespect, racism, and stigma. They state that “Indigenous women were less likely to utilize health services offered by government- run programs or facilities” (Bacciaglia, et al., 2023, p. 6). Many of these women felt their health concerns were dismissed by healthcare providers. As a result, they were less likely willing to use services provided by government-run programs or facilities. The research highlighted that this more limited use of services was linked to factors such as poorer quality of care, limited access to specialists, fewer advanced treatment options, and broader social inequities.

In response, some authors proposed alternative models of care designed to be more empowering and flexible, often available on a walk-in basis. Indigenous women described these models as more accommodating, culturally safe, and responsive to their needs (Bacciaglia, et al., 2023). Participants emphasized that care tailored to the specific context of Indigenous communities could help reduce existing barriers. For instance, primary health care approaches co-developed with Indigenous communities focusing on culturally appropriate services and coordinated access were associated with better maternal health outcomes and stronger relationships between patients and providers. According to Bacciaglia, et al. (2023, p. 6-7) “The main barriers to accessing services included geographical location, diagnosis of diabetes, and experiences of stigma and discrimination. Efforts to increase access to health services, such as remote offerings of health resources, has shown great promise in promoting utilization of care”.

The presence of midwifery care within Indigenous communities also helped reduce physical, financial, and access-related barriers to healthcare. Improved availability of local services was regarded as highly beneficial. Midwifery care was characterized by unrushed appointments and minimal wait times, which Indigenous women deeply appreciated. They also

valued the ability to have family members present and access to continuous, around-the-clock support (Deborah et al., 2024).

Participants also emphasized the importance of midwifery, community-based supports, and respectful, culturally congruent communication with healthcare providers. The findings from (Deborah et al., 2024) found out that "When midwives supported Indigenous women in their choices and did not make assumptions, they felt comfortable and respected" (p. 182). Yet, while these studies span various provinces (e.g., Manitoba, British Columbia, and the Northwest Territories), those centered in Eastern urban centres like Ottawa remain notably absent. As the nation's capital, Ottawa features a distinct sociopolitical context, layered healthcare jurisdictions, and a complex Indigenous demographic landscape that merits focused examination.

2.1 Observations on the existing relevant literature

Despite robust documentation of systemic inequities, the existing literature often aggregates Indigenous experiences without attending to local variation. Wright et al. (2019) acknowledge the limitations of generalizability due to regional disparities in healthcare access and policy implementation. Moreover, while the review identifies intercultural miscommunication and mistrust as key barriers, it does not deeply explore the role of health communication frameworks or how these could be adapted to foster better intercultural interaction in clinical settings. While this may not apply to all reviews, it helps establish a foundation for future research and discussions.

Additionally, few studies have integrated critical health communication theory or examined the interpersonal dimensions of care through a communication lens. This represents a theoretical gap in understanding how cultural assumptions, linguistic differences, and relational cues shape maternal health encounters. By addressing this gap, this research tentatively attempts to explicitly

bridge the fields of health communication and intercultural studies—domains that have traditionally remained siloed in Indigenous maternal health research.

2.2 Ottawa as a site for examination

Ottawa, as the capital city of Canada and home to a growing urban Indigenous population, presents a unique and under-explored context for this research. Indigenous communities in Ottawa are diverse and include First Nations, Inuit, and Métis populations, many of whom have migrated from rural or remote communities. According to the 2021 Census, the Ottawa–Gatineau area is home to approximately 46,545 Indigenous people, including First Nations, Inuit, and Métis individuals. Notably, Ottawa has the largest Inuit population outside of the North (Statistic Canada, 2021). This migration often results in the dislocation from traditional support networks and the need to navigate unfamiliar and institutionally Western healthcare systems.

While national or provincial studies may capture broader trends, they often overlook the complex experiences of urban Indigenous women who face a different set of challenges, such as navigating bureaucratic systems, accessing culturally safe services in hospitals, and contending with urban-specific forms of discrimination or invisibility. The research addresses these gaps by situating maternal health communication within the local urban context, allowing for deeper insight into the lived experiences of Indigenous mothers in Ottawa.

Moreover, Ottawa's institutional infrastructure—home to federal healthcare bodies, Indigenous organizations, and universities—makes it a strategic site for studying how interculturality and communication practices can be transformed within policy and practice. Localized, context-sensitive research is crucial for informing targeted interventions and shaping culturally relevant services at both community and institutional levels.

2.3 Contributions of This Study

Aspects of this research builds on the findings of Wright et al. (2019) by addressing several key limitations in the existing research:

1.Interdisciplinary Lens: By integrating health communication and some aspect of Intercultural communication competence, the research proposes an innovative analytical framework that foregrounds the relational, communicative, and symbolic dimensions of care.

2.Local Focus: A case study in Ottawa offers grounded insights that are not only geographically specific but also transferable to other urban Indigenous populations facing similar systemic challenges.

In doing so, the study contributes to a more holistic understanding of culturally safe care within which Indigenous knowledge systems and communication preferences are not peripheral but central to maternal health services.

2.4 Intercultural Communication in Healthcare Settings

Intercultural communication within healthcare has become increasingly important as healthcare systems serve diverse populations. According to Schouten and Meeuwesen (2006), intercultural communication in healthcare is defined as the interaction between healthcare providers and patients who bring different cultural backgrounds, beliefs, and practices into the healthcare setting.

Schiavo (2013) argues that effective intercultural communication in maternal healthcare involves not only understanding the cultural beliefs and practices of the patient but also fostering a relationship of trust and respect, where both the healthcare provider and patient engage in open, empathetic dialogue that honors the patient's cultural values and needs.

Allan and Smylie's (2015) research indicate that poor intercultural communication can lead to misinterpretations, discomfort, and dissatisfaction, particularly among Indigenous patients. Indigenous women, for instance, may have specific health beliefs and practices rooted in their cultural heritage that may not align with Western healthcare practices. Higginbottom et al. (2015, argue that when health care providers fail to recognize and respect cultural differences, Indigenous patients often feel misunderstood and mistrusted, leading to reluctance in seeking care. They state that "Providing cultural awareness programs for health care providers can reduce the risks of misunderstanding" (Higginbottom et al., 2015, p. 302). This finding is particularly relevant to this study's hypothesis (articulated later in this chapter) on the impact intercultural communication skills could have on Indigenous women's healthcare experiences.

Gudykunst's (2005) Intercultural Communication Competence (ICC) offers insights into these interactions, suggesting that cultural differences in communication styles—such as directness versus indirectness, the role of non-verbal cues, and levels of formality—can lead to misunderstandings in healthcare settings. Applying ICC in healthcare requires that providers develop skills to adapt their communication styles to those of their patients, enhancing mutual understanding and trust. Zhao (2021) also found that "Language barrier presents a huge challenge in the intercultural communication between patients and health professionals on a sexual health-related topic" (p.826). The concept of cultural safety—introduced by Ramsden (1993) and applied by the Public Health Agency of Canada (2023)—further underscores the importance of respectful intercultural communication. Papps and Ramsden (1996) explain that cultural safety goes beyond cultural sensitivity by ensuring that healthcare providers create an environment in which patients feel respected, valued, and safe to express their cultural identity without fear of judgment or discrimination. They argue that "Cultural Safety in nursing and midwifery education and practice

provides a focus for the delivery of quality care through changes in thinking about power relationships and patient's rights" (Papps & Ramsden, 1996, p. 493).

For Indigenous women in Canada, a culturally safe environment would involve healthcare providers acknowledging and respecting Indigenous health practices, such as the use of traditional medicine or healing rituals, which have historically been marginalized by Western medicine (National Collaborating Centre for Indigenous Health, 2019). Cakir (2010) also highlights how as cultural diversity has gradually increased over time and people from various backgrounds have had to coexist, given rise to the concept of "intercultural communication" (p. 1743). In other words, fostering culturally safe spaces in healthcare requires an intercultural communication approach—one that emphasizes mutual understanding, respect, and the integration of diverse cultural perspectives into practice, particularly those that have been historically overlooked or devalued.

Thus, effective intercultural communication involves interactions between patients and healthcare providers from varied cultural backgrounds, built on a shared understanding of each other's cultural viewpoints. Effective intercultural communication serves as the foundation for delivering culturally competent care, as language and communication are the most important tools in establishing a mutual understanding between individuals from different cultures. Cakir (2010, p. 1752) states that "Individuals with high intercultural sensitivity do not avoid communicating with culturally different individuals, and it can be stated that they do not make hasty decisions when interpreting individuals." and strengthening intercultural communication abilities is crucial for acknowledging and respecting individuals as bio-psycho-social and cultural entities. In sum, healthcare professionals are expected to be sensitive to cultural differences and integrate this awareness into their practice to ensure holistic and high-quality care (Cakir, 2010).

This construct is developed within the broader context of increasing globalization and cross-cultural interactions, particularly as societies became more culturally diverse and communication across cultural boundaries becoming essential.

Chen and Starosta's (1996) model of intercultural communication competence comprises three primary dimensions: cognitive, affective, and behavioural. The cognitive dimension refers to intercultural awareness, the affective dimension involves intercultural sensitivity, and the behavioral dimension encompasses intercultural effectiveness. Chen and Starosta further emphasized that the model's goal is to encourage individuals to recognize cultural differences and approach others with tolerance and respect (Chen & Starosta, 1996).

In light of the existing literature on intercultural communication, developing such competence has the potential to greatly contribute to improved quality of care, enhanced patient safety, more effective communication between patients and healthcare professionals, reduced caregiver stress, strengthened professional knowledge and skills, and higher levels of patient satisfaction (Crawford, 2017; Hemberg & Vilander, 2017; Tanriverdi, 2017).

While ICC is a foundational skill that can inform and enhance cultural competence in healthcare, the latter is more specialized, involving clinical knowledge and systemic practices tailored to healthcare delivery, but also of significance for the present study.

2.5 Cultural Competence in Healthcare

Cultural competence in healthcare is defined as the ability of healthcare providers to understand and respond effectively to patients' cultural backgrounds (Betancourt et al., 2005). It involves recognizing and respecting diverse cultural health beliefs and practices, which can improve patient satisfaction and health outcomes (Beach et al., 2005). In Canada, where

Indigenous populations face significant health disparities, cultural competence has become a critical focus in healthcare training programs aimed at improving patient-provider interactions such as San'yas Indigenous Cultural Safety Training Program, developed by the Provincial Health Services Authority (PHSA) of British Columbia. This program was created to address anti-Indigenous racism in healthcare and provided mandatory cultural safety training for healthcare professionals across Canada.

Thus, research demonstrates that cultural competence among healthcare providers can enhance trust, communication, and patient satisfaction, especially among marginalized groups. For instance, Wilson and Neville (2009, p.35) found that cultural competence training for healthcare providers can improve Indigenous patients' trust in the healthcare system, as well as their willingness to engage in healthcare services. Their conclusions support one of this study's hypotheses suggesting that cultural competence training can positively influence Indigenous women's trust and willingness to access maternal healthcare services.

Mannion and Davies (2015) also argue that effective intercultural communication goes beyond recognizing cultural differences; it requires healthcare providers to develop the practical skills to engage with patients in ways that demonstrate respect for their cultural beliefs and facilitate mutual understanding, fostering an environment where patients feel heard and valued. They argue that "Effective voicing of concerns is but the first stage in reshaping better safer healthcare: those with influence have to hear, and they have to act" (Mannion & Davies, 2015, p. 504). In the context of maternal healthcare, culturally competent providers would be expected to consider Indigenous practices and traditions surrounding childbirth and postpartum care. This consideration not only respects the patient's cultural identity but also fosters a more supportive healthcare environment (Kirmayer, 2014).

Furthermore, Smye and Browne (2002) advance that cultural competence must be institutionally supported. They argue that cultural competence should be embedded in healthcare policies and practices rather than merely relegated to individual healthcare providers. They said argued that Healthcare institutions should develop frameworks that promote culturally sensitive practices, such as employing Indigenous healthcare workers, providing language interpretation services, and offering training that emphasizes cultural safety and humility. Smye and Browne (2002) claim that "We need to concern ourselves with how health policy discourses have been shaped in relation to political, social, cultural and economic structures, and in relation to each other" (p. 1). These institutional practices are crucial for creating a healthcare environment that respects and accommodates the unique needs of Indigenous patients.

Educational interventions can also support healthcare providers (HCPs) in recognizing how cultural practices influence health behaviors. Beyond cultural behaviors, it is also critical for HCPs to also understand the broader historical and political factors affecting Indigenous health. Colonialism is an active and ongoing force impacting the well-being of Indigenous peoples in Canada. Mashford-Pringle (2016) claim that even for Indigenous health professionals to 'walk in both worlds,' they must have a strong foundation in their culture, languages, and traditional knowledge, because health is a political issue. They argue that "Health includes spirituality, and that culture and ceremony should be a part of contemporary Indigenous health and healing, and that health care professionals need to be culturally sensitive and aware of the sociopolitical history that has led Indigenous people in Canada to this point" (Mashford-Pringle, 2016, p 98-99). In other words, colonial interventions such as the residential school system, the '60s Scoop, and broader assimilation policies inflicted significant trauma, disrupted cultural knowledge systems, and contributed to chronic socio-economic disadvantage among Indigenous populations. These

cumulative effects continue to negatively impact maternal health and access to healthcare services and need to be acknowledged and taken into serious consideration by maternal healthcare professionals.

Colonialism also disrupted traditional birthing practices, replacing them with imposed European medical models. This practice originated from earlier generations who lived highly active lives and maintained traditional diets, where frequent eating was necessary to prevent dangerous weight loss and maintain sufficient milk supply. For instance, in a qualitative study exploring diabetes prevention and postpartum health in a Cree community, Oster et al. (2014) found that cultural beliefs and traditional practices around postpartum care influenced maternal nutrition and weight retention. Specifically, breastfeeding mothers were traditionally encouraged to eat more frequently to support milk production and healing—an approach that aligns with mainstream medical advice. By recognizing and affirming such overlaps, mainstream maternal healthcare providers are better positioned to build cultural bridges, connect more meaningfully with Indigenous mothers, and promote their well-being in ways that are both medically sound and culturally respectful.

Additionally, other studies have shown that the erosion of traditional cultural practices has led to a decline in breastfeeding rates among Indigenous women (Smylie, 2010). This erosion is, in part, due to the lack of recognition and integration of Indigenous practices within mainstream maternal healthcare systems. Colonial policies, including the residential school system and forced medical evacuations for childbirth, disrupted intergenerational knowledge transfer, including infant feeding practices. Moreover, the medicalization of childbirth often removes Indigenous

women from their communities and traditional support systems, further severing ties to culturally rooted postpartum practices like breastfeeding.

Without culturally safe care that acknowledges and supports traditional approaches, Indigenous mothers may feel alienated from healthcare services, which contributes to lower breastfeeding rates. Recognizing and affirming traditional breastfeeding practices can therefore strengthen cultural identity, rebuild trust in healthcare systems, and improve maternal and infant health outcomes.

Thus, colonialism also resulted in great limitations of resources for medical services in/for Indigenous communities, traditional birthing knowledge was not restored, leading to policies that required pregnant Indigenous women to leave their communities for childbirth (National Aboriginal Council of Midwives, 2013). In response, a 2013 set of national guidelines recommended 24 strategies to promote culturally safe maternity care and advocated for the reinstatement of local birthing options in remote and rural Indigenous communities (National Aboriginal Council of Midwives, 2013).

2.5.1 Cultural Safety in Maternal Healthcare

Cultural safety, as distinct from cultural competence, emphasizes the need for healthcare providers to reflect on their own cultural identities and power dynamics in patient interactions (Association of Ontario Midwives, 2024). In the context of maternal healthcare, cultural safety involves creating environments in which Indigenous women feel respected and understood. Studies from the Association of Ontario Midwives have shown that when healthcare providers

engage in cultural safety training, it leads to improved patient-provider relationships and better health outcomes for Indigenous mothers (Association of Ontario Midwives, 2024).

Implementing culturally safe healthcare practices has been advocated and trialed in various nations, including Canada, Guatemala, Australia, Mexico, and the United States. While some initiatives have led to enhanced patient satisfaction, ongoing efforts are necessary to deepen respect for Indigenous cultures and integrate traditional knowledge into healthcare systems. Midwifery services and educational programs are recognized as culturally appropriate maternal healthcare solutions, particularly in remote communities (Smylie et al., 2020).

