Development of a Framework of Improved Childbirth Care for First Nation Women in Manitoba:

A First Nation Family Centred Approach

by

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This thesis is dedicated to the memory of my late Granny Seymour whose quiet disposition and enduring spirit lives on in her daughters, granddaughters and great granddaughters today. Her steadfast love and strength inspired me to pursue research in this topic.

It is also dedicated to the thousands of women who leave their home and families to give birth each and every year.

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Abstract

This paper reports on a qualitative exploratory study focusing on the childbirth experiences of women and their families from a northern isolated community in Manitoba - who had to leave or were about to leave home to give birth. Perspectives from critical medical anthropology, cultural relativism and human ecological theory provided the theoretical foundation for this study. This study utilized ethnographic approaches to explore the perspectives of the women, their families and "significant others" and how they have been affected by policies, practices and structures at all levels of their environment in an attempt to gain a better understanding of the type of support and services that could potentially improve this experience.

Presently, women from northern, rural and/or isolated communities leave home from a period of a few days up to 10 weeks to deliver their babies in an urban tertiary centre. They stay in boarding homes with others who have left home to obtain medical care, or with family and friends. During this period of time the women often do not access prenatal support or services within the regional health authority, other than medical care from a primary care provider (whom they may not have seen prior in their pregnancy) or to receive specialized medical intervention and monitoring. The boarding homes where they often stay do not offer any prenatal support or outreach services and are not conducive to housing women so close to delivering a baby. The women spoke of their experiences of giving birth marred by memories of fear, anger, frustration, tears and longing for family. They also spoke of a renewed sense of hope and excitement at the opportunity to share their ideas about possible ways that their experience could be improved. This paper breathed life into their thoughts and brought their ideas together to develop a new vision towards a system of supportive childbirth care for First Nation

women in Manitoba, and more specifically, for women who are medically evacuated from the north to deliver their babies in urban Manitoba. For the Faculty of Medicine, it is a Master's thesis, but for me and the many women and residents of Berens River, it is an opportunity for First Nation women to participate in shaping policy and influencing the direction for care and services that is created for them. It is important to acknowledge that evacuation and temporary relocation for birth is not an issue unique to First Nation women, it impacts hundreds of other northern and rural Métis and non-First Nation women every year. However, their experience is not included in this study. This paper suggests immediate and interim solutions for women who must leave home to give birth, albeit, the ultimate aim is to return birthing services closer to home.

Prologue

In order to appreciate why I chose to study the childbirth experiences of women who leave home to give birth and engage them in a conversation on how this experience could potentially be improved, I feel it is important to begin with a reflection of who I am and explain how closely the subject is connected to my own life. I am an Anishinaabe woman and a band member of the Hollow Water First Nation. I am, therefore, a product of this environment. I grew up among very strong women who passed on values, beliefs and traditions that only now, years later, I am only beginning to understand. For many years I obstinately clung to these beliefs, practices and traditions and I am only now beginning to appreciate the role they played in "regulating" behavior, as they related to the mental, physical and spiritual well-being of the reproductive woman. I am only now beginning a journey to understand how significant they were in the perpetuation of life; and how historical, social and economic events, and the quest for "modernization" interrupted a practice of birthing children (that existed for centuries in a harsh and seemingly unforgiving climate) and yet the cycle of life continued. The transmission of child birthing knowledge from one generation of women to another was interrupted and has been so modernized to the point of extinction in my community, as it has in many others. The loss in my community is sad, but all is not without hope. I am also a nurse schooled in western biomedical thought and concepts; and for this reason I will never negate the contributions of western and modern medicine. Chief Ovide Mercredi, a well respected leader in Manitoba who spoke at the Gathering of Children's programs in March of 2009, said "we need to take the best of both worlds and make birthing services better". This will require a new injection of life and energy that I fully intend to take part

in - beginning with this paper. I am taking one very small step toward returning control over birthing back to women - where it rightfully belongs.

As a nurse, I have spent many years working in the north and have firsthand knowledge of the impacts of medical evacuation for birth and I still continue to practice in the north on a part time basis. I have either delivered babies or have assisted at deliveries where the prenatal woman either refused to leave the community, or returned after being sent out of the community. I am presently the Nurse Program and Practice Advisor with the Maternal and Child Health Program and my position resides within the Health and Social Wellness Unit of the Assembly of Manitoba Chiefs (AMC). In this capacity as Co-Manager of this pilot program, I sit on several policy and advisory committees, one of which is the Manitoba Task Force on Maternal and Child Health Services and the Implementation Working Group that spun off from the task force, now named the Relocation Initiatives Working Group (RIWG). The formation of RIWG was in response to a briefing note on this issue presented to the task force by the AMC; and joint advocacy efforts by Lori Rudolph-Crawford of First Nations and Inuit Health and AMC for the women caught in this conundrum. As I gathered information on this topic, the Relocation Initiative Working Group has listened, fulfilling one of the objectives of this thesis - to carry the message from the women to the larger community.

I also felt it necessary also to begin with mine and my grandmother's story. My grandmother gave birth to her first child when she was 16 years old; she had another 13 babies in the 25 years that followed. Eleven of these children she birthed in the homestead or at the "camp", depending on the time of year. I am told that she gave birth to one of the "boys" during berry-picking season on Black Island - the traditional "blueberry" grounds to the Anishinaabe people who now live in the area known as Hollow Water,

Manigotagan, Aghaming and Seymourville. This large, dark island is located in central Manitoba along the mid-eastern shores of Lake Winnipeg at the apex of the Canadian Shield. I studied the image of the Canadian Shield many times on the map when I was still in high school. I pictured it as a blanket wrapped around the shores of the Hudson Bay, protecting the inland from the insults of the Arctic wind. The bay itself resembles the shape of the human heart, and if Black Island sits at the apex of the Canadian Shield, then much like the apex is significant for detecting the strength and rhythm of the human heart; I imagine Black Island holds this special and very spiritual connection for the Anishinaabe people on the eastern shore.

