

INTRODUCTION

Canada has a long history of evacuating Aboriginal women from rural and remote communities to give birth (Stonier, 1990; Douglas, 2006; Couchie & Sanderson, 2007; Moffitt, 2004). There is a growing literature on the negative consequences of this strategy (Stonier, 1990; Muggah, Way, Muirhead, & Baskerville, 2004; Chamberlain & Barclay, 2000), particularly drawing on the experiences of women in the far north. More recent literature is emerging that suggests a relationship between stress and negative birth outcomes (Kornelsen, Stoll, & Grzybowski, 2011) for women in rural communities, making an understanding of evacuation imperative in improving maternal and newborn outcomes. This study documents the experiences of birthing women to emphasize the need for alternative strategies when communities are without local maternity services.

BACKGROUND

The majority of Bella Bella/Waglisla's population belongs to the Heiltsuk Nation and, historically, has always birthed in the local community. This began to decline in 2000, and since 2001, local hospital policy has mandated that all pregnant women must leave the community near the time of their delivery to give birth at a larger hospital. In contrast to previous years when only emergency births needed to be evacuated, 53 births to Bella Bella/Waglisla women between 2001–2005 took place in referral communities. A number of factors contributed to this cessation of service, including challenges to recruitment and retention of practitioners with the skills to provide local access to caesarean section and the reluctance of physicians to offer maternity care without the availability of such services.

Existing research on rural women's experiences indicates that Aboriginal women face significant social, cultural, and financial stress as a result of evacuation for maternity care (Douglas, 2006; Couchie & Sanderson, 2007; Chamberlain & Barclay, 2000; Indian and Northern Affairs Canada, 1996a; Kildea, 1999; Moffitt & Vollman, 2006; Kornelsen & Grzybowski, 2005a, 2005b, 2006; Kornelsen, Kotaska, Waterfall, Wille, & Wilson, 2010). Inuit women in the Canadian north report negative experiences of enforced evacuation from their home communities to give birth, citing separation from family, culture, and community as their greatest stressor (Chamberlain & Barclay, 2000). Once in the referral

community, birthing women experience increased anxiety waiting for onset of labour and, for many, stress at being separated from their children (Kornelsen & Grzybowski, 2005a), which in British Columbia has been linked to increased rates of induction of labor for social reasons (Kornelsen, Moola, & Grzybowski, 2009). Aboriginal women in referral centres often do not receive adequate support for their relocation due to lack of continuity of care and lack of established mechanisms of communication between care providers (National Health and Medical Research Council, 1996). Additionally, women experience limited labour support, particularly when their partners and families cannot accompany them (Couchie & Sanderson, 2007; Chamberlain & Barclay, 2000). A birthing woman's community also experiences negative effects from the relocation of birth, including strain on the woman's family left behind (Douglas, 2006; Moffitt, 2004; Indian and Northern Affairs Canada, 1996a) and, for Aboriginal communities in particular, a collective sense of loss of a significant family and community event in the cycle of life (Douglas, 2006; Wilson, 2003).

Although relocation of rural Aboriginal women to referral centres provides them with increased access to specialized services, the quality of care they receive often does not match the level of physical and emotional support found in their home communities. Kildea (1999) found that rural Aboriginal women in Australia who gave birth in regional centers often experience substandard care, feel unsafe in their accommodations, and are unable to look after their basic needs. Aboriginal women in Canada also report that nutritious, traditional foods are unavailable in referral centres and that the diet available to them is unappealing and unhealthy (Couchie & Sanderson, 2007; Chamberlain & Barclay, 2000).

For Aboriginal women, birth is an event linked through the web of kinship ties and relationships to traditional lands that form their identity (Douglas, 2006; Indian and Northern Affairs Canada, 1996b; Kruske, Kildea, & Barclay, 2006). Evidence strongly indicates that women have a strong desire for perinatal care that balances their cultural and social needs with optimal clinical care (Douglas, 2006; Couchie & Sanderson, 2007; Chamberlain & Barclay, 2000). Chamberlain and Barclay (2000) found that the "research suggests that women are often aware of the physical risks but they have an overriding need to have the support of their families and communities at this time. The social consequences of major disruptions to family and



assistant, who contacted potential participants either by phone through local phone book listings or in person at the health centre day care program. As surveys were also left in public places, it is difficult to determine the exact number distributed. A total of 55 surveys were returned. We presented the findings to the Bella Bella/Waglisla research advisory committee, who provided comments and preliminary interpretations of the data tables.

Interviews

Interviews with Bella Bella/Waglisla women were set up by the community-based research assistant, who, when distributing the surveys, asked if women would be interested in participating in an interview. The interviews took place over the course of 3 days at either a community location or the local hospital. In total, twelve open-ended, hour-long interviews were conducted by the lead investigator and members of the research team.

