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Delivering away from home: the perinatal experiences of First Nations women in northwestern Ontario

Terry O'Driscoll, MD
Len Kelly, MD
Division of Clinical Sciences, Northern Ontario School of Medicine, Sioux Lookout, Ont.

Lauren Payne, MPH
Faculty of Health Sciences, Simon Fraser University, Burnaby, BC

Natalie St. Pierre-Hansen, BA
Division of Clinical Sciences, Northern Ontario School of Medicine, Sioux Lookout, Ont.

Helen Cromarty, RN
Sioux Lookout Meno Ya Win Health Centre, Sioux Lookout, Ont.

Bryanne Minty, BSc
Faculty of Medicine, University of Manitoba, Winnipeg, Man.

Barb Linkewich, RN
Sioux Lookout Meno Ya Win Health Centre, Sioux Lookout, Ont.

Correspondence to:
Dr. Len Kelly; lkelly @univmail.cis.mcmaster.ca

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Introduction: Our objective was to understand the perinatal knowledge and experiences of First Nations women from northwestern Ontario who travel away from their remote communities to give birth.
Methods: A systematic review of MEDLINE, HealthSTAR, HAPI, Embase, AMED, PsycINFO and CINAHL was undertaken using Medical Subject Headings and keywords focusing on Canadian Aboriginal (First Nations, Metis and Inuit) prenatal education and care, and maternal health literacy. This qualitative study using semistructured interviews was conducted in a rural hospital and prenatal clinic that serves First Nations women. Thirteen women from remote communities who had travelled to Sioux Lookout, Ont., to give birth participated in the study.
Results: We identified 5 other qualitative studies that explored the birthing experiences of Aboriginal women. The studies documented a negative experience for women who travelled to access intrapartum maternity care. While in Sioux Lookout to give birth, our participants also experienced loneliness and missed their families. They were open to the idea of a culturally appropriate doula program and visits in hospital by First Nations elders, but they were less interested in access to tele-visitation with family members back in their communities. We found that our participants received most of their prenatal information from family members.
Conclusion: First Nations women who travel away from home to give birth often travel great cultural and geographic distances. Hospital-based maternity care programs for these women need to achieve a balance of clinical and cultural safety. Programs should be developed to lessen some of the negative consequences these women experience.

Introduction : Nous voulions chercher à comprendre les connaissances et les expériences périnatales des femmes des Premières nations du Nord-Ouest de l'Ontario qui vont accoucher loin de leur communauté éloignée.
Méthodes : Nous avons effectué une synthèse systématique à partir de MEDLINE, HealthSTAR, HAPI, Embase, AMED, PsycINFO et CINAHL en utilisant les sujets MeSH (*medical subject headings*) et des mots clés portant sur l'éducation prénatale des Canadiennes autochtones (Premières nations, Métisses et Inuites) et la littératie en soins et en santé de la mère. Cette étude qualitative basée sur des entrevues semi-structurées a été effectuée dans un hôpital rural avec clinique prénatale qui dessert les femmes des Premières nations. Treize femmes de communautés éloignées qui s'étaient rendues accoucher à Sioux Lookout (Ont.) ont participé à l'étude.
Résultats : Nous avons trouvé 5 autres études qualitatives explorant les expériences périnatales des femmes autochtones. Les études ont décrit une expérience négative pour les femmes qui se sont déplacées afin d'avoir accès à des soins de maternité intrapartum. Pendant qu'elles étaient à Sioux Lookout pour accoucher, nos participantes ont aussi ressenti de la solitude et leur famille leur manquait. Elles étaient ouvertes à l'idée d'un programme culturellement adapté de doula et de visites à l'hôpital par des aînées des Premières nations, mais les télévisites avec des membres de leur famille dans

leur communauté les intéressaient moins. Nous avons constaté que nos participantes ont reçu la majeure partie de leur information prénatale de membres de leur famille.
Conclusion : Les femmes des Premières nations qui vont accoucher loin de chez elles parcourent souvent de grandes distances culturelles et géographiques. Les programmes de soins de maternité dispensés à ces femmes en milieu hospitalier doivent établir un équilibre entre la sécurité clinique et la sécurité culturelle. Il faut élaborer des programmes pour atténuer certaines des expériences négatives que vivent ces femmes.