So, what is so important about Black Island? I believe it is important to understand the ecology of this area and to be aware of the conditions upon which my grandmother, aunts and the Ojibway women central to this story gave birth in days long past. The upper lands of the Canadian Shield is densely forested in evergreen, and covered in the summer months with deciduous shrubbery and trees of many shapes, sizes and types. This alternates with lowlands of beautiful igneous rock outcroppings upon which lichen and mosses of many colors grow, a wonderful testimony to its ancient history carved during the ice age. In some areas the soil is too dense or shallow to support forestation, and bogs and marshes have merged with mazes of rivers, streams and water systems making their way to Lake Winnipeg.

Black Island is especially typical of this geography. It is celebrated for its lush forest, fine silica sand and a thick blanket of blueberries that cover the forest floor in July and August. The “Island”, as it is referred to by local residents, is only a short boat ride from where I grew up along the Manigotagan River and was the place, interestingly, where my entire family was when I was about to give birth to my first child 14 years ago.

Daniel made his entrance into the world five weeks early, so sending word to my family who had planned on being there when he was born was a big ordeal – a telephone call to my Aunt Irene in Seymourville; the message then had to be relayed by word of mouth to the boat dock in Hollow Water and then carried across the lake by the boat taxi driver via "moccasin telegraph" and on to my family on Black Island. I feel compelled to tell of this experience because Daniel was born during the time when my family had packed up and moved across to the Island. He was born on the first Friday in August of 1995; the week that my father, stepmother, sisters and brothers packed up and moved across to the Island six days earlier. It was a weeklong retreat back to an old way of life, a tradition revitalized in recent years after it had disappeared for a very long time. When I sent word across to the Island about Daniel's imminent delivery my family packed up "camp" and travelled back across the lake one day early. This was no easy feat; they had nine children, shelter, utensils and necessities to pack up and return to the mainland. It was another two and a half hour by car to Winnipeg. By the time they made it to the hospital and welcomed Daniel, he was already a day old. I now understand his impatience on making his premature entrance to this world. It is no coincidence that Daniel feels drawn to the "Island" today. He now travels every year with his Mama and Papa, aunts, uncles, and extended family every summer for the week-long retreat on the old berry grounds. As soon as he returns with his cousins, they begin planning for the next summer and wait impatiently to return again.

All the children born to my grandmother or women in her day were born in a similar environment like Black Island or on the homestead. In those days they travelled by canoe, but instead of being a two hour car ride by road (as would be available today) they were separated from the "modern world" by two days of travelling by canoe or 15

hp boat and motor in later years. Circumstances have definitely changed in the years that both my grandmother and my aunts had all those babies, but what is remarkable is that my 84 year old Aunt cannot recall one single infant or maternal death; she herself having delivered 7 of her own children on the land. Each of my grandmother's and Aunt's children were delivered by a traditional midwife, an older woman respected for her knowledge and experience in birthing children. I am told she learned her craft from older women born before her, and her classroom was the birthing lodge. Of my Grandmother's 14 children, 12 are still alive today. Only the last three, born in the 1950's were born in a sterile hospital environment. For reasons unknown to my aunts, one died in-utero, and another died, my mother, at the age of 32. Prior to the road being built in the 1950's, my family was separated from the modern world by far more than just geography. They were also separated by beliefs, practices and cultural traditions; yet they all made a safe passage into this world.

I regret today that my Grandmother said very little to me about her childbearing experiences when I was growing up, probably because I never thought to ask her about them back then. My grandfather was entirely different from my grandmother in that he equalled her silence with stories of hardship, survival and mysticism. He told many stories to entertain his grandchildren, many of which had moral lessons I am sure, but what they did was frighten me at the time. He would often gather the children and tell stories with great animation. I would listen so intently that he would appear to move a great distance from me and I would become one of the characters in the story. Back then I believed the stories to be fictional but I understand today that they may have been mixed with some sad elements of truth. Regardless if they were true or not, the stories were always fascinating. When I was much older he told stories of moving "camp" from year

to year, migrating from season to season following the berries, roots and animals that were the mainstay of their diet. He told stories of picking berries in the heat of the summer, of packing up and taking the children along (my aunts and uncles) to pick the blueberries, saskatoons and “shamboomynucks” as we called them when we were young. These were necessary staples in their diet, but they were also sold out of necessity to buy flour, baking powder and beans - goods introduced to them generations before that had become necessary to keep starvation at bay. For a high school project I sat and listened to my grandfather’s story about surviving the Great Depression. Poverty and suffering were very real threats and very present for them in those days, and unfortunately did not end when the road that connected Manigotagan to Pine Falls was built. He spoke of a time and of hardships that I could not comprehend. He spoke of his traditional “homestead”, of meandering through trails and forests, of portages on the river and of navigating along the lakeshore to Pine Falls by boat or canoe; and to the store where he purchased the “store bought” staples. Now, when I think back, I had missed an opportunity to hear my grandmother’s story about following my grandfather; of the 14 pregnancies and what it must have been like to carry, birth, breastfeed and care for all those children.

So now I hear only a small snapshot of grandmother’s story through my aunts, now grandmothers and great-grandmothers themselves. My Granny passed on seven years ago to the spirit world, well deserving of her peaceful rest as I can only imagine the burden that she carried silently with each pregnancy and birth. Most of her babies were welcomed by a traditional midwife. I am told by one of my aunts on my father’s side that the midwives were very gifted and knew the signs of imminent delivery; they would often remain close to the women nearing the end of their pregnancies. She would also offer advice to the women on how to care for themselves during pregnancy and after the

delivery of their babies. My Aunt Mary Jane, like my maternal grandmother, also gave birth on the "Island". She told me her story of getting ready to leave the Island to come back home when she was approached by the traditional midwife whom recommended to her that she should not travel. I questioned my aunt about how the midwife would have known to advise her on such a thing and she replied, "I don't know, she just knew. And she was right". My aunt put her complete trust in the midwife and stayed behind while all the others packed up and moved back home. Like the midwife predicted, she had gone into labor and delivered the baby on the Island. The midwife stayed behind with my aunt and supported her when the rest of the camp was moving home. That baby is my cousin Charles, who is now 58 years old.