In Australia, a settler-colonial context similar to that of Canada, Indigenous midwifery programs have been linked to improved maternal outcomes, such as reduced rates of preterm births, low birthweight infants, and Caesarean deliveries compared to regional averages (Smylie et al., 2020). Conversely, in Guatemala and Mexico, culturally adapted healthcare interventions have faced challenges due to the lack of involvement of Indigenous communities in their design and implementation. For instance, in Guerrero, Mexico, a participatory action research study by Andersson et al. (2022) evaluated a maternal health intervention that prioritized support for traditional midwives through community-led processes. The researchers found that when midwives were empowered on their own terms, without being subsumed into the medical system, there was a notable improvement in both maternal health outcomes and perceptions of cultural safety. The study concluded that “The intervention seems to have improved interaction between traditional midwives and Western practitioners, but further intercultural dialogue is necessary to consolidate it and to extend its benefits” (Andersson et al., 2022, p. 385).

In the United States, community-controlled maternal healthcare programs have successfully empowered participants, fostered trust between patients and providers, improved preconception health knowledge, and enhanced health outcomes for mothers and infants. These successes underscore the necessity of developing culturally safe programs with active participation from the target Indigenous communities (Smylie et al., 2020).

Persistent health disparities between Indigenous and non-Indigenous women in urban areas underscore the need to address structural barriers to healthcare. Browne et al. (2009) highlight that postcolonial theories foreground particular analytical dimensions congruent with the goal of redressing health inequities experienced by Aboriginal peoples. While it is imperative to acknowledge shared histories of oppression and marginalization affecting particular groups (e.g., Aboriginal people in Canada), it is equally important to simultaneously recognize variations in individual experiences (p. 170), emphasizing the importance of addressing historical and ongoing colonial impacts on health. Furthermore, Browne et al. (2016) found that participants described experiences of racism and discrimination in health care settings, which contributed to mistrust and avoidance of health services. They argue that "People who experience inequities and marginalization often experience dismissal and/or stigma when accessing health care or community services" (p. 8), illustrating how systemic issues perpetuate disparities in urban healthcare access and outcomes.

The observed disparities in birth outcomes between Indigenous and non-Indigenous populations often diminish when adjusting for socio-economic and demographic factors. This suggests that socio-economic challenges, rather than inherent differences, play a significant role in these disparities. For instance, National Collaborating Centre for Aboriginal Health (2012)

found that differences in birth outcomes between Aboriginal and non-Aboriginal populations were largely explained by socio-economic and demographic factors, "in remote and rural areas where many Aboriginal communities are located, lack of access to health services can be problematic because of population. density too low to support wide-ranging health services, lack of transportation infrastructure, northern climate conditions, and difficulties in communicating health issues and needs as a result of language and cultural barriers" (p. 9). This underscores the importance of addressing socio-economic determinants to improve maternal health outcomes among Indigenous populations.

Inuit communities, particularly in Nunavut, experience significantly higher rates of preterm births compared to the Canadian national average. This disparity is closely linked to several interrelated factors, including low socio-economic status, high smoking rates, psychological stress, and inadequate nutrition. A study by Luo et al. (2010, p. 237) found that compared with the rest of Canada, "Inuit-inhabited areas had substantially higher rates of preterm birth (risk ratio [RR] 1.45, 95% confidence interval [CI] 1.38–1.52), stillbirth (RR 1.68, 95% CI 1.38–2.04) and infant death (RR 3.61, 95% CI 3.17–4.12)". These elevated rates are attributed to various socio-economic and health-related challenges prevalent in Inuit communities. One significant contributing factor is the high prevalence of smoking among pregnant women in Nunavut.

According to the same study by Luo et al. (2010), in Nunavut, 60–80% of pregnant women report smoking in pregnancy, a rate five times the Canadian average (p. 239). Maternal smoking is a well-established risk factor for preterm birth and low birth weight. Additionally, socio-economic challenges such as poverty, overcrowded housing, and food insecurity exacerbate health disparities. The report highlights that the most prevalent challenging factors affecting early life in

Inuit communities are infant mortality, food insecurity and poor nutrition, overcrowded housing, and exposure to environmental contaminants.

A national maternity experiences survey conducted by the 2008 Public Health Agency of Canada found that women in Nunavut reported receiving less information on pregnancy-related topics, alongside higher rates of smoking during pregnancy (57.9%), experiences of physical or sexual abuse (21.6%), and symptoms suggestive of postpartum depression (23.6%), compared to the overall Canadian average (Public Health Agency of Canada, 2008). The survey, which collected responses from over 6,000 women across Canada who had recently given birth, highlights the heightened vulnerabilities and health inequities facing Inuit women in northern communities (Public Health Agency of Canada, 2008).

Alarmingly, between 60% and 85% of pregnant women in Nunavut reported smoking during pregnancy, a rate significantly higher than the national average. Smoking during pregnancy is a leading modifiable risk factor for adverse pregnancy outcomes, affecting infant mortality and morbidity. Additionally, 26.2% of Inuit women in the Baffin region reported consuming alcohol, illicit drugs, or both during pregnancy (Public Health Agency of Canada, 2009).

Studies focusing on Indigenous populations in both Canada and abroad (e.g., Mexico and Australia) underscore the critical need for policy interventions that acknowledge and actively address historical injustices, cultural dissonance, and socio-demographic disparities that hinder access to healthcare. These studies argue that without culturally responsive frameworks, efforts to improve maternal health will remain inadequate. For example, Andersson et al. (2022) highlight that structural racism and the colonial legacies continue to shape Indigenous women's experiences of maternity care in Mexico, emphasizing the need for systemic reform. They argue that "A recent

cluster randomised controlled trial in four Indigenous groups in Guerrero State tested the idea that a co-designed intervention supporting traditional midwives, on their own terms, would not result in worse health outcomes and would have secondary benefits increasing cultural safety for indigenous groups" (p. 31).

Similarly, Smylie et al. (2020) explain that culturally unsafe care, care that demeans or disrespect's Indigenous identity, remains a key barrier to equitable maternal health outcomes in Australia. These findings point to the necessity of embedding culturally safe practices within healthcare systems as a foundational step toward improving Indigenous maternal health outcomes. These studies collectively underscore that without integrating culturally safe and responsive care, maternal health interventions risk perpetuating systemic inequalities rather than resolving them. Building on this, it is crucial to explore how the examination of critical barriers in healthcare for Indigenous women can deepen the understanding of the structural forces shaping these disparities and may guide more transformative approaches.

2.6 Barriers to Healthcare for Indigenous Women

Indigenous women in Canada face numerous barriers to accessing adequate maternal healthcare, many of which are rooted in historical and systemic discrimination. These barriers include geographic isolation, socio-economic challenges, and experiences of racism within healthcare settings (Browne et al., 2011). Geographic isolation, for instance, poses a significant barrier as many Indigenous communities are in remote areas with limited access to healthcare facilities. According to Richmond and Cook (2016), Indigenous women in these areas often must travel long distances to access healthcare services, which can be especially challenging for prenatal and postnatal care.

Socioeconomic factors also play a significant role in healthcare access. Indigenous women are more likely to experience poverty and limited educational opportunities, which can affect their ability to seek timely and adequate healthcare (Adelson, 2005). These socioeconomic determinants, as outlined by the Social Determinants of Health (SDH) framework, emphasize the broader structural conditions that influence health outcomes. As Marmot (2005, p. 1159) argues, social inequalities are a fundamental cause of health disparities, and addressing these inequalities requires comprehensive policies that target the social determinants of health, including income, education, and employment. Browne et al. (2011) found that Indigenous participants described anticipating that being identified as Aboriginal and poor might result in a lack of credibility and/or negatively influence their chances of receiving help.

Racism and discrimination within healthcare settings further compound the barriers discussed above. Indigenous women frequently report experiencing discrimination based on their ethnicity, which can lead to mistrust and avoidance of healthcare services. In a study conducted by Allan and Smylie (2015), Indigenous patients reported feeling judged or disrespected by healthcare providers, which they identified as a major deterrent to seeking care. "In addition to the uneven access to health services and resources created through the NIHB and other race-based policies, experiences and anticipation of racist treatment by health care providers also act as barriers to accessing needed health services for Indigenous peoples" (p. 9).

Varcoe et al., (2009) also note that discrimination, often rooted in implicit biases and stereotypes, has been linked to poorer health outcomes and decreased patient satisfaction. For Indigenous women in particular, these experiences are exacerbated by historical trauma stemming from colonial practices, which has created a longstanding mistrust of government institutions,

including healthcare. Kurtz et al. (2008) emphasize that control over health services has been paternalistically managed by federal authorities, with communities and individuals often feeling excluded from decisions about their own health and well-being, highlighting how systemic exclusion contributes to this deep-seated mistrust. They argue that “In addition, these experiences of racism and discrimination affect many women at times when they are most vulnerable and least able to protect themselves. This demonstrates a need for urgent action to stop the perpetual cycle that supports such structural violence” (p. 59).

Cultural safety frameworks have been suggested to address these issues by encouraging healthcare providers to examine and challenge their own biases and assumptions (Papps & Ramsden, 1996). The Public Health Agency of Canada (2023) also highlights the importance of cultural safety in Indigenous healthcare, stressing that healthcare settings should not only be free from discrimination but also actively promote and respect Indigenous cultural practices and viewpoints. This approach also aligns with the Critical Medical Anthropology (CMA) framework, which argues that addressing health disparities requires a critique of the social and institutional power structures that disadvantage marginalized groups (Baer et al., 2013 p. 45).

The historical context of healthcare for Indigenous populations in Canada also plays a significant role in understanding these barriers. The Truth and Reconciliation Commission (2015) highlighted the ways in which colonial practices have contributed to health inequities for Indigenous populations, recommending that the Canadian healthcare system address the legacies of colonization and implement culturally safe practices.

This recommendation aligns with the findings of Adelson (2005), who argues that “health disparities among Indigenous Canadians cannot be understood without considering the historical and social contexts in which they exist” (Adelson, 2005, p. 98). The National Aboriginal Council

of Midwives (2020) documents that the resurgence of Indigenous midwifery and holistic maternal healthcare models offers promising alternatives to Western medical practices. Indigenous midwifery integrates traditional knowledge, community-based support, and culturally safe birthing environments.

Research by Lavoie et al. (2010) also demonstrates that Indigenous-led healthcare models result in better maternal health outcomes, increased patient satisfaction, and higher rates of prenatal care engagement. All these studies support Kornelsen et al.'s (2021) findings suggesting that Indigenous women who received care from Indigenous midwives reported lower stress levels, greater trust in their healthcare providers, and improved overall maternal health. Thus, it seems the existing literature and studies examining the topic of Indigenous maternal healthcare clearly advance that culturally congruent care models can bridge the healthcare gap for Indigenous women.

Culturally sensitive care models therefore play a vital role in both preserving traditional healing methods and improving overall medical outcomes (Kornelsen et al., 2021; Lavoie et al., 2010). Establishing such approach, however, requires a deep appreciation of diverse health practices and a dedication to incorporating them into modern healthcare systems (ICEERS, 2023). By adopting an intercultural approach, medical practices can become more inclusive while safeguarding the cultural heritage of Indigenous communities.

Such integration would have the potential to foster a healthcare environment in which traditional wisdom and contemporary medicine could complement each other. In the light of the findings of this study and based on what the literature reveals, a path to a fully integrated intercultural healthcare system may seem challenging, however it seems essential that better promoting equitable and accessible care, particularly for marginalized populations will lead to

improved outcomes for Indigenous people and communities in their experiences of mainstream healthcare, including maternal healthcare (ICEERS, 2023).

Finally, as it will be discussed in more depth later in this thesis, the impact of policies on Indigenous maternal healthcare is addressed in this study. While the contributions this study has the potential to make on policy are modest, it still could form a basis or a starting point for reflecting on the benefits of integrating intercultural communication to Indigenous maternal healthcare. For example, three separate Canadian studies by Bacciaglia et al., (2023) published in BMC Pregnancy and Childbirth have previously explored how government policies influence the availability of services and programs related to Indigenous maternal health and suggested that inconsistent and fragmented policies hindered access to maternal healthcare.

Based on this, this study will put forward an argument for consistent and solid policies grounded in an appreciation for cultural competence and safety in maternal healthcare in Canada.

Indigenous women in Canada face disproportionately higher rates of adverse birth outcomes, including stillbirth, perinatal death, low birth weight, prematurity, and infant mortality. A national study by Sheppard et al. (2017) found that Inuit mothers had the highest preterm birth rate at 11.4%, while First Nations infants exhibited the highest rate of large-for-gestational-age births at 20.9%. Infant mortality rates were more than twice as high for each Indigenous group compared to the non-Indigenous population, with sudden infant death syndrome (SIDS) rates over seven times higher among First Nations and Inuit infants. Additionally, data from the Canadian Institute of Child Health indicate that First Nations mothers living on reserve had the highest high birth weight rate at 21%, and all Indigenous groups, except First Nations on reserve, had higher low birth weight rates compared to the Canadian average. These disparities

highlight the need for targeted interventions to address the unique health challenges faced by Indigenous communities.

Nunavut (NU), the Northwest Territories (NT), and Yukon, located in northern Canada, have the highest proportions of residents identifying as Indigenous compared to the rest of the country's provinces and territories. Within Canada, NU reported the highest percentage of women receiving inadequate prenatal care—defined as attending four or fewer prenatal visits—at 7.7%. Between 2006 and 2007, NT had the highest proportion of women who did not receive any prenatal care (27%), while NU recorded the highest proportion of women accessing prenatal care only after the first trimester (17.3%) (Government of Nunavut Department of Health and Social Services, 2010).

In 2011, NU had the highest infant mortality rate in Canada, a figure more than three times greater than the next highest region. NT held the third-highest infant mortality rate that year and recorded the highest rates for three out of the five years between 2007 and 2011. Furthermore, in 2004, NU reported the highest teenage pregnancy rate nationally, with 24% of live births to mothers under 19 years old, significantly surpassing the national average of 5%. Public Health Agency of Canada. (2013).

Teenage pregnancy is linked to higher risks of low birth weight and premature births. That same year, NU had a preterm birth rate of 12%, compared to 8% in other parts of Canada. Additionally, the rate of neonatal hospital readmissions was higher in NU (5.5%) than the national average (3.5%).

Moreover, Indigenous women in certain regions experience elevated rates of infections during pregnancy, including human immunodeficiency virus (HIV), cervicovaginal infections such as human papillomavirus (HPV), bacterial vaginosis, and the presence of organisms

like *Chlamydia trachomatis*, group B *Streptococcus*, *Mycoplasma hominis*, and *Ureaplasma urealyticum*.

A range of historical events tied to colonial policies has had a profoundly negative impact on Indigenous Canadians. These include the destruction of lands essential to Indigenous ways of life, the forced separation of children from their families through residential schools, the marginalization of Indigenous languages and spiritual practices, the erosion of dignity and autonomy through assimilation policies, and various forms of racial discrimination.

Many Indigenous individuals who endured colonialism have suffered trauma and its lasting effects, including mental illness, anxiety, depression, suicide, violence, low self-esteem, anger, hopelessness, difficulties in emotional recognition and expression, and vulnerabilities related to substance use, including alcohol, drugs, and sexual exploitation (Kirmayer et al., 2007; Gone et al., 2019). Over generations, these trauma effects have persisted as forms of trans-generational trauma—also referred to as historical trauma—and have been major contributors to the health and well-being inequities experienced by Indigenous peoples worldwide (Bombay, Matheson, & Anisman, 2014; Brave Heart, 2003). The intergenerational transmission of trauma is not only psychological but also structural, embedded in social systems such as healthcare, education, and justice, which continue to disadvantage Indigenous communities (Kirmayer, Gone, & Moses, 2014).

Historically, Indigenous women—particularly elder women—held influential positions within their communities, serving as key advisors to younger members and as carriers of important cultural and spiritual knowledge Government of Nunavut Department of Health and Social Services (2010). However, colonialism diminished their roles, ushering in a more patriarchal society that significantly altered Indigenous women's identities and responsibilities. This

transition not only weakened feminine power, autonomy, and agency but may have also heightened Indigenous women's exposure to violence and sexism.

The consequences of these historical events have affected not only women's health but also the health of families and communities. Previous research by the Association of Ontario Midwives (2024) has identified several factors that may further worsen maternal and infant health outcomes among Indigenous populations in Canada. These factors include socio-cultural and socio-economic conditions that influence diet, lifestyle, healthcare access, and rates of gestational infections and illnesses (Kolahdooz et al., 2016; Reading & Wien, 2009). High rates of smoking and alcohol use during pregnancy, along with exposure to hazardous environmental contaminants, also directly and indirectly impact the health and wellness of Indigenous Canadian women (May et al., 2018; Cwik et al., 2015). For example, studies have shown significantly higher rates of smoking and alcohol consumption during pregnancy among Inuit and First Nations women compared to non-Indigenous populations (Currie et al., 2013), while environmental health research indicates that Indigenous communities are disproportionately affected by pollution and toxic exposures due to proximity to industrial activity and lack of clean water infrastructure (Waugh et al., 2017).