Each interview was tape-recorded and transcribed for analysis. The lead investigator and project coordinator read and coded each transcript separately using open coding methodology (Strauss, 1990), and compiled a list of key themes. A high degree of similarity was found between the separate lists of codes. A research assistant then entered the coded parts of the transcripts into a qualitative analysis program, QSR Nudist. Code reports were presented to the research advisory committee in Bella Bella/Waglisla, who worked with the research team on interpretation and presentation of the findings within a culturally appropriate framework. The principal investigator and project coordinator condensed 53 codes into 23.

Upon completion of the final community report, the Heiltsuk Band Council issued a resolution ratifying the project recommendations.

RESULTS

Overview

The results contained in this paper reflect the experiences of Bella Bella/Waglisla women who gave birth away from their home communities. Of the 12 women we interviewed, nine gave birth in Bella Bella/Waglisla and three gave birth in a referral community. Fifty-five women completed the survey. The average age of women completing the survey was 32. Of the 55 women, 19 indicated that they had lived in Bella Bella/Waglisla all their life, while 32 had lived in the community for over 13 years. Thirty-five of participants surveyed gave birth away from the community and 20 gave

birth in the community. For those who gave birth away ($n = 15, 27\%$), the majority birthed at BC Women's Hospital in Vancouver (403.37 miles away) or other Lower Mainland hospitals, while a few gave birth in small communities closer to their home (although still accessible only by ferry or plane).

Participants' narratives conveyed an overriding belief that women should be able to give birth in Bella Bella/Waglisla and expressed a desire to know why this was no longer possible. Themes emerging from the interviews include the influence of care providers in decision-making, the isolating experience of birth in a referral community, the stress of traveling to access care, the value of emotional and practical support from family and community, and community confusion regarding the decision to close local maternity services. Some participants had delivered children in the community before services closed as well as in referral communities afterward. These participants provided comparisons of services before and after the closing of services.

The decision-making process

Many who chose to leave the community before the closure of services did so when the local maternity service began to decline (1999–2000). Some interview participants described their decision in terms of safety and risks: "I would have preferred [to give birth in the referral centre] in case of complications. I feel safer in there in case of emergency," [010:19–20] and "In the end, I want to be safe" [002:245]. Part of the discussion of risks involved the unpredictability of emergency transport due to variable weather conditions.

[The doctor said,] 'Your baby could die by the time you finally get to the hospital or by the time the Medevac gets here.' And so that's it. I wanted to have my baby somewhere else. [006:254–63]

For others, their sense of safety was linked with confidence in local care providers, so when birth numbers began declining, so did the sense of confidence. One participant said, "You know there was lots of talk in the community about how we didn't have enough experienced doctors to deliver" [003:248–52]. Another woman spoke of her need for reassurance from the medical staff and how she felt when that was not forthcoming:

You know, like when you are pregnant you want to hear that it's going to be safe. I wanted to hear that. And I wasn't hearing the things I wanted to hear so that's



what made me really scared to have my baby here.
[003:533–38]

The influence of care providers on participants' decision-making for location of birth was recorded. A significant majority of women who gave birth in a referral centre before loss of services reported being "strongly influenced" by their physician and family while only one person was "slightly influenced" in her decision-making regarding place of birth. Of those women who gave birth in the community, most stated that they were not at all influenced by their physician's and family's advice.

Experiences of birth in a referral community

For women leaving Bella Bella/Waglisla to give birth, time spent in the referral community included the prenatal period spent waiting for labour and delivery, the delivery itself, and the immediate postpartum period. Women in rural British Columbia who must travel to give birth may plan to go to their destination as early as 36 weeks gestation. Rural care providers often recommend this date for evacuation due to the unpredictability of the onset of labour and the lack of local resources for safe care in the event of preterm or precipitous deliveries. According to our survey, the average total time women spent in a referral community was 2.7 weeks before the closure of services, and 3.7 weeks after services closed. The travel costs of these extended stays included food, accommodation, and travel expenses. For women who had left the community prior to the closure of services or soon afterwards, financial issues were less of a concern as travel subsidies were perceived to be adequate to cover expenses. After 2002, there were significant cuts to funding for subsidized trips.