I had also questioned my Aunt Mary Jane about how she thought the midwives were trained and she had told me that she honestly didn't know, but was amazed that they seemed so tuned into the women's physical, mental and emotional state of being. They seemingly could read what was happening with the woman's body and the moon cycle had something to do with it as well. I heard as a young woman still living at home many predictions based on a woman's behavior, or on the cycle or character of the moon. I regret that I didn't care much to pay attention to all that discussion when I was young and I fully intend to capture some of this knowledge in the near future.

As interesting as my grandmother's and aunt's stories are, it is important to clarify that they are not the "subjects" of this study. I only offer a small snapshot of my history to emphasize how things have changed so rapidly in such a short period of time. It is also important because it lends some historical context to the subject of this thesis. The First Nation and childbearing women from northern and remote communities of this province have undergone profound and significant changes in childbearing beliefs and practices in

just a few generations; the memories of “how things once were” are beginning to fade with the passing of our mothers and grandmothers. These stories and many like them have existed for generations as knowledge and experience passed from one daughter to the next in the oral and apprenticeship tradition. There is some urgency today to have these recorded as our traditional means of transmitting knowledge are no longer being practiced and the classroom has moved from the birthing lodge into large institutions. I acknowledge that moving birthing closer to home has been advocated by many predecessors and the topic of evacuating for child birth can be found in numerous reports and papers. It is my hope that this paper is unique in that it seeks to find some very simple remedies from the women themselves who have been affected by a fundamentally flawed system of childbirth which continues to impact women in isolated communities in Manitoba. It also seeks to propose a new framework for child birthing services whose ultimate goal would be to reduce the suffering and the burden that these women have been forced to carry for a very long time.

“You know, it goes far, farther than just the mom and baby. It affects a lot of people. It not only affects the mother and father” (I-1)

This comment was introduced because it further exemplifies why I have chosen to explore the policy of removing women from their communities to give birth. The words were imbedded within a conversation that took place so quickly that I missed how significant they were during the interviewing process, but I do remember being particularly moved by the woman’s story. I believed the written transcript could not do justice to hearing the rhythm, the rise and fall, the inflection and sometimes shaky raw emotion in the spoken voice. Nor, I thought, could it ever capture the experience of being present in the same room - of witnessing pain being etched momentarily on faces (but

forever inscribed in their soul), and of the struggle sometimes to carefully choose words so that they do not speak ill of invisible policies and nameless persons who have deeply scarred their experience. But, listening over and over and reviewing the written transcripts and trying to remember the expressions on their faces - these words jumped forward from the hundreds of pages before me. In reviewing the transcript, my internal voice exclaimed "Wow, that's it! This is the message that I must take forward. I get it". Unfortunately, many do not. And regrettably, some never will. It is my hope that this work will help others to understand the significance of the words, "*…it goes much farther than just the mom and baby"*.

This work was undertaken to fulfill the requirements of my Master of Science Degree in Community Health Sciences. But more importantly, it was meant to give a voice to those that have spoken for a long time and have not been heard. As one community health nurse stated during the early phases of the research project "I have been talking about this for 20 years. It is about time that we are asked about what we think". This work is not laden with theory, but I do have something to say about the culture of childbirth in the broader sense, and how it may have impacted their belief systems in this one particular community. For the women and people of Berens River, Manitoba this project was an opportunity to speak freely about a policy that has harmed individuals, families and communities for a very long time. From the limited perspective of governments, their suggestions and proposed solutions may have a monetary cost - but for the well-being of a group of marginalized women, the savings are immeasurable. The emotional, spiritual, physical and mental health benefits in the end will alleviate much suffering and, who knows, may save lives and rebuild families - if we give their suggestions serious thought. What their ideas really mean, in the end, is something we

take for granted that should be available to all citizens of this country: the freedom to choose where, how and by whom our babies are born; and to have our families and friends there to share and bond in this experience. The voice may at times be my own and sometimes academic; but in the end, I hope that this work will join the voices of the women I've spoken with and many others before me in finding anyone who will listen and understand just exactly what the woman meant in the opening statement that it does indeed go beyond *mom and baby*. Hopefully, this work will move others to do something about the current situation and to ultimately improve the lives of First Nations women in Manitoba.

Miigwech!

Chapter One: The Study

Introduction

The practice of traditional midwifery in my grandmother's day has long disappeared. She was an Ojibway woman that was born, raised and lived most of her life on the eastern shores of Lake Winnipeg in the area now known as Manigotagan and Hollow Water. An all season road built in the late 1950's ushered in a period of cultural contamination in unprecedented proportion and allowed access to western urbanized medical care that forever changed child birth practices and care - as it did in other Ojibway communities like Berens River, Manitoba situated northward from Hollow Water. Women from Hollow Water are fortunate they are connected by an all-season road and are 1.5 hours away from the City of Selkirk, the nearest birthing centre and for the most part, remain at home until delivery is imminent. But for our neighbors in Berens River approximately 150 km north of Hollow Water, and in many First Nation communities across Canada, women are systematically removed from their communities to give birth. Based on the 1465 births reported in 2007 by First Nation and Inuit Health, and on the Manitoba First Nation Regional Health Survey (RHS) that indicated 76 percent of women in 2002/03 had left home to give birth, (Elias, LePlante & AMC, 2005), it is therefore estimated that as many as 1,100 prenatal women relocated temporarily from First Nation community in rural and remote regions of Manitoba to an urban location to give birth[1]. However, these are only estimates, since there are currently no mechanisms in place to track these numbers at present. In the Winnipeg region alone, 523 of the 2,495 (21%) women who left home to deliver a baby in 2007 were from a First Nations community (Winnipeg Regional Health Authority, 2008). Given that there are four other urban centers that receive women to birth their babies, the actual number is

even greater. For the past 30 or 50 years, First Nation, Inuit, Métis and women in other rural or remote regions in Canada leave their home communities due to government evacuation policies. The research has been unclear in regard to whether these policies and practice arose due to inherent "risk" to the well-being of the mother and child or to other factors such as the availability of health care providers, geography, or lack of health care. Efforts to return childbirth to northern communities have taken place in the far north but these efforts have been challenged by the lack of mobilization of providers and communities, concerns about safety, relationships between communities and providers, decision makers and various levels of government (Gold, O'Neil & VanWagner, 2007). In terms of actual lives affected, this has meant that more than 1,100 women in Manitoba in any given year have to leave their homes, First Nation community, children, husbands and any support they may have during their pregnancy. They do so for a period of 1 to 10 weeks and relocate to Winnipeg or another urban centre to await the delivery of their babies (Eni, 2006, Smith, 2003). These numbers do not reflect women from Métis or non-First Nation rural and remote communities. But across Canada, these numbers are cause for great concern.