INTRODUCTION

Hospital-based maternity care has become the norm in Canada. Because maternity services require many resources, many small rural hospitals can no longer provide maternity care. These closures affect rural women and, in particular, Aboriginal women, who tend to live in remote areas.

Travel to a distant centre, referred to in the literature as "medical evacuation," is controversial for many reasons. For many Aboriginal women, the loss of the community experience of birth is seen as a cultural loss, and forced evacuation is associated with colonial practices.

The return of the birthing experience to remote Inuit communities has been very successful since 1986,[1] and excellent outcomes have been demonstrated in the 3 existing birthing centres without the capability for cesarean delivery.[2] The return of local birthing goes hand in hand with the development of an Aboriginal, community-based midwifery program and appropriate risk assessment and triaging. Inuit women have long been known to have low rates of shoulder dystocia and a rate of cesarean deliveries between 2% and 4%.[2,3]

The experience of First Nations women is not as well explored as that of the Inuit.[4] In northwestern Ontario, we see a rate of cesarean deliveries of 24% (lower than the provincial rate of 28%), the highest rate of smoking in the province and high rates of type 2 diabetes, gestational diabetes and large-for-gestational-age babies in our First Nations population.[5]

The Society of Obstetricians and Gynaecologists of Canada supports the return of the birthing experience to all remote and rural Aboriginal communities "to the extent it is practical and safe."[6] The Sioux Lookout Meno Ya Win Health Centre offers a regional maternity program and strives to be a centre of excellence of Aboriginal health care.[5,7] In conducting this study, we sought to understand the experiences and needs of First Nations women who have travelled for maternity services. A goal of the Sioux Lookout Meno Ya Win Health Centre is to mitigate some of the hardships experienced by these women where possible and provide a culturally safe environment for maternity services.

METHODS

Data sources

We conducted a review of the literature using the following databases: MEDLINE (1966–2010), HealthSTAR (1966–2010), HAPI (1985–2010), Embase (1996–2010), AMED (1985–2010), PsycINFO (1987–2010) and CINAHL (1985–2010). We also searched the *Journal of Aboriginal Health* and the *Journal of Obstetrics and Gynecology*. We used the following Medical Subject Headings: "Indians, North American," "Prenatal care (education/organization and administration/utilization)," "cultural competence," "Inuits" and "Canada." We used the following keywords to better structure the search: "prenatal," "prenatal education," "First Nations," "Aboriginal," "antenatal education" and "maternal health literacy." We searched the *Journal of Aboriginal Health* and the *Journal of Obstetrics and Gynecology* independently, because they are not included in the aforementioned databases.

Participants

In the summer of 2010, a convenience sample of First Nations women from remote communities who had travelled to the Sioux Lookout Meno Ya Win Health Centre to give birth (at 38 weeks) or who had just delivered at the centre were asked to participate in the study. The centre provides health care services in northwestern Ontario for a population of 30 000, over 80% of which is First Nations. The centre's maternity program has around 320 deliveries annually. Travel is federally funded for family-member escorts to accompany the pregnant woman to Sioux Lookout, Ont., only if there are medical complications or if the expectant mother is under 18 years of age.

Data gathering

Semistructured questions were designed by First Nations and non–First Nations researchers. The audiotaped interviews were undertaken in English, with assistance from Oji-Cree interpreters if needed. The 3 interviewers were female and obtained written consent for the interviews, which took place either on the maternity floor or in the prenatal clinic. Near the end of the interviews, we included several specific questions concerning the development of the maternity and prenatal program at the Sioux Lookout Meno Ya Win Health Centre.

Data analysis

Three researchers coded the interviews and analyzed them for common themes using immersion and crystallization techniques.

Ethics approval

The centre's advisor on First Nations health care participated in the study's design and approved the article's final draft and submission for publication. This study received ethics approval from the centre's research review committee.