Nonetheless, significant knowledge gaps remain, preventing a full understanding of maternal health among Indigenous women in Canada. Before effective maternal health promotion policies and programs can be designed and implemented to address existing disparities, it is crucial to develop a deeper understanding of Indigenous Canadian women's perspectives on maternal health.

This information is critical for informing future policy development and intervention programs aimed at improving maternal healthcare services and reducing the financial and

emotional burdens associated with pregnancy complications and adverse maternal health outcomes.

2.7 Summary of Key Findings from Literature

Existing literature relevant to this study's focus reveals a complex interplay of cultural, social, and systemic factors that impact Indigenous women's maternal healthcare experiences. First, intercultural communication challenges, as highlighted by ICC, contribute significantly to Indigenous women's dissatisfaction with healthcare services. The studies reviewed indicate that cultural misunderstandings and communication barriers are prevalent in healthcare interactions, underscoring the need for intercultural competence among healthcare providers (Schouten & Meeuwesen, 2006; Gudykunst, 2005).

Second, the importance of cultural competence in healthcare is well-supported by research, with evidence suggesting that training healthcare providers in cultural awareness and communication skills can improve Indigenous patients' healthcare experiences (Betancourt et al., 2005; Wilson & Neville, 2009). However, research also emphasizes that individual provider competence must be supported by institutional policies that promote cultural safety and inclusivity (Smye & Browne, 2002; Public Health Agency of Canada, 2023).

Finally, Indigenous women face multiple barriers to healthcare access due to systemic factors, including geographic isolation, socioeconomic disadvantages, and experiences of racism. These barriers are deeply rooted in Canada's colonial history, as documented by the Truth and Reconciliation Commission (2015), and continue to affect Indigenous health outcomes. Addressing these barriers requires a comprehensive approach that incorporates both cultural safety in healthcare settings and policies that address the social determinants of health.

Thus, the existing relevant literature highlights the challenges Indigenous women face in accessing culturally safe maternal healthcare and underscores the need for interventions that address both individual provider competencies and institutional practices. This review of the literature informs the research question and hypotheses, providing a foundation for exploring the relationship between health communication and interculturality in Indigenous maternal healthcare.

2.8 Significance of the study

This study aims to address significant gaps identified in the existing literature on intercultural communication, healthcare disparities, and cultural safety in Indigenous maternal healthcare. There is a paucity of research that specifically addresses the unique experiences of Indigenous Canadian women in urban maternal healthcare, highlighting a significant gap in the literature. The experiences of Indigenous peoples are also frequently excluded from conversations about racism and anti-racism (Lawrence & Dua, 2005). These exclusions are often justified by emphasizing the distinct histories, policies, and current realities that shape Indigenous lives (Nestel, 2012; Levy et al., 2013). Asim et al. (2015) explain that "these women tend to have higher susceptibility to anxiety and depression as compared to majority and native women. Moreover, there is potentially increased risk of prematurity, low birth weight, increased maternal and infant morbidity and mortality" (p. 2). This study, thus, has the potential to contribute to the literature by contextualizing these issues within the framework of Canadian Indigenous maternal healthcare, offering new insights that may have the potential to inform both healthcare policy and practice.

2.9 Marginalization Experiences in Ottawa

In Ottawa, Indigenous mothers often encounter marginalization within maternal healthcare services. Barriers include a lack of culturally appropriate care, experiences of racism, and a healthcare system that does not accommodate Indigenous worldviews (Mann, 2018).

These factors contribute to a reluctance among Indigenous women to seek prenatal and postnatal care, leading to adverse health outcomes (Yeung, 2016), Indigenous-led initiatives, such as those by the Wabano Centre in Ottawa, offer culturally grounded maternal healthcare services. These programs integrate traditional knowledge and practices with Western medical care, providing a holistic approach to maternal health and become a framework for the mainstream healthcare providers.

Such community-based models have demonstrated success in improving health outcomes and building trust between Indigenous communities and healthcare providers (Sharma 2016). Providing maternal healthcare within Indigenous communities enables pregnant women to establish trusting relationships with local healthcare providers (HCPs). Familiarity with HCPs during childbirth contributes to increased comfort and confidence in their care.

Conversely, the inability to form such relationships—due to factors like medical evacuations or high staff turnover in remote areas—can introduce stress into the maternal healthcare experience (Payne, 2010).

Culturally safe care extends beyond cultural competence, emphasizing responsiveness to women's and families' needs, strengths, and desires for control and choice in the birthing experience. While cultural competence focuses on practitioners' skills and knowledge, culturally

safe care requires systemic changes that empower patients and respect their cultural identities (Payne, 2010).

The Aboriginal Prenatal Wellness Program (APWP) in Alberta exemplifies culturally safe care by addressing the specific needs of Indigenous women who previously had limited access to prenatal services. The program trains staff to understand traditional practices, cultural histories, and health disparities affecting Indigenous peoples. Following its implementation, the percentage of women delivering in hospitals without adequate prenatal care decreased significantly, indicating improved access and trust in the healthcare system (Heaman et al., 2014).

Similarly, the Sioux Lookout Meno Ya Win Health Centre (SLMHC) in Ontario integrates culturally safe practices by incorporating traditional healing, medicine, and food into its services. SLMHC's approach includes interpreter services, cultural awareness training for staff, and the involvement of Elders in patient care, all aimed at creating a healthcare environment that respects and supports Indigenous cultural values (SLMHC, 2024).

2.10 Addressing Intercultural Communication Gaps

One of the primary potential contributions this study could make resides in its focus on intercultural communication dynamics specific to Indigenous maternal healthcare. The literature review shows that intercultural communication challenges, particularly misunderstandings arising from cultural differences, are prevalent in healthcare settings (Schouten & Meeuwesen, 2006; Gudykunst, 2005). However, much of the existing research does not adequately address the impact of these communication barriers on Indigenous women's maternal healthcare experiences. By applying Gudykunst's (2005) Intercultural Communication competence (ICC), this study aims to

gain a better understanding of how cultural misunderstandings in healthcare affect Indigenous women's trust and satisfaction with healthcare providers.

Furthermore, this research draws from the work of Zhao (2021), who identified language barriers and a lack of cultural awareness as significant obstacles in intercultural healthcare communication, by specifically examining how these issues impact maternal healthcare access. This focus on the maternal healthcare experience is critical, as pregnancy and childbirth are deeply personal events often embedded in cultural traditions and practices that may differ from Western medical norms (Higginbottom et al., 2015). By investigating these dynamics, the study could contribute to a nuanced understanding of these issues emphasizing the importance of cultural competence in maternal healthcare, particularly in culturally diverse settings.

2.11 Expanding Cultural Competence Frameworks

The literature indicates that cultural competence in healthcare is associated with improved patient satisfaction and trust, especially among marginalized groups (Betancourt et al., 2005; Wilson & Neville, 2009). Yet, many existing frameworks for cultural competence are generalized and may not fully capture the specific needs of Indigenous populations, whose historical and social contexts influence their healthcare experiences (Browne et al., 2011; Kurtz et al., 2008). Public Health Agency of Canada (2023) study expands on current cultural competence frameworks by incorporating the concept of cultural safety. Cultural safety emphasizes the need for healthcare providers to critically examine their own biases and the systemic power imbalances that affect Indigenous patients' healthcare experiences.

By combining cultural competence with cultural safety, this study intends to offer a more comprehensive approach to addressing Indigenous healthcare disparities. Smye and Browne

(2002) argue that cultural competence is only effective when supported by policies that actively promote inclusivity and respect for Indigenous cultural practices. Thus, this research also questions and evaluates the significance of cultural safety as an essential component of intercultural healthcare and communication.

2.12 Examining Structural Barriers through a Social Determinants Lens

Another key contribution of this study lies in its examination of the structural barriers Indigenous women face in accessing maternal healthcare, which are often overlooked in cultural competence discussions (Richmond & Cook, 2016). Applying the Social Determinants of Health (SDH) framework allows this study to analyse how factors like geographic isolation, socioeconomic status, and educational attainment affect healthcare access for Indigenous women. As demonstrated by Adelson (2005, p. 47), health disparities among Indigenous populations cannot be fully addressed without considering the broader social and economic conditions that shape their health outcomes.

This study extends the work of Marmot (2005) by examining these social determinants within the context of maternal healthcare, a critical area where timely access to services can have life changing implications. It focused on the social determinants of health, particularly how factors like income, education, and social status influence health outcomes. The study emphasized how these social factors contribute to health disparities across different populations.

The social conditions in which people are born, live, and work are the single most important determinant of good or ill health. Marmot (2005, p. 1099) discusses key approaches to addressing inequalities in the healthcare system, claiming that "to address global health inequalities, a third key approach is needed—one that complements both health system development and poverty

alleviation: action on the social determinants of health. This approach goes beyond poverty reduction, aiming to enhance the broader living and working conditions that shape people's health".

Therefore, by applying these insights to maternal healthcare for Indigenous women in Ottawa, this study has the potential to provide evidence-based recommendations for the development of policies taking into more serious consideration the social determinants contributing to Indigenous maternal health disparities in urban settings.

2.13 Problematization

Statistics from the Truth and Reconciliation Commission report (2015) show that there has been marginalization of Indigenous women in Canada in the specific context of maternal healthcare access. Getting medical attention seems 'risky' as an Indigenous woman, (Truth and Reconciliation Commission report, 2015). There is also an acute shortage of health services for Indigenous women in Canada, Truth and Reconciliation Commission report (2015).

Canadian Indigenous women also often encounter a lack of cultural safety (a concept that goes beyond cultural awareness and sensitivity, as mentioned in above) (Bourassa et al. (2004), and that involves the creation of an environment in which individuals from diverse cultural backgrounds feel respected and safe. In other words, cultural safety is the competence of recognizing, protecting, and advancing the inherent rights, cultures, and traditions of different cultural groups (Public Health Agency of Canada, 2023). Canadian Indigenous women also face diverse additional challenges when seeking care, including anti-Indigenous racism in health institutions, and acceptance of Indigenous healing and health practices. Moreover, less than 1% of

physicians in Canada identify as Indigenous, even though they make up more than 4.5% of the nation's population.

This study will investigate the causes Canadian Indigenous women themselves see as reasons for their lack of healthcare access and marginalization, including cultural differences, geographic location, lack of support from their community, etc., to determine how interculturality might be incorporated into health communication to address this gap.

This research holds significance for several reasons. While the theoretical contributions of the study have been discussed previously, its findings are also relevant for policymakers and medical professionals. The Canada Health Act outlines the objectives and responsibilities of the Canadian healthcare system, yet the government remains accountable for improving healthcare services for Indigenous populations, particularly Indigenous women and new mothers. The outcomes of this research could help inform strategies for enhancing health communication policies and fostering behavioral change among healthcare workers and providers who serve Indigenous women in Canada.

There are ongoing misconceptions regarding the quality and accessibility of prenatal, delivery, and postnatal care for Indigenous women, including significant barriers, inequities, and disparities in accessing healthcare services and information within the Canadian healthcare system (Richmond & Ross, 2009). This study, drawing on the theoretical traditions of intercultural communication (Martin & Nakayama, 2010) and health communication (Rimal & Lapinski, 2009), is highly relevant for addressing these issues. Given the communication-centered nature of the research question, the role of intercultural communication competence in health communication remains a critical aspect in resolving these ongoing challenges.

2.14 Research Questions and Hypotheses

This study aims to understand the role of intercultural communication in maternal healthcare for Indigenous women in Canada and the barriers they encounter due to cultural differences, systemic biases, and socioeconomic challenges. The research is guided by the following primary question: *How do Indigenous mothers in Ottawa experience marginalization within the context of accessing maternal healthcare services?*

This question aims to investigate specific social, economic, and cultural factors contributing to the barriers Indigenous women face in healthcare settings. It includes examining the impact of historical discrimination, socioeconomic status, and geographic isolation on Indigenous women's maternal healthcare experiences. This overarching question addresses the core of the study, seeking to understand how interculturality influences healthcare outcomes and maternal health promotion efforts among Indigenous populations. It will examine the extent to which healthcare communication that acknowledges and respects cultural differences can improve healthcare access and quality for Indigenous women. This primary question will be also be supported by three hypotheses that seek to highlight specific aspects of intercultural communication and health disparities in maternal healthcare.

2.15 Hypotheses

The study proposes the following hypotheses, each operationalized to be measurable through survey data and qualitative responses:

2.15.1 Hypothesis 1*:* There is a positive correlation between healthcare providers' intercultural communication skills and Indigenous women's satisfaction with maternal healthcare experiences.

Operationalization: Intercultural communication skills will be measured through survey items assessing providers' respect for Indigenous cultural beliefs, openness to traditional practices, and ability to communicate effectively across cultural barriers. Satisfaction will be measured through patient feedback on experiences in healthcare interactions.

2.15.2 Hypothesis 2: Indigenous women's perceived barriers in maternal healthcare access are significantly influenced by systemic factors, including geographical accessibility, socioeconomic status, and cultural biases.

Operationalization: Perceived barriers will be measured through patient surveys identifying challenges in accessing healthcare facilities, affordability of care, and experiences of discrimination. Responses will be categorized by type to analyse how each factor contributes to reported barriers.

2.15.3 Hypothesis 3: Training healthcare providers in cultural safety practices significantly improves Indigenous women's trust and willingness to engage in maternal healthcare services.

Operationalization: This will be assessed by comparing levels of trust and healthcare engagement among Indigenous women treated by providers who have undergone cultural safety training versus those who have not. Trust and engagement will be measured through survey responses on perceived respect, comfort, and willingness to seek care.

This research question and hypotheses are designed to be empirically tested through mixed-methods research, allowing for both quantitative correlation and qualitative insights. By exploring these hypotheses, this study will clarify how interculturality influences healthcare interactions and identify actionable strategies to reduce healthcare disparities for Indigenous Canadian women in maternal health.

2.16 Theoretical Framework

In exploring intercultural communicative challenges in maternal healthcare for Indigenous women in Canada, a theoretical framework that allows understanding and analysing the dynamics at play in health communication is essential. The proposed framework combines Intercultural Communication Competence (ICC), Critical Medical Anthropology (CMA), and Social Determinants of Health (SDH). Each theory offers a unique lens for examining how cultural, social, and systemic factors impact healthcare access and the quality of care for Indigenous women. These theories collectively provide a foundation for the study, anchoring the exploration of intercultural exchanges in healthcare within well-established theoretical traditions.

2.17 Intercultural Communication Competence (ICC)

Intercultural Communication Competence (ICC) examines how communication across different cultures operates, and it is particularly relevant in understanding communication dynamics in healthcare. This theory, which originated from the work of scholars like Gudykunst (2005), seeks to explain how misunderstandings arise in cross-cultural interactions due to differences in cultural backgrounds, values, and communication styles.

ICC posits that individuals bring with them cultural schemas—cognitive structures shaped by culture that influence perception, interpretation, and response in interactions. In healthcare, ICC can help illuminate why healthcare providers and Indigenous patients may struggle to achieve mutual understanding because of differing cultural schemas (Gudykunst, 2005).

In the context of maternal healthcare for Indigenous women in Canada, ICC highlights the challenges that healthcare providers and patients may face in understanding each other's perspectives and expectations. Many Indigenous women report experiencing cultural

misunderstandings that lead to inadequate care or discomfort in healthcare settings (Truth and Reconciliation Commission report (2015). By applying ICC, this study aims to analyse how these intercultural miscommunications emerge and explore how enhancing cultural competence among healthcare providers may help bridge these communication gaps.

The theoretical foundation provided by ICC underscores the necessity for healthcare practitioners to not only understand but also adapt to the cultural backgrounds and communicative expectations of their patients to foster more effective and respectful interactions.

ICC's framework of cultural adaptation and accommodation is particularly useful in the healthcare context. Henderson et al, (2018) emphasizes the importance of healthcare providers developing skills to recognize and adapt to the cultural backgrounds of their patients. Healthcare providers should be trained to be aware of their own cultural background and biases, and to adapt their communication to the cultural context of the patient. As Sarwari et al., (2024, p. 3) note, "Intercultural competence can be defined as individuals' capability to apply attitudes, knowledge, understanding, and skills in their performance when interacting with people from other cultural backgrounds to have helpful and pleasant communication." This adaptability can help mitigate feelings of alienation that Indigenous women may experience in healthcare settings dominated by Western medical practices.

Furthermore, ICC informs strategies to improve patient-provider interactions by encouraging healthcare practitioners to foster cultural awareness and sensitivity, ultimately leading to enhanced patient satisfaction and better health outcomes. Presbitero and Attar (2018, p. 37) support "the assertion that intercultural communication effectiveness can serve as a mediator in the relationships between anxiety and knowledge sharing, and uncertainty and knowledge sharing." Individuals engaging with multiple cultures often experience significant anxiety and

uncertainty. Cross-cultural interactions tend to be unpredictable and mentally challenging (Molinsky, 2007), which can heighten these feelings. Such elevated anxiety and uncertainty, stemming from cultural differences, may negatively impact individuals' ability to communicate effectively in intercultural contexts. In this study, intercultural communication effectiveness is considered a mediating factor—serving as a means to manage anxiety and uncertainty and, in turn, enhance knowledge sharing. Research indicates that effective communication plays a crucial role in promoting more successful knowledge exchange.