The prenatal women from First Nation communities often stay in boarding homes or they sometimes stay with family or friends. They are supported in a very limited capacity to travel to and from the community by the federal government, but no such support exists for non-registered Indians, Métis or non-First Nation women. First Nations women have voiced many concerns with this arrangement, as they often feel lonely, bored, isolated and are without any community or public health support for this period of time (Eni, 2006). Having a baby is a stressful event in itself and having a baby away from home without any social or emotional support can only compound this stress. (Whitty-

Rogers, Etowa & Evans, (2006) reported that removing the mother away from the community posed increased hardship on the prenatal woman that included lack of social support, vulnerability due to language barriers and separation from family and resulted in ineffective family coping. They also faced challenges in regard to accessing prenatal care services, culturally competent care and providers (Whitty-Rogers, Etowa & Evans, 2006). Although it is policy of the Winnipeg Regional Health Authority (WRHA) to make contact with these "temporary residents", the arrival, location and departure of these women in the city is often difficult to track as no systematic communication occurs between the sending community and the receiving regional health authority (personal communication with D. Girard, 2007). First Nation and Inuit Health Branch (FNIHB), the federal department responsible for the provision of care to First Nation residents living on reserve, provide transportation to and from the community and to and from their temporary residence and to their medical appointments. However, they do not provide any direct health or ancillary services to them when they are away from their community. As the regional health authorities have no means of locating the prenatal women, the First Nation prenatal women awaiting the birth of their babies have found themselves in an apparent service gap, unless they have been admitted to the Winnipeg Antenatal Home Care Program available in the City of Winnipeg.[2] This study differs from other precursors in that it focused on this gap in services for maternal and childbirth care for women who left their community to give birth. The primary objective was to involve the women in the development of a culturally relevant, holistic and family centered approach to childbirth care that builds on the current work of health care providers involved in First Nation childbirth health care delivery.

Study Significance

This study is significant for several reasons: the information gathered is brought together to develop a vision for a new system of childbirth health care for First Nation women; and more importantly, to give a voice to First Nation women and an opportunity to shape broader social policy and direction for care and services that are created for them. Historically, the development of health and social programs has not included consultation with First Nations people and their development has served to perpetuate patriarchal policies of colonialism resulting in programs and services that have failed to meet their needs. ONeil, Lemchuk-Favel, Allard & Postl (2004) argued that rebalancing of a system in favour of [Aboriginal] values will improve the self-esteem of those working within the system, as well as those whom the system services.

In examining this issue, it is important to have a basic understanding of the major socio-economic and demographics of this population. It is known that the First Nations population is a fast growing population in Manitoba, with the largest proportion of the population under the age of 20 (Elias, 2005, Martens, et al., 2003). Fifty percent of the First Nations Regional Health Survey (FN-RHS) respondents who reported themselves as a caregiver indicated that they did not have a high school education and 54.2 percent derived the majority of their income from social assistance. Only 50 percent reported that they were either married or living with a common law partner (Elias, 2005). This means that there is 50 percent chance that the First Nation prenatal woman is single, and relies solely on social assistance for her income. There is also a 60.3 percent chance she has chosen to breastfeed, compared to the general population breastfeeding rate of 79.9 percent, but she may chose to breastfeed longer than the general population. Rates of smoking among prenatal women during pregnancy were higher among younger mothers,

mothers with lower incomes and mothers with a family history of residential school attendance and resided in a remote or isolated community (Elias, 2005). Due to the sheer volume of factors and varying number of elements of the First Nation prenatal environment that can be explored, only those that may add some context to understanding her environment will be outlined in the following section.

Theoretical Perspective

A blending of theoretical approaches was utilized to explore the perspectives of those that are impacted by the medical evacuation (confinement) policy. The first draws upon critical medical anthropology, mindful that with this approach the "sufferer" at the individual level begins with the recognition that experience is constructed and reconstructed in the action arena between socially constituted categories of meaning and the political-economic forces that shape the context of their daily lives (Scheper-Hughes and Lock, 1987). Medical evacuation policy and practices did not take place in a vacuum, nor is there any evidence that they were implemented precisely at any particular point in time or by any individual government. It was an evolution of processes that have also been shaped by social, cultural and economic forces occurring within a forever changing political and historical landscape. Referencing an earlier work of theirs, Singer and Baer (2007) wrote that critical medical anthropology (CMA) involves "paying close attention to what has been called the "vertical links" that connect the social group of interest to the larger regional, national and global human society and to the configuration of social relationships that contribute to the patterning of human behavior, belief, attitude and emotion" (p. 33). It also emphasizes structures of power and inequity in health care systems and the contributions of heath ideas and practices by reinforcing inequalities in the wider society (Singer & Baer, 2007). Augmenting this approach, a human ecological

framework adds another level of understanding to political and economic forces that shape human experience in that it draws on the biological, social, and physical aspects of the individual within the context of their environments. Human ecological theory is a useful way of looking at the interactions of humans with their environments and considers this relationship as a system. These environments may be the natural world, reality as constructed by humans, and/or the social and cultural milieu in which the individual exists. Human ecological theory has been one of the prominent theories in understanding human development and the family and how the natural and human created environments affect our behavior, and how individuals and families in turn, influence these environments. In this adaptation of human ecological theory, I consider the prenatal system of support and her environment as being interconnected in an active process of mutual influence and exchange, similar to Swick and William's (2006) adaptation of Bronfenbrenner's bio-ecological perspective. Their application provided a valuable foundation for understanding the individual who is under stress. In the case of the prenatal woman who must leave her community and system of support to deliver her baby, it is important to understand all levels of her environment – individual, community, health system and beyond and how these systems interact to support or not support her. This perspective takes into consideration that there are many factors in the external environment that interact to influence her behavior, her well-being, the well-being of the child and the childbirth event itself.