RESULTS

Literature review

We retrieved 22 articles and reports that discussed prenatal or maternal care among rural or remote indigenous populations, most of which focused on Canadian Aboriginal populations in the far north. Included were 5 qualitative research studies exploring the birthing experiences of Aboriginal women.

A 1993 study in Moose Factory, Ont., explored "dissatisfaction with medical evacuation for childbirth" as portrayed by avoidance to attend prenatal clinics, refusal to leave the community or an unwilling acceptance of a medial evacuation.[8] The authors found that one of the greatest challenges for pregnant woman was leaving behind other young children. Participants experienced loneliness and boredom in hospital and suggested improvement, which included funding for transportation for the partners of all women who travelled to give birth and apartment-type accommodations. After a discussion of the risk of delivering in their community, most participants expressed a preference for hospital-based deliveries.

In 2000, Chamberlain and Barclay interviewed 20 postpartum Inuit mothers about the psychosocial costs of delivering away from their community.[9] These participants were also preoccupied with the family they left behind. Participants documented the costs associated with a distant delivery, which included long-distance phone calls, babysitters and airfare for their partners' travel. They also noted difficulty reintegrating mother and newborn into the community after their (often) 3-week absence.

In a series of West Coast studies from 2005 to 2010 (including a participatory mixed-method study conducted with members of the West Coast Aboriginal community of Heiltsuk), Kornelson and colleagues examined the effects of closures of rural maternity services on rural and First Nations women.[10–12] Although some participants had positive experiences of medical care and accommodations, they also noted social disruption and loneliness. They described how stressful it was to leave their other children behind and the financial costs incurred. The authors spoke of the "cultural and geographic context of the birth experience": participants noted the importance of support from extended family and community and their historic and emotional ties to the land where they live. Participants pointed out the need for adequate social supports for those who travelled for deliveries.

The Sioux Lookout Meno Ya Win Health Centre seeks to bring culturally competent care closer to home through its regional location, traditional programming and 24-hour interpreting services.[7] The studies described above generally document the experiences of parturient women who travelled to distant centres as negative. Our qualitative study sought to understand whether the development of culturally competent programming could mitigate any of these effects.

Delivering away from home

Participant characteristics

About half of the 13 women who participated in our study were primigravida. The participants' ages ranged from 17 to 34 years.

Experience in Sioux Lookout

Not surprisingly, participants were lonely and missed the families they had left behind: "It's kind of lonely when you have nobody around ... nobody to talk to because I hardly know people around here."

"I always need a person to support me during the pregnancy, and leaving my partner behind ... when I leave him behind, it feels different." "The hardest part is not having my (3-year-old) baby here."

Several participants directly mentioned the absence of funding for family escorts in the region: "Another thing that sucks when you come out here is that they don't allow escorts." "My boyfriend took it really hard, he really wanted to be here ... if you're over 18, you don't get an escort, you just come out here by yourself."

Many participants expressed having fear of pain during labour: "You know you are getting close to the date, and you're feeling more nervous or more scared." "I heard 'it hurts ... you're going to be in pain.' ... I was scared and actually hoping for a c-section." "My cousins and friends told me when the baby is coming out, that's when the pain feels worse, so when it happened to me I just decided to keep on pushing."

They usually recounted a positive experience at the hospital: "I just feel more secure ... I feel safe."

Prenatal knowledge

Most participants learned about how to care for themselves during pregnancy from their immediate and extended family, rather than from nurses or physicians. They learned that a healthy diet, exercise and avoiding alcohol and drugs were important: "I had to cut out drinking, that was one of my big accomplishments." "There's a really big pill problem [oxycodone] ... with pregnant ladies, most of them can't stop ... so I didn't quit for me, I quit for my baby." "They always tell me to eat right and don't go crazy on junk food." "My mom suggested being active during pregnancy ... we usually walk most places, so I get quite a bit of exercise like that."

Breastfeeding was commonly encouraged by family and friends: "My boyfriend's mom wouldn't let me buy formula, because she said that babies don't get sick as much and it would help my body get back to normal." "My mom told me if you breastfeed the baby will grow faster."