2.18 Critical Medical Anthropology (CMA)

Critical Medical Anthropology (CMA) offers a critical perspective on how power dynamics and social inequalities shape health and healthcare access. Rooted in anthropological theory, CMA investigates the structural forces—such as colonialism, socioeconomic inequality, and institutionalized racism—that impact the health outcomes of marginalized communities.

In the context of Indigenous maternal healthcare, CMA provides insight into the historical and systemic marginalization that Indigenous populations face in Canada's healthcare system, which is also illustrated in the observations and recommendations of the Truth and Reconciliation Commission work.

Indigenous healthcare disparities are deeply intertwined with Canada's colonial legacy, which has systematically disadvantaged Indigenous communities, affecting everything from economic opportunities to access to healthcare facilities. CMA's focus on structural determinants of health sheds light on how these forces continue to shape Indigenous women's healthcare experiences.

For instance, systemic racism, often manifested through anti-Indigenous biases among healthcare providers, is a critical barrier to effective healthcare communication (Adelson, 2005). The literature reviewed for this article indicates that health disparities are both directly and indirectly associated with or related to social, economic, cultural and political inequities; the end result of which is a disproportionate burden of ill health and social suffering on the Aboriginal populations of Canada. Adelson (2005) notes that “The health disparities outlined in this synthesis article reflect the present-day health effects of decades of inequity as Aboriginal peoples, First Nations, Inuit and Métis continue to work toward economic, political, social, community and individual health” (p.S45).

CMA helps frame these barriers within the broader context of historical and social injustices, advancing that the unequal power relations embedded within healthcare systems must be addressed to achieve equitable healthcare for Indigenous women (Adelson, 2005).

CMA also brings attention to the cultural safety of healthcare environments. Cultural safety goes beyond cultural awareness or sensitivity, requiring healthcare systems and providers to understand and address the power imbalances that exist between Indigenous patients and the predominantly Western healthcare model.

This concept is especially relevant in maternity care, as Indigenous women may feel vulnerable and may be reluctant to seek care if they perceive that their cultural beliefs and practices will be disrespected. CMA advocates for healthcare practices that not only respect but also actively support Indigenous cultural beliefs and healing methods, have the potential to create an environment where Indigenous women feel empowered and respected during their maternal care journey (Adelson, 2005).

2.19 Social Determinants of Health (SDH)

The Social Determinants of Health (SDH) framework explores how social, economic, and environmental factors influence health outcomes. The World Health Organization (WHO) defines SDH as "the conditions in which people are born, grow, live, work, and age" (WHO, 2017). The social determinants of health such as income, education, employment, housing and access to appropriate health services are major contributors to the health inequities experienced by Indigenous women. "Social determinants of health are those factors that focus on the economic and social conditions that govern peoples' lives." National Collaborating Centre for Aboriginal Health (2012, p. 5). Indigenous women often experience disadvantages across these determinants, which affect their ability to access and benefit from healthcare services, (National Collaborating Centre for Aboriginal Health, 2012).

In fact, within the Canadian healthcare, Indigenous populations face unique challenges, with many Indigenous communities situated in remote areas with limited access to healthcare facilities. Additionally, Indigenous women are more likely to experience lower socioeconomic status, which has been linked to poorer health outcomes (Bourassa et al., 2004). The SDH framework is crucial for understanding these disparities, as it contextualizes healthcare access within the broader socioeconomic environment. By applying SDH, this study aims to examine how social and economic factors contribute to the barriers Indigenous women face in accessing maternal healthcare.

SDH further highlights the importance of culturally competent healthcare policies that address these social factors. Policies and programs aimed at improving Indigenous health must address the broader social determinants of health, including housing, education, income, and access to culturally appropriate care**.** Reading and Wien (2009, p. 24) argues that **"**in order to

ensure the most favourable intermediate determinants of health, Aboriginal peoples must participate equally in political decision-making, as well as possess control over their lands, economies, education systems, and social and health services". They, however, also note that "Unfortunately, […] the colonial agenda has enforced unequal access to and control over property, economic assets and health services. In many ways, this restrictive structure has encouraged Aboriginal social, political and economic development that is not self-determined". The study includes policies that expand healthcare infrastructure in remote areas, improve transportation to healthcare facilities, and provide financial support for low-income Indigenous women seeking healthcare.

Through the SDH framework, this study thus underscores the need for healthcare policies that go beyond individual healthcare encounters to address the broader social and economic conditions affecting Indigenous maternal health.

2.20 Conclusion

In sum, this study aims to contribute to the field by addressing critical gaps in the literature on intercultural communication and healthcare disparities in Indigenous maternal healthcare in primarily urban settings. Through a focused analysis of cultural competence, cultural safety, social determinants, and intersectionality, this research offers a comprehensive framework for understanding and addressing the unique challenges Indigenous women face in accessing maternal healthcare in Ottawa. The findings from this study are expected to highlight the importance of culturally competent and inclusive healthcare environments that respect and support Indigenous cultural identities.

Chapter 3

Methodology

3.0 Justification of Methodological Approach

This study primarily adopts a qualitative research design, supplemented by limited quantitative data. While some quantitative analysis is included to support the interpretation of findings, the extent of this component does not warrant classification as a fully mixed-methods approach. Rather, the research prioritizes a qualitative in-depth exploration of cultural dynamics and patient-provider interactions. In other words, the inclusion of quantitative elements serves to enhance, rather than define, the analytical process, aligning with an understanding of methodological pluralism (Rimal & Lapinski, 2009) an emphasis on contextual understanding in health communication research.

3.1 Methods and Procedures

This section summarizes the methods used to collect and analyse data, ensuring the validity and reliability necessary for a comprehensive understanding of the study's focal issues.

3.1.1 Data Collection

i. Systematic Literature Review

The study began with a systematic literature review (presented in Chapter 2), focusing on existing research related to healthcare communication, intercultural dynamics, and Indigenous maternal health. Reviewing peer-reviewed studies, policy documents, and government reports from the last

15 years enabled the researcher to incorporate contemporary understandings while grounding the analysis in established research (Whittemore & Knafl, 2005; Matusitz & Spear, 2014). This review provided a foundational context for understanding the cultural, structural, and communicative challenges later highlighted in the empirical findings of this study.

ii. Survey Design

Qualitative and quantitative (demographic) data were collected using structured survey questionnaires via google survey forms, which were designed to capture both participants' perceptions and some measurable patterns. The survey includes open-ended questions for qualitative insights and some closed-ended questions for quantitative analysis, consistent with methods that explore both broad trends and individual narratives (Silverman et al., 2004; Wiseman & Aron, 1970).

For instance, closed-ended questions assessed the level of access to maternal healthcare services, while answers to open-ended questions allowed the researcher to explore participants' deeper experiences with intercultural communication barriers, such as language difficulties or perceived discrimination mothers face when accessing healthcare.

iii. Sampling and Recruitment

Participants were selected through Simple Random Sampling (SRS) to ensure an unbiased sample representing Indigenous mothers and expecting mothers in Ottawa. This sampling method provides each potential participant with an equal chance of selection, improving generalizability and mitigating selection bias. Collaboration with Indigenous community organizations, such as the Wabano Centre for Aboriginal Health and The Christian Fellowship of the Indigenous assisted with contacting other indigenous groups and organizations to recruit respondents. Survey

responses were collected online and via email, allowing participants adequate time to respond thoroughly to questions. This approach maximized convenience and accessibility, given that some participants may have had varying levels of familiarity with digital communication. However, recognizing the limitations of digital-only responses, efforts were also made to mitigate any selection biases by ensuring access to online tools when possible (Street, 1991). This was done publicizing the study through multiple channels, using both online and offline methods (e.g., flyers and providing phone numbers for the respondents to reach out when necessary) to reach a broader demographic.

3.2 Cultural Sensitivity and Ethical Considerations

Ensuring cultural sensitivity in survey design and participant interactions is paramount in research involving Indigenous populations. Despite consultations with Indigenous leaders and community members during survey design, there remains the risk of misinterpretation due to the complexity of intercultural communication (Schinkel et al., 2016; Gibson & Zhong, 2005). To address this issue, questions were carefully crafted to avoid unintended discomfort or offense. Additionally, ethics approval was sought, and participant confidentiality was strictly upheld, recognizing the importance of trust-building in studies involving Indigenous participants (Public Health Agency of Canada, 2023).

3.2.1 Research Strategy

The choice of a qualitative method strategy in this study is driven by the complexity of examining healthcare communication and intercultural issues among Indigenous populations. Qualitative insights provided context for understanding the cultural sensitivities and personal experiences of participants while the supplementary quantitative data offered measurable data

regarding accessibility barriers. Concretely, while quantitative findings may have revealed the extent to which Indigenous women experience challenges in accessing healthcare, the qualitative data was primarily used for its potential to reveal the underlying reasons behind these challenges (Holliday, 2018; Gibson & Zhong, 2005). This combination enabled a richer understanding of how communication disparities affect healthcare delivery, addressing the primary research question: *How do Indigenous mothers in Ottawa experience marginalization within the context of accessing maternal healthcare services?*

The study's primary use of qualitative method and approach aligns with Intercultural Communication Competence (ICC), a theoretical foundation that underscores the importance of context and cultural sensitivity in communication practices (Jackson, 2016). ICC supports the study's goal of capturing the nuanced interplay between healthcare providers' communication styles and Indigenous women's healthcare experiences, thus providing a more complete perspective than single-method approaches would allow (Gudykunst & Nishida, 2001; Corcoran, 2007). Moreover, the combination of mainly qualitative data with some quantitative data enriches data reliability by allowing a blend of already existing literature into this current study and enabling more comprehensive insights into health communication practices (Kourkouta & Papathanasiou, 2014).

3.2.2 Justification of Qualitative Approach

A qualitative research approach is particularly well-suited for exploring intercultural healthcare experiences, as it allows for an in-depth examination of the nuanced, lived realities of Indigenous women navigating healthcare systems. This method enables researchers to capture the emotional, cultural, and relational aspects of healthcare encounters that are often missed by

quantitative measures (Higginbottom et al., 2015). By centering participants' voices, qualitative research reveals the ways systemic issues—such as cultural insensitivity, language barriers, anti-Indigenous racism, and institutional bias—shape access to and the quality of maternal care.

The study draws on elements of Intercultural Communication Competence as a guiding framework, which provides a valuable lens for understanding how differences in language, customs, and values influence healthcare interactions (Schiavo, 2013; Martin & Nakayama, 2010). This framework supports a qualitative exploration of communication within broader cultural and power dynamics.

Qualitative methods are also particularly important in contexts involving marginalized populations, as they prioritize context-specific narratives and support culturally responsive interpretations of data (Verhoef & Casebeer, 1997). Moreover, this approach aligns with calls for more inclusive, relational, and community-informed research practices in Indigenous health studies (Arnold & Boggs, 2015; Abedin et al., 2022). Ultimately, qualitative inquiry enhances our understanding of the systemic and interpersonal barriers Indigenous women face, and contributes to the development of more equitable and culturally safe healthcare models.

3.3 Rationale for Selecting a Primarily Qualitative Approach with Supplementary Quantitative Data

This methodological choice for this study is grounded in the recognition that Indigenous women's access to maternal healthcare in Ottawa is shaped by both structural inequities and deeply personal, lived experiences. This said, and as mentioned above, while some quantitative data are used to identify broad patterns (e.g., service availability, missed prenatal appointments, or general barriers to care), these measures serve only a secondary role; they help orient the research toward key areas

of concern but are insufficient to capture the cultural, emotional, and interpersonal dimensions at the core of this inquiry (Creswell & Clark, 2017; Ivankova, Creswell, & Stick, 2006; Rimal & Lapinski, 2009).

Qualitative inquiry, in this study, offers the interpretive depth required to examine how Indigenous women navigate and experience maternal healthcare systems. It is also particularly well suited to addressing issues of intercultural communication and systemic bias—dimensions that cannot be fully understood through numeric data alone. Through open-ended responses and narrative accounts, participants can articulate their experiences in ways that reflect their identities, histories, and worldviews. For example, while quantitative surveys might reveal high rates of missed care, only qualitative narratives can uncover underlying causes such as fear of discrimination, cultural misunderstandings, or unsafe care environments (Martin & Nakayama, 2010).

This approach is further supported by the study's theoretical framework of Intercultural Communication Competence (ICC), which emphasizes both observable aspects of communication and the deeper cultural meanings that shape them (Gudykunst & Nishida, 2001). A qualitative orientation allows the study to explore not only the existence of communication gaps, but also their roots in power, trust, and identity, offering a more holistic understanding of patient-provider dynamics (Jackson, 2016; Schiavo, 2013).

In addition, this design aligns with the ethical and cultural principles embedded in Indigenous research methodologies, which emphasize relational accountability, participant voice, and cultural safety. By prioritizing qualitative methods, the study provides participants with space to speak on their own terms, contributing meaningfully to knowledge production while honoring values of respect, storytelling, and reciprocity (Kovach, 2009; Smith, 2012).

3.4 Thematic analysis

The research employed a qualitative method approach, integrating both thematic qualitative analysis and descriptive statistical analysis, each of which was designed to address the research question and objectives. Below, I outline how the data analysis process was conducted. Prior completing the thematic analysis that followed Braun and Clarke's (2006) six-step process, we ensured that the data collected would provide for substantial analysis by following the process described below:

1. Familiarization with the data

I engaged with the data by repeatedly reading through the responses of the participants and taking notes to gain a comprehensive understanding of the intrinsic opinions of the participants.

2. Generation of initial codes

Initial codes were developed from notes and participants' responses collected during the survey period. This first stage involved reading through the dataset to gain an understanding of the responses, followed by a process of deeper interpretation through thinking, questioning, and reflection. For example, when respondents addressed questions about their feelings when visiting health facilities, their responses indicated that they were experiencing feelings of discrimination and dismissal (e.g., dismissal of traditional healing; insensitivity to cultural perspectives). This stage of the analysis was concerned with identifying the underlying factors of marginalization women face. The respondents lived experiences and expressions provided for the basis of understanding the data, which helped generate initial codes such as 'Mistrust in Healthcare', 'Marginalization from mainstream system', and so on. Marginalization also resonated the

historical context of colonial experience (e.g., mistrust in Western practices and/or Western people).

3. Search for themes

This phase involved searching through a cluster of linked responses conveying similar meanings. As mentioned above, the data collected was sorted into diverse initial codes from which I drew categories of themes and sub-themes. These initial themes were then reviewed to establish the final themes used in this study. This phase also involved questioning the lived experiences of some responses, as well as identifying their significance and potential implications for a better understanding of underlying factors of marginalization. For example, “if” health care providers had ‘welcoming spaces’ and personnel relationships with patients seemed enhanced. Approaches to care (considering the cultural background of patients) were also factors the respondents mentioned as key to addressing these feelings of marginalization. In other words, respondents’ responses eschewed the nuances of healthcare providers not creating a welcoming a safe space for them hence not creating an atmosphere where they feel safe and culturally secured.

4. Review of themes

The review of themes involved narrowing down the initially identified main themes and sub-themes and ensuring that each of these was clearly discernible and substantiated by the raw data. In a few cases this involved the collation or collapsing of some themes and sub-themes. Table M1 illustrates the main themes resulting from a preliminary analysis of results from the data set of the respondents and archival research, while table M2 shows a refinement of the themes identified during further analysis.

Figure M1: Main themes generated

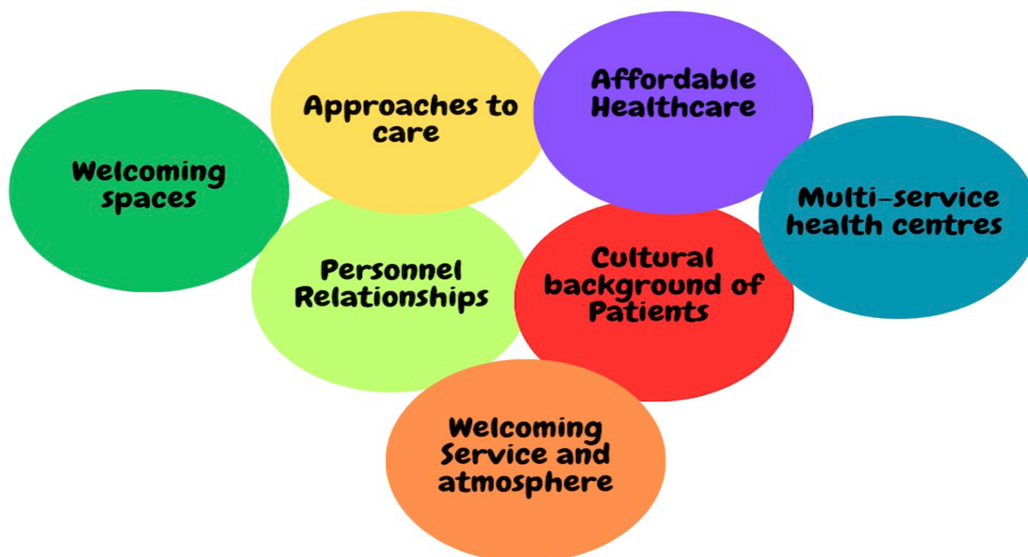


Figure M2: Main themes generated

5. Definition and naming of themes

During this phase, the theme and sub-theme categories were grouped together and ascribed meanings consistent with the research question. Figure M3, shows the major themes, as well as the sub-themes they were linked to.