In this model, the individual, and in this case the First Nation prenatal women, are considered to be at the center of their interconnected environment. This system includes the prenatal woman's most immediate environment, her mental, physical, emotional and spiritual state of being. This *microsystem* is surrounded by an *exosystem*, an environment

that includes the community, school, health and social systems as well as intimate relationships with family, friends and significant others. The *macrosystem* is the organizational level consisting of the social, economic and political environments. The *chronosystem* frames all the dynamics of all systems within the cultural environment and historical context. The elements in each circle influence the environments within.

In this model, the prenatal woman is most directly impacted by her *immediate environment* which includes her home, family, friends, and peers. However, it is important to acknowledge that the individual is not a passive recipient of experiences in this environment, but is also a biological human organism who participates in the construction of these experiences in complex reciprocal interactions both within the immediate and external environment (Bronfenbrenner & Evans, 2000).

The immediate environment of the individual is, in turn, impacted by health, social and educational systems. This also includes the community. All of these systems dwell within broader social, economic and political environments. For example, the prenatal woman that lives in a small isolated community such as our study community may live in a house with as many as 10 other individuals. This home environment is influenced by community level factors such as housing availability. The availability of housing, in turn, influences the number of individuals in the home. The family will be influenced by such factors as employment and the availability of work in the community, social and economic factors. The social and economic environments are also influenced by the cultural environment. This cultural environment includes the beliefs, values and attitudes that people in a particular society tend to share. A change in one outer sphere can influence and produce change in one inner sphere and vice-versa (see Diagram 1: The First Nation Prenatal Women and her Environment page 11).

Health systems, practices and the rules and regulations within those institutions that fall within the macro level have the potential to have a more far reaching effect than simply influencing individual behavior and have even greater potential to influence prenatal behavior and the birthing experience. Interventions, programs and policies that take the focus away from the individual, and those planned at the broader social context can help alleviate some of the stress experienced by prenatal women who relocate to larger urban centers to deliver their babies. Browne and Smye (2002) wrote:

> In order to promote better understanding and to respond appropriately to the complex range of factors influencing health and health care for aboriginal women, discourses generated within the dominant health care system ought to further examine how wider historical, structural and social issues influence women's involvement in health programs (p.37).

This study therefore focused on the policy, interventions and change required at the exo and macro system level and informed by the voices of First Nation prenatal women. It takes the gaze away from the individual and puts it rightly where it belongs - at broader systemic change beyond her mircrosystem. The overall research question that was posed was therefore:

Given that the movement of birthing services closer to home may be many years in the future, or not at all possible for some northern and remote communities in Manitoba, what do First Nation women feel is needed today to improve current child birthing practices and the maternal and child health care for their First Nation community.

It is hoped the voices of the prenatal women and a greater understanding of their daily lives at the microlevel, combined with the researcher's position within the health care system, could potentially gain the capacity and momentum necessary to influence change at the macro level of the environment.

To examine meaning and belief systems surrounding childbirth in Berens River and to attempt to understand how these systems may have been impacted by forces in the

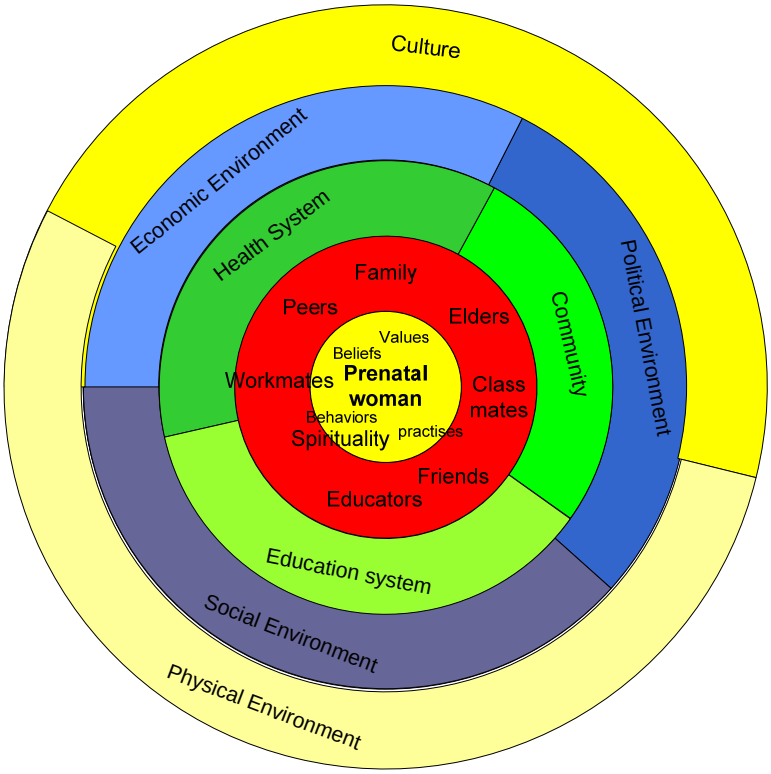
larger dominant social and cultural environments, I also drew upon cultural relativism, specifically the work of Kleinman, Eisenberg & Good (1978). These medical anthropologists saw a need for understanding and treating individuals from the perspective of culture and urged health care practitioners to consider a new framework that would free ourselves from an "ethnocentric" view point so that we may begin to recognize important issues that have been systematically ignored. Although their treatise was concerned with the "medical encounter", their concepts in understanding how culture influences the perception of illness, proved very useful when applied to the changing landscape of childbirth and the birth experience. Quoting Engelhardt (1974), they wrote: "Neither disease nor illness should be regarded as entities. Both concepts are explanatory models mirroring multilevel relations between separate aspects of a complex, fluid, total phenomenon: sickness" (p. 252). I will explore the "culture" of childbirth today, the term culture used here in its' broadest sense and explore how the dynamic interplay between biologic, psychological and socio-cultural levels have come to shape the way childbirth is perceived by the women in this study.