Traditional teachings were not something many participants acknowledged receiving. It was attested to by only one participant. However, several participants did know of the traditional importance of keeping the detached stump of the umbilical cord: "The elders take a piece, so the child doesn't have that feeling that something is missing." "Once it comes off the baby you wrap it in leather and keep it with the baby."

Almost all of the participants planned on using the traditional cradleboard, the tikinagan: babies are swaddled to the board in a cocooning fashion. "It's better for the baby because the baby feels secure and sleeps longer." "Like when they are inside you, once they come out they still want to be secure." "It helped my boy a lot with him calming down."

Doulas, elder visits and tele-visitation

We asked directed questions about several areas in which the hospital was exploring program development.

Most participants answered positively about the possibility of having First Nations doulas help them through their labour: "That would be good with your first baby as you don't know what you're doing."

They were also generally in favour of having the option of having First Nations elders visit them while they were in Sioux Lookout and in hospital: "I think the elders are important in the community ... it is important that they are able to teach their kids." "The old ways are kind of interesting; it's supposed to be our heritage." "You could balance the old with the new."

A proposal for establishing tele-visitation with family members back home met with divided responses. Those not in favour expressed a general discomfort with the idea mainly because of shyness: "I tried that with my last child. It was embarrassing seeing someone on TV and then they're looking at me ... my kids were all too shy."

DISCUSSION

The other studies we reviewed found parturient women who travelled for delivery struggled with that model of care. Our patients expressed similar feelings. Although women in our study were generally positive about their medical care, they commonly expressed loneliness being away from their family and community members. This finding is in keeping with the social and emotional disruption documented by Kornelson and colleagues in British Columbia.[10–12] The absence of a funded escort program for mothers over the age of 18 was consistently identified as a difficulty. The Society of Obstetricians and Gynaecologists recommends integrating Aboriginal values into the development of programs.[6]

Participants did not report any difficulty in reintegrating into their communities on their return, as Chamberlain and Barclay found in their far north study.[9] The participants in our study generally noted

positive community support for their pregnancies and motherhood.

Lines of questioning about ideas for improvement were not productive. It is unclear whether this was because there was no glaring change identified or the participants felt uncomfortable expressing ideas for improvement.

Because the Sioux Lookout Meno Ya Win Health Centre looks at all fruitful integration of traditional ways into patient care, we asked participants about having a doula program developed. This generally met with positive responses, as did having an elder drop by occasionally. These are program areas now being explored by the centre.

Questions about providing a tele-visitation program for expectant mothers to contact family members back home revealed a negative attitude toward tele-visitation. Shyness was stated as the main concern. This was surprising to some of the researchers, who generally had more experience and comfort with virtual communication in their own professional and personal lives. This attitude is, however, in keeping with regional cultural norms as best we could discern. This finding may change in coming years when virtual communication becomes more common in our region, especially in remote communities.

Limitations

One of the limitations of this study was the difficulty we often encountered in getting participants to fully engage in the interview process. Despite the offer of interpreters, the young women we spoke to were reticent in sharing their feelings. The 3 interviewers were themselves young women, one of whom brought along her own newborn son. None of the interviewers were First Nations, and that may have contributed to awkward communications at times.

Because we used a convenience sampling of 13 women, our sample may not be representative of the population as a whole. As with all qualitative studies, our ability to identify all of the issues participants felt, but did not want to disclose, was a limiting factor. We did reach saturation of information and themes with our present sample, even though it was small. Our findings are not necessarily applicable to other First Nations regions in Canada. Further study to understand attitudes toward tele-visitation may be prudent.

CONCLUSION

Delivering away from home for women from remote First Nations communities places emotional hardship on the mother and her family. Personnel at the medical facilities caring for these patients should understand the perinatal knowledge and emotional needs of these patients and develop culturally appropriate responses. Some of the negative aspects of this experience may be lessened by successful program innovations, which is the intention at our centre. At the policy level, there is a need to understand the implications of the absence of funding for partners or escorts to be present for birthing.

Competing interests: None declared.

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