Data from Heiltsuk Band Council travel records indicate that from 2004–2005, the average cost incurred by a woman giving birth in a referral community was \$3,732.87, with a total cost to the band council of \$115,719 for 31 births outside the community. Although a birthing mother's travel expenses are covered by the Heiltsuk Band through First Nations and Inuit Health (FNIH)'s non-insured health benefits program, the costs for escorts and extended family are not. Financial concerns were paramount to most of the women who gave birth outside the community after 2000. Women spoke of the costs incurred for themselves and their families above the subsidies available through the band office. Many women expressed the tension they felt in trying to find ways to have their husbands or mothers accompany them, sometimes being forced to choose one over the other.

Some women made compromises in their arrangements, such as traveling by ferry instead of air or staying in cheaper accommodations, so that family members could accompany them. This sometimes led to difficult situations for the new mom, one of whom told us of traveling 10 hours by bus and ferry to get home 5 days after hemorrhaging at birth and receiving four blood transfusions. If a woman was transported out of Bella Bella/Waglisla by Medevac during labour, cost-saving strategies were not possible: "[My husband] had to pay his own way down: there wasn't room on the Medevac for him" [11:120–22]. To finance their time in the referral community and cover the travel expenses of extended family, many participants in this study undertook fundraising in the community through bake sales, flea markets, and TV bingo.

Once in the referral community, participants either stayed in hotels/hostels or with extended family and friends. Many women found it helpful when they were able to go to a referral community where relatives lived: "It was a lot more comfortable living with my parents for 6 weeks than going to live in a hotel" [008:90–93]. Others, however, recalled the stress of living with family members, or were acutely aware of the burden their presence placed on them.

Mothers who were unable to travel with their children spoke of the stress of being separated from them for a long time, as well as the stress their children experienced due to the separation (Kornelsen & Grzybowski, 2005b):

One girl, she was in grade six or seven, her mother had recently had a baby, and she came to school and she was feeling really sad. She started crying and her teacher didn't know why. She didn't realize that her mom had left to have the baby. And I told the teacher, 'Ask her if she is lonely for her mom, because her mom went down to have the baby,' and the teacher said, 'I hadn't realized that.' [011:334–40]

Just as several of the women noted a sense of celebration when birth occurred in the community, some women also noted the lack of celebration when birth occurred away:

There are several aspects of it...the celebration has been taken away. Like now, if a baby was being born there would be at least 50 people in this hospital, waiting. And as soon as the baby was born, people would be on the phone, on the radio, celebrating. [007:169–74]

This participant went on to wonder if the high rate of depression in the community was due in part to the



celebration of birth being removed from their lives.

Travel concerns

Although our survey did not find that the time of year was a significant concern, women did voice concerns about travel logistics and the possibility of bad weather. Common concerns included the fear of bad weather keeping them in the community if they needed to leave, or preventing them from returning after the birth. Participants expressed concerns about traveling half-way home and encountering impassable weather conditions, which motivated several women to travel by boat instead of plane:

In January, during the winter, I prefer to come on the ferry, even if it's rough... just because the weather turns on a dime. It's really unpredictable during those months. [004: 264–270]

Travel by bus and boat was nonetheless difficult for some women traveling home after giving birth:

It is a long ride from Vancouver to Port Hardy on the bus. I mean, you're on the ferry for 2 hours from the mainland to the island and then 6 hours up the island, stopping everywhere. And you have a 5-year-old child and a newborn: it is really tiring. ...And then you have the ferry up to Bella Bella. [004:253–260]

The importance of family

The presence and support of family members—either immediate or extended—often mitigated some of the negative aspects of being in a referral community. Survey results indicated that about half of the women who gave birth in a referral centre were able to have family members present during labour and delivery. Several women also noted the benefits of being able to see band members who lived in the referral centre right after they had given birth. As one said,

I love the city and my daughter really loved the city and seeing band members I haven't seen...you know, band members down there are really happy that they're able to see the baby whereas if I was here, they would have to wait. [002:273–76]

For the many women who left Bella Bella/Waglisla to give birth, however, family members remained behind. The

absence of family and friends often gave rise to a profound sense of sadness. As one person told us,

So I really didn't want to leave because my whole family is here and I wanted them to be around. My husband came with me and his mother came with me but I wanted my mom to come. There wasn't enough room and she couldn't afford to come. I was lonely. The hardest part of leaving is the family. [011:20–25]

The desire to be home

Many of the mothers who left the community to give birth spoke of the pull they felt to return home as soon as possible. Sometimes this led to travel immediately postpartum, despite the physical discomfort experienced or the need for medical attention in the referral community. As one mom said,

They were going to keep my baby there because his bilirubin was a bit high, on the high end of normal. But I was just sort of messed up. I was a wreck. It almost felt like postpartum depression, just because I wouldn't stop crying, because I was so worried about him. But they couldn't convince me at all that he was fine. I just couldn't stop crying. I just wanted to be home. [004:244–50]

The draw to familiar and comforting things was strong, as many women spoke of longing for day-to-day routines usually taken for granted. The desire for home-cooked meals and familiar foods was noted by many.