It is very humbling to try and explain in just a few sentences the concepts posed by Kleinman et al. (1978), and how their ideas apply to this study. What I found most relevant and interesting was the way they proposed we define and distinguish between the concepts of disease and illness. They urged health care providers to consider the experience of illness, rather than looking only at the biological diseased state. From their perspective the illness/experience is a construct of one's own environment and is therefore essentially shaped by the individual cultural environment in which the individual dwells. Applying these concepts to childbirth and understanding the difference between disease and illness could potentially transform the childbirth experience and the

credence we have attached to it at both the individual and at the macrosomic level. System level processes and individual beliefs systems may appear as separate entities at first glance, but they are also intimately related. This was evident as I began to gather information for this topic. I hypothesized that transformative change was necessary on several planes and at many levels involving both individual and macro level processes. Considering all of this, I ascertained a merging of approaches with aspects of critical medical anthropology, cultural relativism and ecological theory was necessary to explore the individual and all the environments that surround her; horizontally, vertically and on many different levels in order to gather a truly comprehensive understanding of the issue.

Diagram 1

The First Nation Prenatal Women and Her Environment*



- The human-ecological model considers the interconnectedness and relationship that exists between the individual and their physical, social, political, and economic environment.
- While the individual or the First Nation woman is responsible for instituting and maintaining the behaviors necessary to maintain or improve health and wellbeing, individual behavior is determined to a large extent by social, social, economic and political environments, community practices, values, regulations, policies and practices.
- Barriers to wellbeing are shared among the community and all levels of the environment as a whole. As these barriers are lowered or removed, well-being becomes more achievable and sustainable.
- The most effective approach leading to well being is a combination of the efforts at all levels--individual, interpersonal, organizational, community, and public policy that supports the health of the prenatal women and her unborn child.

***Based on Bronfenbrenner's Ecological model of Human Development

The Context: Understanding the Prenatal Woman and her Environment

Imagine you are 19 years old, living in an isolated northern reserve since the time you were born, you are 36 weeks pregnant, and told you will have to leave the community because you are a "high risk" pregnancy. Imagine, if you have never left the community except accompanied by one of your family members and your experience outside of the community was only for short visits during the summer. This time you are told you have to leave on your own, because you are over 18 now. You are about to experience one of the most significant life changing events - giving birth to your first child. Imagine yourself thinking*: "I am high risk that must be something serious, maybe me or my child are in great danger"*.

Then, you actually leave the community, your duffle bag is packed, your mother, father and baby's father wave goodbye to you at the airport and you fly off to the city to await the delivery of your baby. You have never been to the city alone, so thoughts race through your head and you become fearful. You become anxious at the thought that you will not know anyone at the place where you will be staying. Worse, what if you are staying in the same place that the man across from you is going, and he appears to be coughing a lot, and he appears to be very sick. You wish that you would have asked the nurses and staff more about what to expect when you arrived in the city, but you didn't think to ask and no one offered to tell you either. Then, you arrive in the city, de-board the plane and follow everyone else to the baggage claim. You clutch the envelope in your hand with all the contact information that you need for your stay; the transportation number, the referral unit in Winnipeg. Again you experience the same fear when you realize that you didn't ask for a number for your doctor, if anything should go wrong.

Your partner is hoping to travel into Winnipeg by winter road and you worry about him because the road is not yet officially opened.

You arrive at the boarding home and are greeted by a smiling administrative assistant who gives you directions to your room. Your room is up two flights of stairs; you grab your two bags and prepare to make what seems like a mammoth climb up Mount Everest. The only stairs you had climbed were the front steps to your parents three bedroom house that you shared with twelve other family members.

You arrive in your room, place your bags on the floor and the wait begins. At least you think to yourself, "I have an appointment for a 'fetal assessment', maybe I will be told that I will have the baby very soon". You don't think that you can wait the four or five weeks for the baby to be born. No one comes to visit you, because no one can afford the flight out of the community to be with you. You wait for three long weeks in the boarding home in the city, you make the occasional phone call home at scheduled times, have your baby and return to the community with your new baby three and a half weeks later. Then, and only then is your baby welcomed into your family.

The Prenatal System of Support

This above scenario is typical and described by one participant in this study. The fear, isolation and anxiety that we heard is very real for many of the First Nations women who gave birth outside of their community. While they are away they stay in various settings – either in private accommodations with family or friends or boarding homes. These women who leave their community often leave with little notion of what to expect (Eni, 2006) or they are inadequately prepared (Watson, Johnson, Kemp & May, 2002).

First Nations women from northern regions leave behind their families, friends, peers, educators, elders, community health care providers and any other supports that they may have had. According the Regional Health Survey 60 percent of First Nation adults reported that they depended on an immediate family member or friend for support, and another 44.7 percent reported they depended on another family member. Also, 23.5 percent reported seeking out the help of a family doctor and 15 percent of a traditional healer. Interestingly a decreasing dependency relationship existed on specialized professional health service providers for support (Elias, 2005). Dr. Marten's (2002) study in Sagkeeng, Manitoba found that women having two or more breastfeeding problems were 7.6 times more likely to wean compared to women reporting (0) or (1) problems. Numerous other studies have shown that breastfeeding has a protective effect against obesity, diabetes, respiratory disorders and a number of other chronic illnesses. (Young, et al, 2002, Gillman et.al, 2001, Hanson, 2001, Hediger, Overpeck, Kuczmarski & Ruan 2001, Ip et. al, 2007). Given that First Nation women sometimes do not return immediately to their home communities, there is concern that these women are lost in the system in the first few critical days after delivery to assess whether they are experiencing any breastfeeding difficulties (Maternal and Child Healthcare Task Force, 2008).