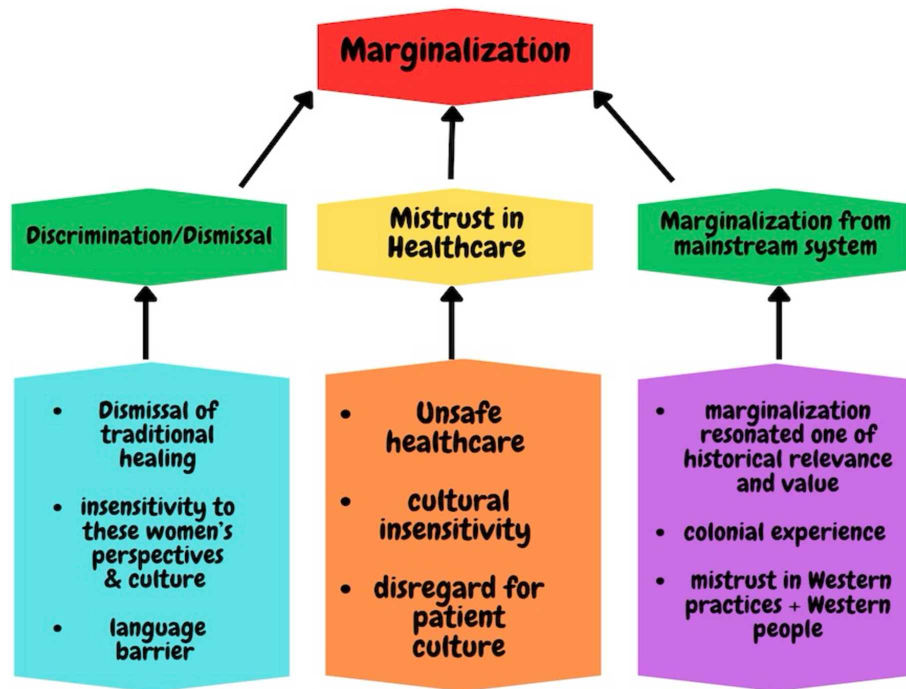


Figure M3: Major themes and sub-themes

6. Production of the report

This phase consisted of identifying the implications of themes and their sub-themes for the present study. This phase also involved moving from the analysis back to the raw data in an attempt to

understand not only the patterns but also the inconsistencies, paradoxes, irregularities and ambiguities between several themes.

Accordingly, this study's analysis is guided by themes that capture the participants' "experiences, interpretations, and perceptions of reality" while also exploring "how events, experiences, and realities are shaped by multiple discourses present in society" (Braun & Clarke, 2006, p. 81). Nevertheless, as Clarke and Braun (2006) point out, undertaking this form of analysis requires making several preliminary decisions.

Braun and Clarke (2006) emphasize the importance of making several foundational decisions that shape the direction of the analysis. These include determining what qualifies as a theme, the extent of detail to be provided in describing the dataset, whether an inductive or deductive analytical approach will be used, and the level at which themes will be identified either at the surface (semantic) level or a deeper (latent) interpretive level.

Unlike in quantitative research, where the frequency of occurrence can often indicate significance, qualitative research requires a more nuanced understanding of what makes a theme important. As Braun and Clarke (2006, p. 82) point out, "ideally, a theme should appear multiple times throughout the dataset; however, a higher frequency of occurrence does not automatically indicate that the theme holds greater significance." The authors suggest that instead of relying solely on frequency, researchers should remain open and flexible, assessing whether a theme "reflects something meaningful in connection to the main objectives of the research" (Braun & Clarke, 2006, p. 82). In the context of this study, the analysis was firmly rooted in the research question, ensuring that the thematic development aligned with the overall aim and scope of the investigation.

Braun and Clarke (2006) also highlight the need to decide on the depth and scope of the analysis—whether to provide a comprehensive overview of the entire dataset or to concentrate on a more detailed analysis of selected data segments. They note that "detailed descriptions are especially valuable when exploring areas that have not been extensively studied" (Braun & Clarke, 2006, p. 83), while a narrower focus can provide deep insight into specific phenomena. This posed a methodological challenge for the current research, as pre-selecting certain data for detailed focus could risk overlooking valuable, unexpected findings. Given the exploratory nature of this study, a broad and descriptive approach was taken. This allowed for a thorough examination of each participant's account, facilitating the identification of subtle patterns and providing insight into a field that remains relatively under-explored.

With respect to analytical strategy, Braun and Clarke (2006) discuss the distinction between inductive and deductive approaches. This study employed an inductive method, allowing themes to emerge organically from the data rather than being imposed by pre-existing frameworks. As Braun and Clarke explain, in an inductive approach, themes are "closely grounded in the data itself" (2006, p. 83). This aligns with Holloway's (1997, p. 155) definition of inductive reasoning in qualitative research as "moving from specific trends to broader insights that is, beginning with the examination of individual cases or events and identifying overarching patterns or connections among them." By following this approach, the researcher ensured that coding was not constrained by a predetermined structure or "existing coding frame" (Braun & Clarke, 2006, p. 84), thereby allowing for a more open exploration of the factors contributing to the marginalization of Indigenous mothers.

Finally, Braun and Clarke (2006) advise researchers to decide whether themes will be identified at the semantic level focusing on explicit meanings in the data or at the latent level, which seeks to interpret the underlying assumptions and ideologies embedded within participants' narratives:

"A semantic approach focuses on identifying themes based on the explicit or surface-level meaning of the data, without interpreting beyond what the participant has said or written. […] In contrast, a latent thematic analysis delves deeper than the surface meaning, seeking to uncover the underlying ideas, assumptions, conceptual frameworks, and ideologies that are believed to shape or influence the semantic content of the data" (Braun & Clarke, 2006, p. 84).

In line with this distinction, the present study employed both semantic and latent thematic analysis. The process began by identifying patterns in participants' written responses and gradually shifted to an interpretive, thematic analysis that incorporated results from the review of existing literature.

3.5 Descriptive Statistics

Descriptive statistics were employed in this study to provide a clear and concise summary of the quantitative data collected from survey respondents. These statistics include measures such as frequencies, percentages, means, and standard deviations, which help to organize and present patterns in participants' responses related to healthcare access, language barriers, perceived discrimination, and service utilization.

The use of descriptive statistics allows the research to quickly identify trends and distributions within the dataset, thereby offering a foundational understanding of how Indigenous women in Ottawa experience maternal healthcare (Field, 2013; Creswell & Clark, 2017). For

instance, reporting the percentage of respondents who experienced language barriers provides a snapshot of the scope of the issue before deeper qualitative analysis is conducted.

Descriptive statistics were particularly useful even in primarily qualitative research as they provide the necessary context for interpreting more complex findings. In this study, they were instrumental in identifying key areas of concern—such as high rates of perceived discrimination or limited access to culturally appropriate care—which also informed the direction of the qualitative inquiry.

These statistics offered a structured means to compare experiences across demographic subgroups, such as age or educational background, allowing for a more nuanced picture of maternal healthcare disparities (Mertler & Vannatta, 2017). Furthermore, summarizing data in this way enhances transparency and facilitates replication, as patterns in the responses can be clearly visualized and verified.

However, while descriptive statistics are valuable for highlighting "what" is occurring in a dataset, they do not explain "why" these patterns exist. They are inherently limited in their ability to account for context, motivations, or the socio-cultural meanings behind the numbers. For example, a high frequency of missed prenatal appointments may be documented, but descriptive statistics alone cannot uncover the reasons—such as fear of racism or lack of culturally safe services—that underlie those numbers (Silverman, 2020; Jackson, 2016). This limitation underscores the importance of incorporating qualitative methods and thematic analysis that allow for the exploration of participants' lived experiences, thus filling the interpretive gaps left by numerical data.

In short, descriptive statistics serve as a necessary but not sufficient component of the analytical framework. They provide the groundwork for identifying important trends and disparities in healthcare access among Indigenous women but must be interpreted alongside qualitative data to fully understand the complexities of intercultural communication and systemic bias in maternal healthcare.

This combined approach ensures that the study not only captures the breadth of issues through quantitative data but also explores the depth and nuance through personal narratives and thematic interpretation (Ivankova, Creswell, & Stick, 2006; Schiavo, 2013). Therefore, the integration of descriptive statistics is aligned with the overall design of this research, supporting a comprehensive analysis of the multifaceted challenges Indigenous women face in accessing equitable and respectful maternal healthcare.

3.6 Conclusion

This chapter outlined the methodological approach guiding this study on Indigenous maternal healthcare in Canada. By employing a qualitative method design, the research effectively integrates qualitative (systematic literature review with thematic analysis) and a slight component of quantitative approach (survey questionnaires) ensuring a comprehensive examination of maternal healthcare communication and maternal services accessibility challenges for Indigenous women in Ottawa. The study is anchored in key theoretical perspectives, including Intercultural Communication Competence, Critical Medical Anthropology and Social Determinants of Health. These frameworks provide valuable insight into the systemic, cultural, and communicative factors shaping Indigenous women's healthcare experiences. While the study's design enhances reliability and depth, limitations such as sample size and geographic focus highlight areas for further research. Ultimately, this methodology supports a nuanced understanding of the barriers faced by

Indigenous women in accessing culturally competent maternal healthcare, setting the stage for the study's findings and discussion in the following chapters.

Chapter 4

Results and Discussion

4.0 Introduction

This chapter presents the findings of the study and discusses their implications in the context of the research objectives and its research question: *How do Indigenous mothers in Ottawa experience marginalization within the context of accessing maternal healthcare services?* The data collected focuses on the intersection of health communication and intercultural communication competence particularly in addressing maternal healthcare experiences among Indigenous Canadian women in Ottawa. The findings are presented statistically and thematically, followed by a critical discussion earlier contextualized by the literature reviewed in Chapter 2. By integrating statistical data and thematic insights from qualitative responses, the chapter explores how intercultural communication dynamics influence healthcare outcomes and experiences among Indigenous women accessing maternal care in Ottawa. The analysis is guided by some aspects of Intercultural Communication Competence (ICC) framework and reflects on how the findings align with or diverge from the literature reviewed in Chapter 2. Descriptive statistics provide a foundational approach for summarizing and interpreting quantitative data in research. These statistics offer a snapshot of the data, helping to describe the basic features and patterns within the dataset. According to Babbie (2020), descriptive statistics are critical for summarizing datasets and providing a foundation for deeper statistical analysis. Similarly, Frankfort-Nachmias and Leon-Guerrero (2021) highlight that descriptive statistics are particularly useful for exploring trends and disparities in healthcare research. The findings presented here highlight a pattern of systemic

barriers, communication breakdowns, and cultural insensitivity, all of which significantly affect maternal healthcare access and satisfaction for Indigenous women in Ottawa.

4.1 Presentation of Results

4.1.1 Demographics and Participant Profile

This section summarizes participant demographics, such as age, cultural background, and healthcare accessibility.

A majority of respondents (84.2%) were aged 35–44, with 63.2% identifying as First Nations. 78.9% reported incomes under $25,000, revealing underlying economic vulnerability. Most had two or more children and had previous interactions with healthcare services.

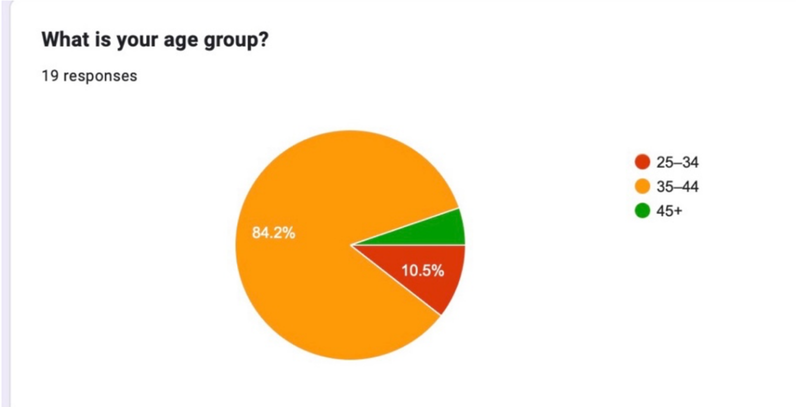


Figure 1: Age of Respondents

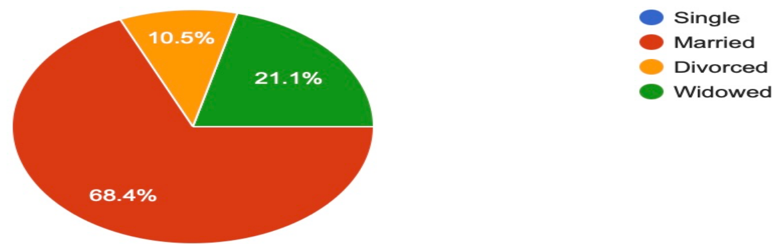


Figure 2: Marital Status

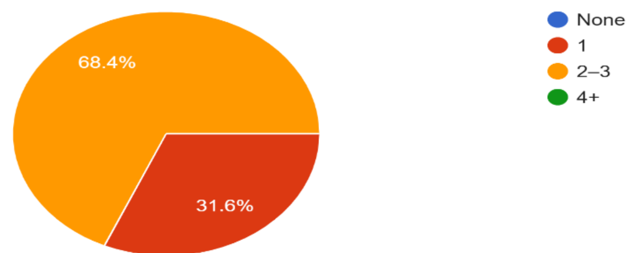


Figure 3: Number of Children

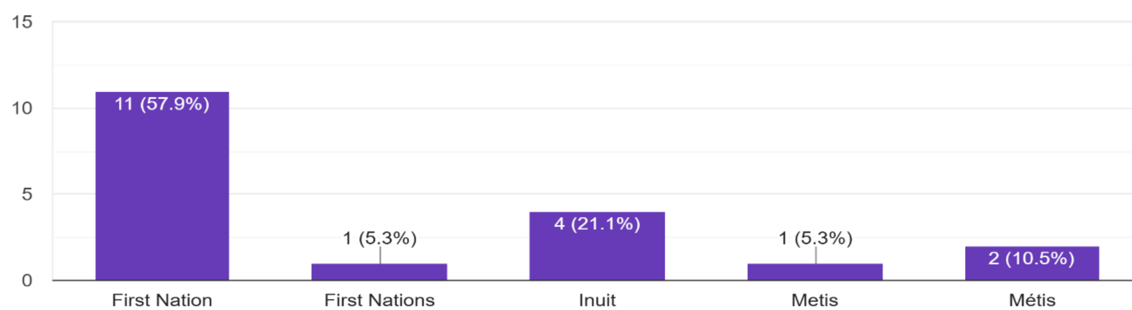


Figure 4: Indigenous Group

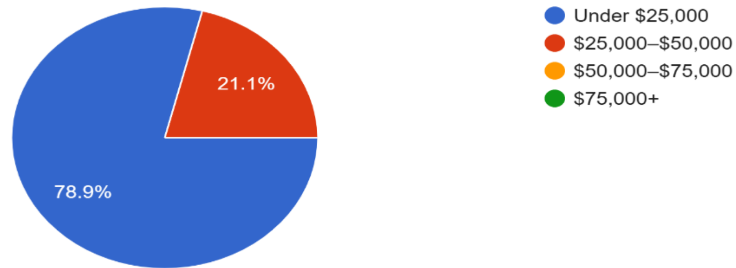


Figure 5: Annual Income

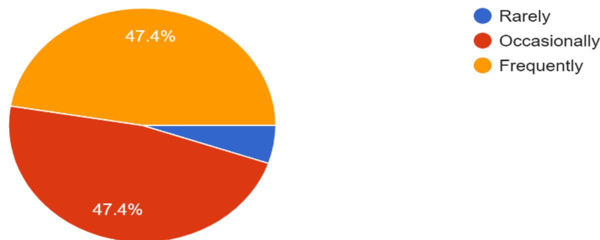


Figure 6: Maternal Healthcare Services Access

The role of traditional knowledge and practices in maternal healthcare

Figure 7: Concerns for accessing healthcare

The results of the quantitative data collected and presented above indicate that the most significant concern for respondents in accessing healthcare is the lack of Indigenous healthcare practices, with 57.9% of the participants identifying this as their primary issue. This highlights a strong desire for culturally grounded approaches in health services. Additionally, 26.3% of participants expressed concern about cultural insensitivity among healthcare staff, pointing to ongoing challenges in intercultural communication and respect within clinical settings. A smaller proportion cited practical barriers, with 10.5% concerned about the distance to healthcare facilities and 5.3% identifying the cost of services as a key issue. These findings suggest that while logistical barriers exist, cultural relevance and sensitivity are far more pressing concerns for the majority of respondents.