Longing for home gave rise to a sense of exasperation with having to be in the referral centre and difficulty respecting the natural rhythms of the birth process. As one woman said,

You're counting down like, 'I hope it's today I go into labour, I hope it's today, I hope it's today...' Whereas here, it would just be, 'When it happens, it happens.' So to me a good birth [is] just being able to be comfortable in your own surroundings, not having to worry about, 'What am I going to eat today?' 'What's on the menu?' Or having to worry about who is going to be there. Yeah, that's a good birth to me. [007:212–20]

Understanding the change in services

Many women expressed a lack of understanding about why maternity care was no longer available in their community,



particularly when they had birthed children locally. Some evoked the historical context for birth in Bella Bella/Waglisla and the perceived irrationality of the change:

It is documented that people have delivered here over 10,000 years. Why change it now? I'm sure that our community, if given that choice, would say, 'Yeah, we want our babies born here. Yeah, we're willing to take that risk.' [007:154–57]

Services in Bella Bella/Waglisla were revoked 6 years prior to this study. Stories of women who had birthed before and after this time provide a glimpse into a crucial part of the culture of care for Heiltsuk peoples. The positive impacts of local birth extend into the life of the community.

DISCUSSION

Overview

Participants in this study had divergent experiences of childbirth outside of their community. The nature of the experience was influenced by whether they chose or were required to leave. Birthing outside the community was associated for some women with a sense of alienation congruent with Seeman's framework (Seeman, 1959). Seeman identified five components of alienation: powerlessness, meaninglessness, normlessness, isolation, and self-estrangement. Powerlessness or loss of control is a common response in medicine (Fogarty & Cronin, 2008; Giske, Gjengedal, & Artinian, 2009; Cassell, 1998) and a leading cause of anxiety in childbirth (Beck, 2004; Sjogren, 1997; Willmuth, 2006). Not being able to make decisions regarding care, including where to give birth, is common to many rural women (Kornelsen & Grzybowski, 2005b) and an undercurrent of the participants' stories in this study. They articulated this feeling most clearly in questioning why local services had closed and noting that an answer was not forthcoming. Tied closely to this was the sense of meaninglessness, or a lack of clarity in what was to be believed. Instead of internalizing these feelings, however, women in this study sought answers and, more importantly, expressed the belief that they deserved answers.

A sense of isolation (Nettler, 1957) was experienced by many of the women who left behind family members, particularly children, and was the most distressing consequence. The consequence of this separation has been noted in earlier work by the authors (Kornelsen, 2006) and others. In her work on the evacuation of birthing women

from far northern communities, Stonier (1990) documented the consequences of separation as loneliness, worry, anxiety, loss of appetite, and increased smoking among the mothers. She also noted the impact on children and other family members left behind, including school problems and increased rates of illness. Although the immediate consequences of separation can be felt and documented, we have less of an understanding of the long-term consequences at such a critical time in the mother-child relationship, or, if the father has remained behind, his relationship with his new child and the relationship of the child to the rest of the community. Anecdotally, women have told us of differing relationships enjoyed by children born at home compared to those born away, even if those perceptions are held only by the mother. How does this affect the child's integration into the community? More long-term research is needed to understand the psychosocial effects of giving birth outside their home communities for First Nations mothers and also the implications for being born away for First Nations children.

A further sense of isolation was felt through estrangement from larger cultural norms surrounding birth (such as missing the traditional gathering to honour the newborn baby). Seeman (1959) expands on the idea of alienation to include the act of partaking in activities without intrinsic meaning; although the birth of one's child, regardless of the location, will hold meaning in a woman's life (Kornelsen, 2005), it is diminished when it is not shared by family and community (Kornelsen & Grzybowski, 2005b). Geyer (1993) proposes further causes of alienation, one of which is the actual constraints imposed on the individual by the environment, such as the lack of local services. Clearly, when women would like to birth in their home community but do not have the support from the medical infrastructure, the constraints felt may lead to a sense of alienation.

Hobart (1965) suggests that isolation and self-estrangement are two further consequences of alienation, possibly leading to loneliness, anxiety, or even depression. Further complicating this is Seeman's (1959) finding that there is a correlation between levels of alienation and knowledge about health-relevant information of patients. The more alienated the patient the less informed they tend to be. In this way, he suggests, powerlessness is a self-fulfilling prophecy.

However, alienation within a First Nations context should not be discussed without also considering its twin concept of resilience. In her article, "Exploring Resilience and Indigenous Ways of Knowing," McGuire (2010) cites