The Community

Berens River, Manitoba - the community in which this study took place - is an Ojibway speaking isolated community located approximately 350 km north of Winnipeg on the eastern shore of Lake Winnipeg. The community is only accessible by air during most of the year, with two airlines providing scheduled service into the community. A winter road is constructed on the frozen terrain during the coldest weeks of the year and

provides access to Winnipeg for a very short period of time. Travelling time to Winnipeg during those weeks can vary from five to six hours and is not recommended for pregnant women, elderly or those in poor health. Currently, primary health care, including prenatal care is provided by Community Health Nurses employed by the Berens River First Nation. Prenatal women may also be seen by a visiting physician usually once within the first trimester at the initial visit, but may be seen more often depending on the physicians availability in the community and based on the prenatal woman's perceived "risk" status.

Prenatal care for women in Berens River consists of coming to the Nursing Station on Tuesday mornings (Prenatal clinic) and having their weight, blood pressure, random blood sugar, hemoglobin and urine crudely checked for glucose, protein, blood and white blood cells by urine dip stick. The Community Health Nurses function in the capacity of a nurse practitioner, a registered nurse working in an expanded role. The prenatal women check in at the front reception, take a seat and wait for their name to be called. Generally, the wait is not that long and can range anywhere from a few minutes to 30 minutes. This morning is known in the community as "prenatal clinic" and those presenting to the clinic are asked to return at another time if the matter is not urgent. However, any medical condition that requires immediate attention is a priority and is seen before regular prenatal clients. The Canada Prenatal Nutrition Program (CPNP) worker will often have a nutritious meal or snacks prepared and the prenatal women will wait before being called in the large community kitchen that is accessible from the front waiting area. The CPNP worker is a lay community member who has received additional training in pregnancy, breastfeeding and nutrition (in other communities the CPNP worker may be a registered nurse). The CPNP worker will often take the opportunity to do some education on various topics that pertain to a healthy pregnancy or promoting

breastfeeding. They will offer some incentives to the prenatal women to attend the educational sessions while they are present for their prenatal appointment on Tuesday mornings at the Nursing Station.

Generally, the prenatal women will first be seen by the Community Health Representative (CHR) or Licensed Practical Nurse (LPN) who works along with the Registered Nurses during prenatal clinic. One CHR has been identified in the community as the lead in coordinating the prenatal appointments and keeping track of the appropriate charts and forms that are needed. This "Assistant", the LPN or CHR, takes their preliminary weight, and checks the blood glucose and hemoglobin (oxygen in red blood cells – screening for anemia) by finger blood droplet. The "Assistant" will also check the urine or ask that she bring the urine into the clinic room for the nurse to check. Once the prenatal woman has had this preliminary assessment, she either is seen immediately by the registered nurse or if the clinic rooms are full, she may go back to the community kitchen or waiting room. Often the women will bring their children with them and they can be heard playing in the waiting area, or allowed to accompany mom to the clinic area to be seen. The prenatal women will chat with the LPN's or CHR's in Ojibway and laughter can often be heard as their weights or blood is checked. Often this exchange is educational, but is not reflected in the documentation of the visit, and the nursing assessment is restricted to the physical assessment of both mom and baby.

Lastly, the prenatal woman is called into the clinic room to see the nurse. The nurse evaluates the values for the weight, sugar, hemoglobin and urine that are recorded in the chart. Anything out of the ordinary is either addressed immediately or discussed with the prenatal women during or after the physical assessment. The nurse is also responsible for checking the prenatal women's blood pressure, fetal heart rate, fundal

height and fundal presentation, if the prenatal women are beyond a certain amount of weeks in gestation. The women's abdomen is also palpated to determine the "lie" or presentation of the baby during the latter part of the second and third trimester. Any abnormal finding, whether it occurs in the prenatal women or baby, is reported to the physician. If no doctor is present in the community, a consultation is made by way of a phone call to the physician "on call" with the Northern Medical Unit (NMU). Referrals to secondary care outside the community are made by the physician who had been consulted but can also be made by the nurse caring for the women.

Often, teaching on a one-to-one basis is done during these visits and the focus depending on the questions that arise from the prenatal women or from any finding that may be slightly out of the ordinary. Based on personal experience, these teaching sessions often address only the physical or biomedical issues that arise from the visit (any abnormal value such as anemia, a slightly elevated blood pressure, fetal growth), but may occasionally focus on nutrition, smoking or some personal or relationship issues. If all is well in the visit, the prenatal woman is asked to return at a later date, determined by the number of weeks she is in her pregnancy, and based on the FNIH practice guidelines[3]. The recommended schedule is one initial visit in the 1st trimester; monthly visits until 28 weeks; every two weeks until 36 weeks and weekly thereafter until she leaves the community at 36 to 38 weeks. This schedule amounts to 14 visits if it is actually followed, and for those that do not experience any difficulties they may only see a physician once until they are sent out of the community. The evacuation policy in Berens River is generally referred to as the "confinement policy" and the terminology used to describe the women leaving the community is "out for confinement", or "OFC" for short. The OFC date is determined as 38 weeks gestation for low risk females, using the date

confirmed by ultrasound and 36 weeks or sooner based on her risk score (based on personal experience, confirmed by community practitioners). The Prenatal women are sent out for an ultrasound, usually to confirm gestational dates, at or around the 20th week, but can also be referred to for other reasons. Interestingly, ultrasound technology has not shown to have any significant difference in improving outcomes in pregnancy (Dowswell & Hewison, 1994). It is also recommended that the prenatal woman be seen by a physician once during the first trimester for a complete initial assessment, and at least once per trimester thereafter, but she may see the physician at other times during the course of her prenatal care, depending on whether a physician is available on a regular basis in the community.