4.1.2 Communication barriers between Indigenous patients accessing mainstream maternal healthcare providers

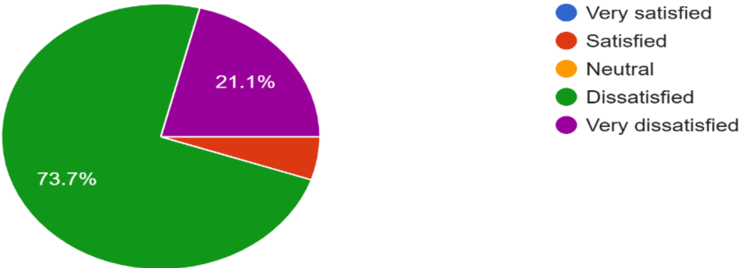


Figure 9: Satisfaction with healthcare providers

The findings reveal a high level of dissatisfaction with mainstream maternal healthcare providers among respondents. Specifically, 73.7% reported being dissatisfied, and an additional 21.1% stated

they were very dissatisfied. Only 5.3% of participants indicated they were satisfied with the care they received. These results underscore a widespread perception of inadequate or culturally misaligned care, suggesting a critical need for improved provider-patient relationships, greater cultural competence, and more responsive healthcare services tailored to the needs of Indigenous communities.

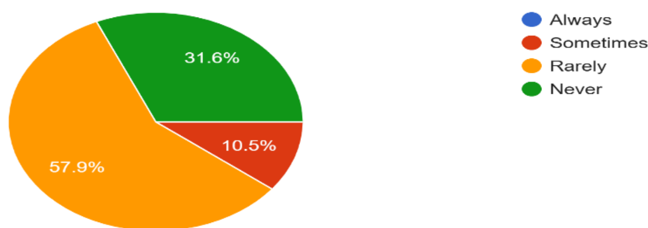


Figure 10: Healthcare providers inquiry on cultural preferences

The data shows a mixed experience among respondents regarding whether healthcare providers inquire about their cultural preferences or practices. While 57.9% of the participants reported that they are asked about these aspects, a significant 31.6% stated they are never asked, and 10.5% said they are only sometimes asked. These findings suggest that although some providers are making efforts to engage with patients' cultural backgrounds, there remains a considerable gap in consistently integrating cultural inquiry into healthcare interactions. This inconsistency may contribute to feelings of marginalization and limit the effectiveness of culturally appropriate care.

Experiences with cultural sensitivity in healthcare.

Have you ever experienced any of the following during healthcare visits?
19 responses

Figure 11: Experience during healthcare visit

These results reveal significant challenges faced by respondents during healthcare visits. A majority, 63.2% of the participants, reported experiencing the dismissal of Indigenous healthcare practices, indicating a lack of recognition or respect for traditional approaches within the healthcare system. Additionally, 21.1% of participants experienced discrimination based on their cultural identity, highlighting ongoing issues of bias and inequity. A further 15.8% of the participants encountered communication challenges due to language differences, which can hinder understanding and trust. These findings point to systemic issues in the delivery of culturally safe care and emphasize the need for healthcare environments that are inclusive, respectful, and responsive to the diverse cultural needs of Indigenous patients.

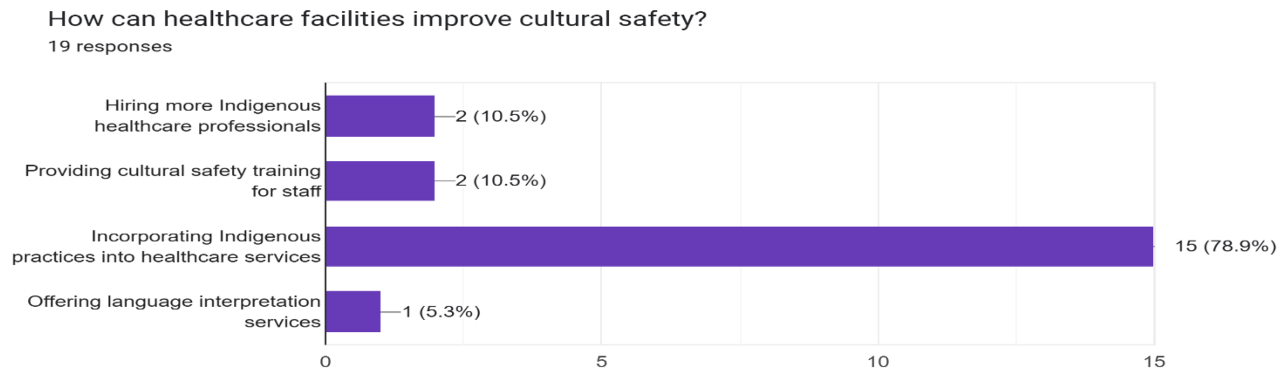


Figure 13: Healthcare facilities improve cultural safety

The findings suggest that the majority of participants believe improving cultural safety in healthcare facilities requires the integration of Indigenous practices into healthcare services, with 78.9% identifying this as the most effective approach. Additionally, 10.5% of the participants emphasized the importance of providing cultural safety training for staff, while another 10.5% highlighted the need to hire more Indigenous healthcare professionals. A smaller proportion, 5.3%, suggested that offering language interpretation services would enhance cultural safety. These results underscore a clear call for systemic changes that focuses on Indigenous knowledge, increase representation, and equip staff with the skills needed to provide culturally respectful and inclusive care.

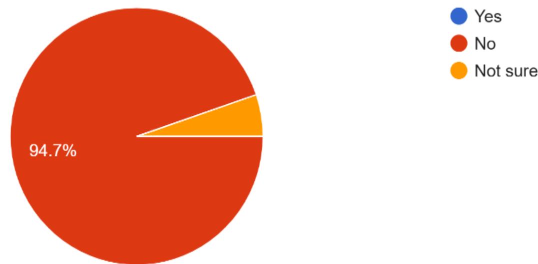


Figure 8: Healthcare facilities on cultural needs

An overwhelming majority of participants (94.7%) indicated that they feel healthcare facilities are not equipped to address their cultural needs, while only 5.3% felt that their cultural needs are being met. This stark disparity highlights a significant gap in the cultural responsiveness of healthcare services. It suggests that most participants perceive current maternal healthcare providers as lacking the knowledge, practices, or structures necessary to provide culturally safe and appropriate care. These findings emphasize the urgent need for reforms that prioritize cultural competence, inclusion of Indigenous perspectives, and meaningful engagement with Indigenous communities in healthcare planning and delivery.

These findings address the central question in various ways. They demonstrate how structural issues such as socioeconomic status (*Figure 5: Annual Income*), location (*Figure 7: Concerns for accessing healthcare)*, and policy gaps (*Figure 10: Healthcare providers inquiry on cultural preferences)* compound these communication barriers, leading to a cycle of mistrust, avoidance, and underservice (*Figure 8: Healthcare facilities on cultural needs* shows this as respondents notes that their cultural needs are not met and that leads to underservice and mistrust on the part of the patient). The survey data and qualitative responses further demonstrate that communication is not

merely a tool but a cultural and relational practice that either enables or impedes care. Based on the results of *Figure 8*, it can be argued that cultural insensitivity represents a significant barrier to maternal healthcare access for the participants. Among the participants, 94.7% felt healthcare services were not culturally equipped, 63.2% experienced rejection of Indigenous approaches to care (theme correspondence: dismissal of Indigenous practices), and 21.1% reported discrimination. It is also worth noting that 15.8% of the participants cited language-related misunderstandings during visits with healthcare providers.

The data results also show that respondents desire to have healthcare services that consider their cultural beliefs and background. In one of the survey questions, when asked "what are your main concerns when accessing healthcare?", 57.9% of the participants replied that the "lack of Indigenous healthcare practices" was a major concern for them. This result aligns with the argument that, when upheld, cultural practices enable for improved healthcare outcomes. This echoes what Wright et al.'s (2019) review of 13 qualitative studies reveal, which is that Indigenous women's experiences with maternal healthcare in Canada reveals persistent themes of racism, cultural insensitivity, disempowerment, and logistical barriers such as relocation for birth and inadequate postpartum care.

Recommendations from Participants

Figure 12 below illustrates how respondents ranked the importance of integrating Indigenous healthcare practices into mainstream medical care, highlighting the value placed on culturally inclusive approaches.

What level of importance do you place on integrating Indigenous healthcare practices into mainstream medical care?
19 responses

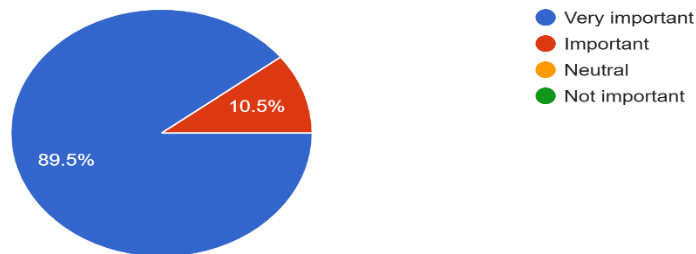


Figure 12: Level of importance placed on integrating indigenous healthcare practices into mainstream medical care

This figure shows a strong consensus among participants regarding the importance of integrating Indigenous healthcare practices into mainstream medical care. A significant majority of the participants (89.5%) stated that this integration is very important to them, while the remaining 10.5% said it is important. These findings indicate a widespread desire for a more inclusive and culturally respectful healthcare system that values and incorporates traditional Indigenous knowledge and healing practices among the participants. This could underscore the need for healthcare policies and services that not only acknowledge, but also actively integrate, Indigenous approaches to promote culturally safe and holistic care. The strong demand among participants for integrating Indigenous knowledge systems into healthcare services reflects a clear plea for a more inclusive and culturally respectful approach to care. Participants also advocated for several key changes to improve cultural safety, including mandatory cultural safety training for healthcare staff, increased hiring of Indigenous healthcare professionals, and the adoption of patient-centred approaches that respect diverse cultural backgrounds.

4.2 Alignment with and Divergence from Literature

The following section discusses four key themes that emerged from the study, each reflecting both alignment with and divergence from existing literature. These themes include a) racism and disrespect in healthcare, b) avoidance of government services, c) value of culturally safe care, and d) specificities of the urban setting.

a) Racism and Disrespect in Healthcare

Figure 0 illustrates the most significant barriers participants identified when accessing healthcare, providing a visual summary of the challenges discussed throughout this section.

In your experience, what are the most significant barriers to accessing healthcare?

19 responses

Failure to understand indigenous beliefs

We have face a shortage of healthcare professionals, including doctors, nurses, and mental health specialists, making it challenging to get the care we need in a timely manner.

Lack of interpreters at the healthcare facility

Financial barriers

Racism and Discrimination

Many healthcare providers so no know of our existence so upon arrival at the facility they look at us awkwardly just by seeing us dress, i feel more safe when i go to a facility that is indigenously inclined. I sometimes experience negative treatment from healthcare professionals, leading to reluctance for me to seek care or inadequate treatment.

Racism and Discrimination towards my culture

Financial Barriers

Figure 0: Significant barriers to accessing healthcare

Wright et al. (2019) found persistent racism and institutional disempowerment involved in issues of maternal healthcare access for Indigenous women. The findings of this study confirm similar issues through participants' experiences of discrimination and disregard. For example, one respondent noted from Figure 0 that "[We] have faced a shortage of healthcare professionals, including doctors, nurses, and mental health specialists, making it challenging to get the care we need in a timely manner". While this was a participant's concern, another one also echoed the dissatisfaction in "treatment with western medicine instead of indigenous treatment such as herbal". Most participants' responses resonate the theme of "Lack of Access to Traditional Healing", which leads them to believe that there exists "Racism and Discrimination towards [their] culture." These experiences of racism and systemic neglect contribute not only to dissatisfaction with care but also to a broader pattern of disengagement from mainstream healthcare services, leading to the next theme: avoidance of government services.

b) Avoidance of Government Services

As observed with Bacciaglia et al. (2023), Indigenous women tend to avoid mainstream healthcare systems due to perceived lower quality and systemic barriers. This tendency was echoed in the participants' responses in this study. For example, one respondent claimed, "I seek care from traditional healers rather than Western medical systems, but there is a lack of integration or recognition of traditional healing practices within the mainstream healthcare system". This has curtailed the ability of other respondents to also seek medical care and they express concern that "Many healthcare providers do not know of our existence so upon arrival at the facility they look at us awkwardly just by seeing us dress, [I] feel [safer] when [I] go to a facility that is indigenously inclined. I sometimes experience negative treatment from healthcare professionals, leading to reluctance for me to seek care or inadequate treatment". This pattern

of avoidance reflects a deep mistrust in government run healthcare systems, often stemming from experiences of exclusion, cultural disconnect, and historical trauma. Participants' preference for traditional healing methods despite limited integration within mainstream services demonstrates the urgent need for more inclusive and respectful healthcare models.

Building on this, the next theme highlights what participants see as a potential solution to address these issues, including the value of culturally safe care that centers Indigenous voices, practices, and community involvement.

c) Value of Culturally Safe Care

Participants also emphasized the importance of culturally specific models of care with one arguing that "Healthcare providers should receive ongoing training on Indigenous cultures, traditions, histories, and health beliefs. This would include understanding the diverse languages, worldviews, and values of different Indigenous communities. It's essential for providers to recognize the importance of family and community in health and healing and respect the role of traditional medicine alongside Western approaches". This is consistent with calls in the literature for community-driven and culturally grounded maternal services. According to the participants in this study, care tailored to the specific context of Indigenous communities could help reduce existing barriers. This aligns with the observation of better maternal health outcomes and stronger relationships between patients and providers when primary health care approaches co-developed with Indigenous communities focusing on culturally appropriate services and coordinated access (Bacciaglia, et al., 2023). This emphasis on culturally safe care underscores participants' desire for healthcare systems that respect and reflect Indigenous identities, values,

and community-driven approaches. Such models are seen as key to improving access, trust, and health outcomes for Indigenous patients.

While much of the literature focuses on rural and remote Indigenous communities, the experiences of participants in this study highlight a critical gap in urban contexts. The final theme explores how the urban setting specifically Ottawa presents its own set of barriers and challenges, often overlooked in existing research.

d) urban setting

As mentioned earlier, this study diverges in its focus on urban Indigenous populations, a context less explored in existing research. Unlike much literature focusing on rural and remote areas, this study reveals that urban settings like Ottawa do not necessarily better mitigate barriers. In fact, they may exacerbate them through institutional invisibility and fragmented services. In this context, *institutional invisibility* refers to the lack of recognition, representation, and tailored services for Indigenous people within mainstream urban healthcare systems. Indigenous patients may feel unseen or overlooked, as their unique cultural, historical, and social realities are often not acknowledged in policies, programs, or provider interactions. This invisibility can result in healthcare experiences that feel impersonal, dismissive, or culturally irrelevant. The concept of *Fragmented services* refers to the disjointed or uncoordinated nature of healthcare delivery in urban areas. Indigenous patients may have to navigate multiple systems or agencies to access care, with little integration between services such as mental health, maternal care, and traditional healing. This lack of cohesion can lead to confusion, inconsistent care, and additional stress especially for those already facing systemic barriers. Similarly, Deborah et al. (2024) suggest that "When midwives supported Indigenous women in their choices and did not make assumptions,

they felt comfortable and respected" (p. 182). Yet, while these studies span various provinces (e.g., Manitoba, British Columbia, and the Northwest Territories), those centered in Eastern urban centres like Ottawa remain notably absent. As the nation's capital, Ottawa features a distinct sociopolitical context, layered healthcare jurisdictions, and a complex Indigenous demographic landscape. The exploration of this urban setting in this study reveals that, contrary to assumptions, urban environments do not necessarily reduce barriers to healthcare access for Indigenous populations. Instead, participants described experiencing institutional invisibility—that translates to their cultural needs and identities being largely unacknowledged—and a fragmentation of services, that means that healthcare delivery is disjointed and difficult to navigate. These urban-specific challenges highlight a critical gap in the literature and call for more focused attention on Indigenous health in cities like Ottawa, where multiple healthcare jurisdictions and a complex sociopolitical landscape shape access and quality of care.

With these contextual and experiential insights in place, the next section turns to theoretical reflections, particularly the value of applying the Intercultural Communication Competence (ICC) framework, The Social Determinant Theory framework, Critical Medical Anthropology framework in understanding and addressing these challenges.

4.3 Theoretical Insights:

a) Insights from using The Intercultural Communication Competence (ICC) framework

There are several benefits of using ICC, including gaining a better understanding of conceptualizing communication as a barrier and solution, identifying perceived incompetence, and exploring the advantages of a relational and contextual approach. 'Perceived incompetence' here refers to the impression that healthcare providers lack the cultural understanding, empathy, or

communication skills necessary to engage effectively with Indigenous patients, often leaving patients feeling dismissed or misunderstood. In contrast, a relational and contextual approach emphasizes the importance of building respectful, trust-based relationships that are informed by the social, cultural, and historical contexts of Indigenous communities, ensuring that care is both culturally responsive and community centered.

When focussing on identifying communication as both a barrier and solution, ICC highlights how misaligned cultural schemas (Gudykunst, 2005) between healthcare providers and Indigenous patients contribute to dissatisfaction, mistrust, and service avoidance. The Intercultural Communication Competence (ICC) framework also helps to identify and interpret issues of perceived incompetence, shedding light on why many participants felt misunderstood, disregarded, or undervalued during healthcare encounters. This perceived incompetence often stems from providers' limited cultural empathy and a lack of skills in adapting their communication and care practices to align with the cultural norms and expectations of Indigenous patients. When healthcare professionals are unable to recognize or appropriately respond to cultural differences, it can result in patients feeling alienated or invisible within the system. ICC thus provides a useful lens for understanding how these breakdowns in communication and cultural responsiveness contribute to broader patterns of mistrust, disengagement, and unequal care.

ICC also highlights the importance of mutual respect, listening, and engagement in building effective healthcare relationships by pointing to the critical role of mutual respect, active listening, and meaningful engagement in establishing effective and trustworthy healthcare relationships. Within the context of Indigenous healthcare, this means recognizing and valuing patients' cultural knowledge, experiences, and perspectives as integral to the care process. By fostering an environment in which patients feel heard, respected, and genuinely involved in their care decisions,

providers can begin to repair damaged relationships and build trust. ICC underscores that communication is not merely about the exchange of information, but about creating relational connections grounded in empathy, cultural sensitivity, and a commitment to equity. This approach is especially important for Indigenous patients, whose historical and ongoing experiences of marginalization make relational trust a foundational element of culturally safe care.

The deployment of the Intercultural Communication Competence (ICC) framework highlights that the significance of the above findings, as *Figure 8* shows that 94.7% of the participants said they feel that healthcare facilities are not equipped to address their cultural needs, while only 5.3% think the opposite. ICC can help shed light on why healthcare providers and Indigenous patients may struggle to achieve mutual understanding due to differing cultural schemas (Gudykunst, 2005). The results of the survey show that from the participants' perspective, most healthcare providers struggle to achieve mutual understanding because of cultural communication differences. For example, *Figure 9* shows that 73.7% of the participants said they were dissatisfied with their communication with healthcare providers, 21.1% reported to be very dissatisfied, while only 5.3% said they are satisfied.

In the context of maternal healthcare for Indigenous women in Canada, the use of ICC in this study highlights that healthcare providers and patients may face challenges in understanding each other's perspectives and expectations. The participants' answer to the question illustrated in *Figure 10* shows that 57.9% of the participants said they were asked about their cultural preferences or practices, 31.6% said they are never asked about cultural preferences or practices and 10.5% said they are sometimes asked about cultural preferences or practices.

Many Indigenous women also reported experiencing cultural misunderstandings that can lead to inadequate care or discomfort in healthcare settings. *Figure 11* shows that 63.2% of the

participants said they experienced dismissal of indigenous healthcare, 21.1% reported experiencing discrimination based on their cultural identity, and 15.8% said they experienced communication challenges due to language differences.

ICC is useful in analysing how these intercultural miscommunications emerge and in exploring how enhancing cultural competence among healthcare providers may help bridge these communication gaps. As *Figure 13* shows, 78.9% of the participants said that healthcare facilities could improve cultural safety by incorporating Indigenous practices into healthcare services, 10.5% said providing cultural safety training for staff would be ideal, 10.5% indicated that hiring more Indigenous healthcare professionals would be ideal, and 5.3% reported that offering language interpretation services would be ideal.

This study highlights three key benefits of using Intercultural Communication Competence (ICC): recognizing communication as both a barrier and a solution; addressing issues of perceived incompetence; and emphasizing a relational and contextual approach. Thus, ICC provides valuable insights to explain how misaligned cultural schemas contribute to distrust and disengagement in healthcare settings, sheds light on feelings of being misunderstood due to providers' lack of cultural empathy and underscores the value of mutual respect and engagement in building effective relationships. However, while ICC provides such valuable insights, it does not fully capture the depth and complexity of all the communication challenges experienced.

While ICC provided tools to analyze interpersonal and cross-cultural dynamics, it did not sufficiently account for structural racism or colonial legacies embedded within healthcare systems. These are not just intercultural "misunderstandings" but reflections of historical power imbalances and institutional violence, which often require the use of broader critical frameworks (e.g.,

decolonial theories; critical race theory) that the theoretical combination of this study intends to address.

b) Benefits of using The Social Determinant Theory framework

The use of Social Determinant theory also comes with some benefits. First, this approach allowed for a holistic understanding of health and behavior. Using Social Determinant Theory allowed for the examination into broader socioeconomic and environmental factors that influence outcomes, rather than focusing solely on individual behavior or biological causes (e.g., *Figure 5: Annual Income* and *Figure 7: Concerns for accessing healthcare* show how Social Determinant theory played a key role in the intersection of the nuances of the dataset and the theory). This provided a more comprehensive understanding of disparities in health or social outcomes in the participant population. Marmot (2005) also emphasized that addressing social determinants such as education, income, and employment is crucial for reducing health inequities.

Secondly, the identification of structural inequities also enabled to advance that some systems of power and inequality such as racism, classism, and gender discrimination affect access to opportunities and services. Solar and Irwin (2010) already highlighted how structural determinants shape the distribution of health outcomes through unequal access to resources and exposure to health risks. In addition, the SDT provided grounds for exploring issues of policy relevance and application, as findings based on social determinant theory can inform public policy by identifying social and economic conditions that need reform to improve population outcomes. The World Health Organization (2008) highlighted that action on social determinants is essential to achieve health equity and sustainable development goals. In the survey responses submitted by the participants, a clear call emerges for healthcare systems to "engage Indigenous communities in decision-making processes regarding healthcare delivery"; and for "involving Indigenous

women in the planning and implementation of healthcare services would ensure that services are culturally relevant and meet the specific needs of these communities."

Furthermore, this theory encouraged a multidisciplinary approach, combining insights from sociology, economics, public health, and political science, broadening the theoretical and methodological scope of the research. As noted by Braveman and Gottlieb (2014), addressing social determinants requires integrated strategies across sectors, including education, housing, and employment. A respondent called for need to train (educate) healthcare workers on indigenous culture claiming that "Healthcare providers should receive ongoing training on Indigenous cultures, traditions, histories, and health beliefs. This would include understanding the diverse languages, worldviews, and values of different Indigenous communities. It's essential for providers to recognize the importance of family and community in health and healing and respect the role of traditional medicine alongside Western approaches."

Finally, using the Social Determinant theory allowed for a deeper and more targeted exploration of the needs to improve interventions. By identifying upstream causes of issues, interventions can be more effectively designed to target root causes rather than symptoms. For instance, research by Adler and Stewart (2010) suggests that upstream interventions addressing education and income can yield long-term improvements in health. One participant noted that healthcare improvements could be realistic if there are interpreters available for indigenous communities, she said that "In most parts of our indigenous communities, language plays a central role in cultural identity. Having interpreters available for Indigenous languages or promoting bilingual healthcare staff would help us a slot and ensure that we can communicate in the language we are most comfortable with. This would also demonstrate respect for our culture and improve understanding."

c) Benefits of using Critical Medical Anthropology framework

Critical Medical Anthropology (CMA) complemented ICC and SDT by allowing a deeper examination of the structural and political-economic determinants at play in the issue of maternal healthcare access for the participants in this study. CMA focuses on how global capitalism, state policies, and institutional power affect individual and community health. This allows the research to explore how macro-level structures like poverty, inequality, and neoliberal reforms, impact micro-level health experiences. For instance, Singer and Baer (2018) argue that CMA reveals the "hidden" political and economic forces that shape local health realities. *Figure 0: Significant barriers to accessing healthcare,* shows how systemic political-economic determinants are a barrier to accessing healthcare for the respondents, due to low income (e.g., lack of high earning jobs), these affect the Indigenous women.

In this context, CMA also challenges the dominance of biomedical models that treat illness as purely biological and apolitical. It critiques how medical practice following linear and strict approaches living little room for Indigenous traditional practices may overlook social suffering or reinforce social hierarchies. As Lichterman (2004) explains, ignoring structural violence in favor of biomedical explanations perpetuates health disparities and limits effective interventions. In this sense, CMA prioritizes the perspectives of the oppressed and marginalized, helping to document lived experiences of health and illness that are often excluded in mainstream health research. This aligns with Scheper-Hughes and Lock's (1987) call for a "three bodies" approach that connects the individual, social, and political dimensions of health; this is highly relevant to this research. Furthermore, because of its critical orientation, CMA is well-suited to inform activist scholarship and social justice-oriented policy recommendations. It highlights how transforming structural

conditions is essential for meaningful health improvements. According to Baer, Singer, and Susser (2013), CMA is explicitly committed to using anthropological knowledge to challenge inequality and promote equity.

Finally, CMA integrates perspectives from anthropology, sociology, political economy, and critical theory, offering rich conceptual tools to analyze complex health issues in their social and historical contexts. Hahn and Inhorn (2009) note that CMA provides a comprehensive framework that connects individual health to broader societal forces.

In conclusion, Critical Medical Anthropology (CMA) enriches this study by offering a powerful lens through which to understand the structural and political-economic forces that shape Indigenous maternal healthcare access. By moving beyond individual behaviors or cultural misunderstandings, CMA reveals the deep-rooted systemic inequities, such as poverty, colonial legacies, and institutional power dynamics, that underpin the health disparities experienced by participants. Its emphasis on integrating individual, social, and political dimensions of health underscores the need for structural transformation rather than superficial reforms. As such, CMA not only complements frameworks like ICC and SDT but also grounds this research in a broader call for equity, justice, and the inclusion of Indigenous knowledge systems in healthcare policy and practice.

4.4 Synthesis and Implications

This chapter demonstrates that Indigenous women in Ottawa continue to face major obstacles in accessing equitable maternal care, not just because of misunderstandings at individual level, but because of systemic exclusion and neglect. Communication breakdowns, when layered with socioeconomic hardship, cultural insensitivity, and historical trauma, result in deep disparities,

which are reflected in the qualitative answers of the participants in this study. By grounding the analysis in participants' voices and applying the ICC, SDT and CMA frameworks, this study makes visible the urgent need for culturally safe, accessible, and relational healthcare systems. These findings support both scholarly inquiry and practical reform.

In fact, when the respondents were asked the following question: 'If you could share one message with healthcare providers, what would it be?', they answered as follow:

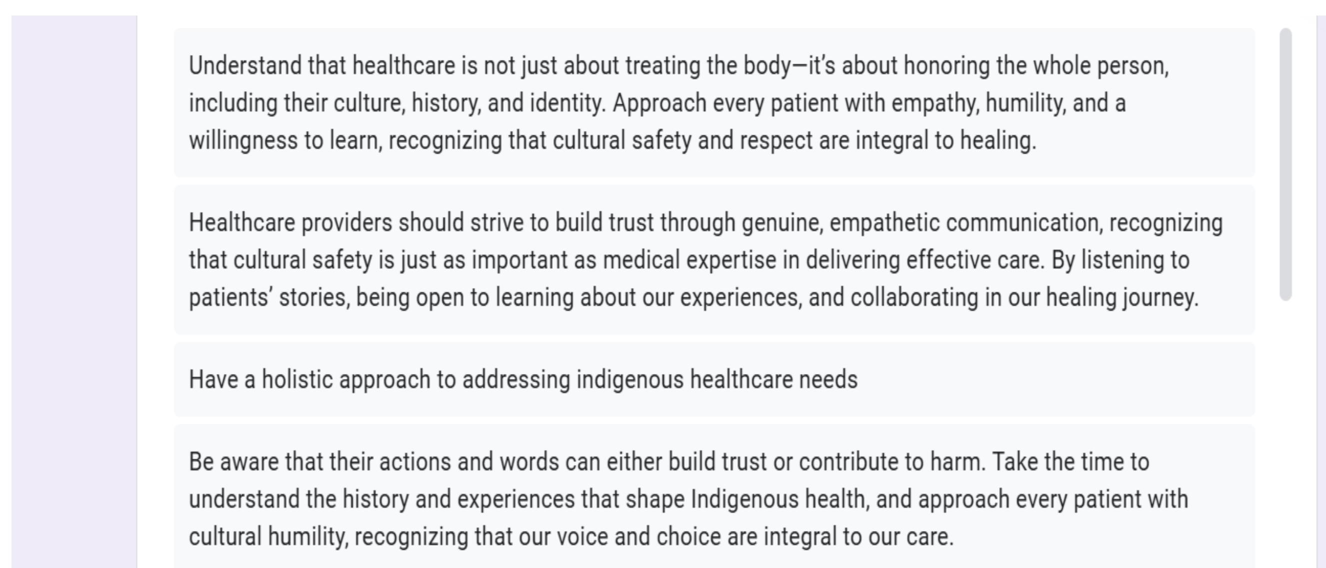
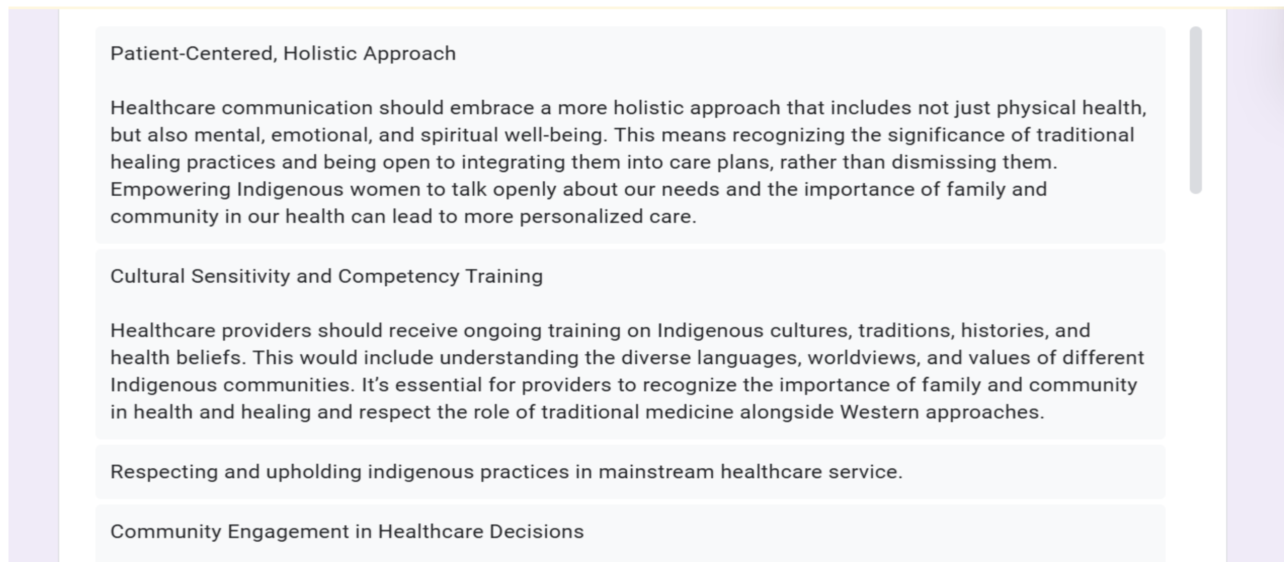


Figure 14: Message to healthcare providers

In *Figure 14*, the respondents' major proposal to healthcare providers is that they should have a holistic approach to addressing Indigenous healthcare and come up with a strategic communications plan to address Indigenous maternal mothers' healthcare. In other words, the participant expressed the wish to see healthcare and healthcare providers' communication practices to better serve Indigenous women.

Figure 15 below also illustrates the respondents' wish for a healthcare approach that is "patient-centered and holistic" they also advocated for "cultural sensitivity and competency training" when

asked about the changes they would like to see in healthcare communication to better serve Indigenous women:


Patient-Centered, Holistic Approach

Healthcare communication should embrace a more holistic approach that includes not just physical health, but also mental, emotional, and spiritual well-being. This means recognizing the significance of traditional healing practices and being open to integrating them into care plans, rather than dismissing them. Empowering Indigenous women to talk openly about our needs and the importance of family and community in our health can lead to more personalized care.

Cultural Sensitivity and Competency Training

Healthcare providers should receive ongoing training on Indigenous cultures, traditions, histories, and health beliefs. This would include understanding the diverse languages, worldviews, and values of different Indigenous communities. It's essential for providers to recognize the importance of family and community in health and healing and respect the role of traditional medicine alongside Western approaches.

Respecting and upholding indigenous practices in mainstream healthcare service.

Community Engagement in Healthcare Decisions

Figure 15: 'What changes would you like to see in healthcare communication to better serve Indigenous women?'

These insights from participants do not only reinforce the call for a more culturally, respectful and patient-centered healthcare system, but also provide critical context for evaluating the broader structural and systemic barriers outlined in this study.

4.5 Evaluation of Hypotheses

4.5.1 Reviewing the Hypotheses:

Indigenous women's perceived barriers in maternal healthcare access are significantly influenced by systemic factors, including geographical accessibility, socioeconomic status, and cultural biases.

Figure 11 presents key data on the experiences of Indigenous individuals during healthcare visits. The results reveal that 63.2% of respondents report experiencing dismissal of Indigenous healthcare needs, which speaks to a clear lack of cultural safety and understanding within the healthcare system. This finding is significant because it aligns with broader discussions on how Indigenous populations often feel their healthcare needs are ignored or undermined by practitioners who do not adequately recognize their cultural context.

Furthermore, 21.1% of respondents reported experiencing discrimination based on their cultural identity. This is particularly concerning, as discrimination can exacerbate existing barriers to care, fostering an environment where Indigenous patients may be reluctant to seek help, fearing prejudice or unequal treatment. The impact of discrimination on healthcare access and outcomes for Indigenous communities is well-documented, reinforcing the hypothesis that systemic marginalization influences access to healthcare services.

Lastly, 15.8% of respondents indicated challenges with communication due to language differences. This finding highlights another barrier to effective healthcare access, particularly for Indigenous individuals who may speak their native language or dialects that are not adequately accommodated in healthcare settings. Language barriers are known to contribute to misunderstandings and misdiagnoses, further complicating healthcare delivery.

Together, these statistics provide compelling evidence supporting the hypothesis that marginalization, in various forms, underpins the barriers Indigenous populations face in accessing healthcare. The experiences reported in Figure 11 underscore the need for targeted interventions that address cultural safety, discrimination, and communication challenges in healthcare settings.

4.6 Key findings: summary

Demographic Profile of Participants

The study shows that most respondents (84.2%) were aged 35 – 44. The majority (68.4%) were married, and 63.2% identified as First Nations. A significant percentage (78.9%) reported annual incomes below $25,000, highlighting socioeconomic vulnerabilities.

Barriers to Maternal Healthcare

The results of the survey points to an issue that heavily relates to cultural sensitivity. A majority (94.7%) of the respondents felt that healthcare facilities were ill-equipped to address their cultural needs; over half (57.9%) were concerned about the lack of Indigenous healthcare practices, while 26.3% identified cultural insensitivity as a primary issue. Satisfaction with healthcare providers also seems to be identified as an issue by the respondents. 73.7% of the respondents expressed dissatisfaction with their healthcare providers, citing the dismissal of Indigenous healthcare practices (63.2%) and experiences of discrimination (21.1%).

Role of Communication and Cultural Safety

Only 57.9% of the respondents reported being asked about their cultural preferences (e.g., values, beliefs, practices, and customs,) with many experiencing miscommunications due to language or cultural differences (15.8%). Participants also overwhelmingly (89.5%) valued integrating Indigenous healthcare practices into mainstream medical care, emphasizing the need for cultural safety.

Recommendations for Improvement

Incorporating Indigenous practices in healthcare (78.9%), cultural safety training for staff (10.5%), and hiring more Indigenous professionals (10.5%) seems to be key recommendations that would emanate from the responses to the survey.

4.7 Contributions to Understanding Maternal Healthcare Challenges

Highlighting Structural Barriers

This study underscores the systemic challenges Indigenous women face, including economic insecurity (Indigenous women often experience economic hardship as their income according to this study was under $25,000, which can limit their access to essential healthcare services), cultural insensitivity, and lack of representation in healthcare facilities.

Revealing Communication Gaps

Using the Intercultural Communication Competence (ICC) framework, the research shows that mutual understanding between healthcare providers and Indigenous patients is hindered by cultural and linguistic differences. These barriers contribute to dissatisfaction and marginalization in maternal healthcare experiences.

Importance of Cultural Integration

Findings demonstrate the significant role of cultural safety in healthcare delivery. Integrating traditional Indigenous practices and perspectives into medical care could improve trust, satisfaction, and health outcomes.

Bridging Health Communication and Intercultural Communication

The study offers promises to bridge gaps in Indigenous maternal healthcare and intercultural communication by applying the ICC framework to examining issues faced by Indigenous mothers accessing maternal healthcare. It emphasizes the following:

- **Cultural Adaptation:** The need for healthcare providers to understand and respect Indigenous cultural practices is highlighted by the survey responses.
- **Enhancement of Cultural Competence:** Training programs focusing on cultural safety and effective intercultural communication are of paramount importance to address the issues raised by the respondents.
- **Policy Recommendations:** Encouraging the integration of Indigenous perspectives into health policies could have the potential to address disparities and promote equity. Reviewing participants' answers about their level of satisfaction in reference to their visits to the health centre, this study can suggest that encouraging the integration of Indigenous perspectives into health policies could have the potential to address disparities and promote equity. The survey responses highlight a significant gap in cultural safety, with many respondents reporting experiences of cultural insensitivity, discrimination, and dismissive attitudes during healthcare visits (e.g., 63.2% reported dismissal of Indigenous healthcare needs, 21.1% experienced discrimination based on cultural identity, and 15.8% encountered communication challenges). These findings underscore the need for policies that not only recognize but actively integrate Indigenous cultural values, traditions, and healing practices into healthcare systems. By incorporating Indigenous perspectives at all levels of policy-making—from the inclusion of Indigenous health professionals to the consideration of traditional healing methods—health policies could better serve Indigenous communities, fostering an environment of trust and respect. This approach could help

mitigate the systemic barriers identified in the survey and promote greater healthcare equity for Indigenous women and communities.

The study also shows that the combination of quantitative and qualitative data with a thematic analysis, offers the opportunity to articulate actionable insights for improving maternal healthcare for Indigenous women in Ottawa, contributing to both scholarly knowledge and real-world issues.

4.8 Limitations

The study faced various limitations that are discussed in the conclusion of this study. Despite these limitations, we firmly believe that this study has its own value and contributes to addressing some of the gaps it has identified in the existing literature on indigenous maternal healthcare for Canadian Indigenous women.

4.9 Conclusion

The results of this study highlight the significant cultural and systemic barriers Indigenous Canadian women face in accessing maternal healthcare. The findings underscore the critical need for healthcare providers to integrate cultural safety, respect traditional knowledge, and enhance intercultural communication competence. By addressing these challenges through policy reform, provider training, and increased representation of Indigenous professionals in healthcare, the system could move toward more equitable and inclusive maternal healthcare. The insights from this research contribute to the broader discourse on intercultural health communication and provide a foundation for future studies aimed at bridging the gap between Indigenous communities and healthcare services. As the study moves into its conclusion, attention will be directed toward

synthesizing these findings within the broader theoretical framework and offering concrete recommendations for policy and practice.

Chapter 5

Conclusion

This chapter synthesizes the findings of the study, offering insights into their theoretical, methodological, and empirical implications. It also identifies potential areas for future research. The overarching goal is to underscore the significance of improving health communication and intercultural competence in maternal healthcare for Indigenous Canadian women. Additionally, this chapter discusses the limitations of the study, acknowledging the challenges encountered in data collection and analysis while highlighting areas for future inquiry.

5.0 Summary of Results

The results of this study highlight the critical role of intercultural communication can play in shaping the quality and effectiveness of the maternal healthcare experiences of Indigenous women in Ottawa. Key findings of the survey highlighted the following:

- **Cultural Sensitivity Deficit:** 94.7% of the participants believed that healthcare facilities were not equipped to address their cultural needs, with 63.2% reporting instances of Indigenous healthcare dismissal and 21.1% experiencing discrimination based on cultural identity.
- **Communication Gaps:** Most participants expressed dissatisfaction with healthcare providers, citing inadequate consideration of their cultural preferences. Only 57.9% were ever asked about these preferences.

- **Integration of Indigenous Practices:** An overwhelming majority (89.5%) of the participants valued the integration of Indigenous healthcare practices into mainstream care, emphasizing cultural safety and respect.

These results validate the research hypotheses and point to systemic and communication barriers, underscoring the urgency of culturally safe healthcare practices.

5.1 Importance of the Results

5.1.1 Theoretical Implications

The findings support the use and combination of the frameworks of Intercultural Communication Competence (ICC) and Critical Medical Anthropology (CMA) to examine the issues related to access to maternal healthcare among Indigenous women in Ottawa. By demonstrating the critical influence of cultural misunderstandings on healthcare delivery, the study validates ICC's emphasis on the need for cultural adaptation in communication. Simultaneously, it reinforces CMA's assertion that systemic power imbalances and socio-economic disparities must be addressed to achieve health equity.

5.1.2 Methodological Implications

The qualitative approach, integrating surveys that also collected some quantitative data, proved effective in capturing the nuanced experiences of the Indigenous women participating in this study. This methodology enabled the identification of both measurable trends and personal narratives, offering a fairly comprehensive understanding of intercultural dynamics in maternal healthcare access for the population under study.

5.1.3 Empirical Implications

Empirically, the study sheds light on the need for culturally responsive healthcare policies and practices. It highlights actionable steps, such as considering the incorporation of pertinent Indigenous practices into care plans, offering solid cultural safety training, providing equal educational opportunities for indigenous people and hiring more Indigenous healthcare professionals. These findings could provide a starting point for healthcare providers and policymakers willing to improve maternal healthcare for Indigenous populations.

5.2 Practical Implications

The results of this study carry significant practical implications for healthcare systems and providers. First, they point to the need for mandatory cultural safety training for healthcare professionals, particularly in settings where such training is not yet standard. This could help bridge communication gaps and build trust with Indigenous patients. Second, participants expressed a strong desire to see traditional Indigenous practices, such as midwifery and holistic healing methods, integrated into mainstream maternal care, indicating that such incorporation could improve their overall healthcare experience. Finally, the findings suggest that policymakers should prioritize reforms that create culturally inclusive healthcare frameworks while also addressing broader social determinants of health, including income, education, and geographic accessibility.

5.3 Contributions and future directions

As briefly mentioned in the previous chapter, several factors that could affect data generalizability arise when evaluating the strengths and limitations of this study. A more explicit deployment of

an intersectional framework in future research would enrich understanding of how these interlocking systems of oppression shape healthcare access and outcomes. Such an approach could lead to more nuanced, equity-focused strategies that account for the full complexity of Indigenous women's lives and health needs (Hankivsky, 2012).

5.4 Limitations

This section outlines these limitations and their potential implications for the study. While the study contributes valuable insights into the maternal healthcare experiences of Indigenous women in Ottawa, several limitations must be acknowledged. These limitations span methodological, contextual, and theoretical domains and should inform both the interpretation of my findings and directions for future research.

1. Sample Size and Generalizability

The study engaged a relatively small number of participants (as reflected in the demographic data), which limits the generalizability of the findings. While the insights gathered are rich and context specific, they may not represent the full diversity of experiences across all Indigenous communities in Canada or even within Ottawa. The heterogeneity of Indigenous identities including First Nations, Inuit, and Métis women is vast, and not all groups may be equally represented or have identical healthcare experiences.

- 2. Urban Centric Focus

The research focuses specifically on Indigenous women living in urban Ottawa, which, while underexplored, means the findings do not account for the experiences of Indigenous women in rural or remote areas, where access to healthcare is often even more limited. This geographic

limitation narrows the scope of applicability and may understate barriers that are unique to non-urban settings.

- 3. Self-Reporting and Social Desirability Bias

Data collected through questionnaires and surveys relied heavily on self-reported experiences, which are subject to memory limitations and potential bias. Participants may have under- or over-reported experiences due to social desirability, mistrust of the research process, or discomfort in sharing negative experiences especially when discussing culturally sensitive or traumatic encounters.

- 4. Limited Integration of Diverse Indigenous Epistemologies

While the study adopts the Intercultural Communication Competence (ICC) framework, it does not fully integrate Indigenous knowledge systems or theoretical paradigms (e.g., Two-Eyed Seeing, Indigenous methodologies, or decolonial theory). This may constrain the interpretive depth and risks analyzing Indigenous experiences through a primarily Western academic lens.

- 5. Systemic and Institutional Barriers to Participation

There may have been barriers to participation stemming from distrust of institutions, research fatigue, or a lack of familiarity with the research process. Some Indigenous women may have chosen not to participate due to historical and ongoing harms caused by research conducted on Indigenous communities without benefit or consultation, thus affecting the comprehensiveness of participant perspectives.

- 6. Lack of Healthcare Provider Perspectives

This study exclusively captures the voices of Indigenous women but does not include healthcare providers' perspectives, which could provide a more holistic understanding of communication breakdowns and institutional limitations. Including providers might have illuminated gaps in training, awareness, or structural support from within the system.

5.5 Sample Size and Representation

While the sample size of about 20 participants is practical for in-depth qualitative analysis, it presents limitations for broader generalizability. The study's sample represents a single urban Indigenous population, which may not fully capture the experiences of Indigenous women in other geographic or cultural settings. Geographic constraints are particularly relevant in Canada, where Indigenous communities often face distinct healthcare challenges depending on rural or urban location (Adelson, 2005; Richmond & Ross, 2009). Future research could expand to other urban settings and include and compare those settings to rural areas to offer more generalizable insights across diverse Indigenous communities.

5.6 Scope of the Study

The research's focus on maternal healthcare limits its applicability to other healthcare domains, such as paediatric or elder care, where intercultural communication may similarly impact service quality. Additionally, the study focuses solely on Ottawa, an urban setting with specific healthcare resources, potentially limiting the applicability of findings to other Canadian regions where healthcare infrastructure and Indigenous population demographics differ substantially (Richmond & Ross, 2009; Arriagada, 2016).

5.7 Data Collection Constraints

The reliance on self-reported data introduces potential response bias, as participants may respond based on perceived social expectations. Self-administered surveys, while practical for large sample sizes, cannot capture non-verbal cues that could provide additional insights in an interview setting. Moreover, while digital surveys are accessible, the lack of in-person data collection might exclude certain demographic segments of the population who may have limited access to digital platforms (Silverman et al., 2004).

Despite these limitations, we strongly believe that this study holds significant value and helps to fill some of the gaps it has identified in the current literature on Indigenous maternal healthcare for Canadian Indigenous women. In other words, these limitations do not undermine the significance of the study but rather underscore the complexity of researching intercultural health experiences within marginalized populations. Recognizing these constraints is essential for interpreting the findings responsibly and for informing more inclusive, long term and community led research in the future. This said, while acknowledging the inherent limitations of this study, we contend that, despite these constraints, the study offers significant value and contributes to bridging several gaps identified in the existing literature on maternal healthcare for Indigenous women in Ottawa.

5.8 Future Research Directions

Future research could benefit from longitudinal studies that examine how sustained interventions, such as cultural safety training, influence healthcare outcomes for Indigenous women over time. Additionally, applying an intersection of lenses to healthcare research, considering the overlapping effects of gender, race, and socio-economic status, could provide a more nuanced understanding

of the systemic barriers Indigenous women face. Comparative analyses between Indigenous and non-Indigenous maternal healthcare experiences would also be valuable, as they could further highlight disparities and help inform more targeted, culturally appropriate solutions.

5.9 Conclusion

This study underscores the critical importance of integrating intercultural communication and cultural safety into mainstream maternal healthcare and the framework used to examine issues related to Indigenous maternal healthcare in urban settings. Addressing the systemic and communicative barriers faced by Indigenous women is not merely an ethical obligation but a necessary step toward more equitable maternal healthcare. By fostering mutual understanding, respect, and inclusivity, mainstream healthcare systems and providers could not only improve health outcomes but also contribute to issues of reconciliation and social justice in Canada. The findings of this study can serve as a call to action for maternal healthcare providers, policymakers, and researchers to work collaboratively in creating a healthcare environment in which every woman, regardless of her cultural background, feels respected and valued.

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