All prenatal women are evacuated from Berens River at 36 weeks, although the First Nation and Inuit Health Clinical Practice Guidelines for Primary Care Nurses policy indicates that arrangement for transfer should occur at 36-38 weeks or sooner if a high-risk pregnancy. Interestingly, the Clinical Practice Guidelines do not define what constitutes a high risk pregnancy. The Manitoba Prenatal Record[2], endorsed by the College of Physicians & Surgeons of Manitoba has a specific box for assessing "Risk Factors" that include Past Obstetrical History, Associated Conditions such as diabetes, and cardiac disease, Lifestyle/Social Issues and Present Pregnancy factors. A very good working relationship has been established with one Obstetrician in Winnipeg and the nurses are able to call him directly. Occasionally, the NMU physician is consulted and he/she in turn makes the necessary referral to the OBS physician. Obstetrical emergencies and women in early labor are sent out if the risk of delivering on route is low. According to a local CHR, about 15 babies have been delivered in the "new nursing station" which is now 9 years old. One baby was delivered the very day after I had left the community

during one research trip into the community, and another baby was delivered in the ambulance just after de-boarding the plane while I was working as a Community Health Nurse. I had actually provided maternity care to the young woman as she came into the clinic in the early morning on my shift. I arranged for transportation to Winnipeg and travelled with the medevac nurse to transport the prenatal woman to Winnipeg. The time it took to transfer the woman over to the ambulance attendants in Winnipeg from the time she arrived at the nursing station was 6 hours. We experienced several delays, and adjusted "ETA's" (estimated time of arrival) by the medevac company due to foggy weather. This young mom was 16 years old and had returned to the community after being sent out of the community four days earlier.

Visiting physician services are provided by the Northern Medical Unit of the University of Manitoba. A variety of other health and social programs are offered in the community through transfer agreements with the federal government. New programs to address prenatal health are available in the community such as the Canada Prenatal Nutrition Program, but little integration and coordination of services occurs between the primary care and health promotion programs. The on-reserve population is approximately 1,743 and there are 40 to 50 births per year. All prenatal women leave the community to give birth in the city of Winnipeg, 45 minutes away by air. In the best of conditions, it takes approximately four to five hours to get a seriously ill patient from the community to the hospital for emergency care. Sometimes when the weather is bad, it can be 48 hours or even longer (personal experience). The women carry information with them which included their prenatal record, results of specimen tests and exams and a *blue card* that contained the number for the *Referral Unit* in Winnipeg. This card contained information specific to transportation services only - some basic guidelines of when they were to be

ready for pick up and some reminders about what to take with you to appointments (papers, medications) and to "follow all medical instructions" prior to appointments.[6]

The Geographical / Social / Economic Environments

There are 64 First Nations in Manitoba. Of these, 24 are considered isolated or semi-isolated, 19 of the 24 are accessible only by air for the major part of the year, or by seasonal winter road. Another 19 communities are more than 200 km from a tertiary centre. A search of the literature did not find any documentation in regard to referral patterns for birthing and the exact number of evacuations that took place for birth. An inquiry placed to FNIH requesting the number evacuations specific for birth was not responded to. I suspect that these numbers are not adequately tracked. Berens River has a local band administration with an elected Chief for a term of three years. The present Chief and Council have been in place for two years. Most families derive their income from social assistance. Limited employment is available through local retail businesses or work in the nursing station, school, housing construction, road maintenance, logging, tourism and the fishing industry. Commercial fishing on Lake Winnipeg still contributes significantly to the local economy as well. The community has a large school operated by the Frontier School Division and offers education through to grade 9, upon which time the children leave the community to Winnipeg for High School.

First Nations Health Care System

The delivery of primary health care services to First Nations people has a long and complicated history in Canada that predates universal health care coverage. It is a topic far too complicated to examine and is beyond the scope of this study. However, it is

important to understand that the evolution of primary health care has lead to a dual health care delivery system in Canada, one for mainstream and the other for First Nations living on reserve. This is a significant factor in understanding how gaps in health services may have occurred for First Nations in Canada. The FNIHB is responsible for health services in First Nation communities, while constitutionally the provincial government has responsibility for any other citizen in their respective provinces (Waldram, Herring & Young, 2006). Health Canada has also taken responsibility as a matter of "policy" for some non-insured health benefits, such as dental, pharmacy and vision to First Nation residents regardless of whether they live on or off reserve while First Nations maintain that Health and Health Care is an inherent "treaty right"[9]. Some unique arrangements in service delivery have occurred in some provinces and territories, but for the most part, the provision of public and primary health care is either delivered directly by First Nation and Inuit Health or through transfer agreements with tribal councils or individual First Nation communities. First Nations have spoken of the lack of funding and limited support for community based programs and services for First Nations living on reserve and/or to the fact that the health needs of Aboriginal people are not met by all levels of government (AMC, 1997, AFN, 2008). This has also been brought to light in the academic literature as well; studies have often criticized the health transfer arrangements between the government and communities as an attempt to off-load federal responsibilities for health care that are often transferred and taken over by First Nation organizations, underfunded and without adequate support (Smith, 2003; O'Neil, Lemchuk-Favel, Allard & Postle, 1999).

Generally, community-based programs such as the Canadian Prenatal Nutrition Program (CPNP) Fetal Alcohol Spectrum Disorder (FASD), Maternal Child Health

(MCH) and Brighter Futures are delivered and funded through contribution agreements with tribal councils and/or First Nation communities, but are not available universally in all communities, with the exception of the CPNP program. Programs such as Maternal Child Health and the Fetal Alcohol Spectrum Disorder program are proposal driven processes and communities must compete for resources. Overall, health services to the 600 plus First Nation communities across the country are primarily delivered through nursing stations, health centers or offices and for the more remotely located, are delivered by Registered Nurses who work in an expanded role with limited diagnostic, treatment and prescribing functionality. In Manitoba, First Nations people living off-reserve generally access health services as any other citizen of the province, through the provincial health system and the Regional Health Authorities. The prenatal women who leave the community to give birth could potentially access some support and services that are available in the regional health authority, but there is a general lack of communication between the sending and receiving communities, or general lack of knowledge of support available to them (Manitoba Maternal and Child Healthcare Task Force, 2008). Once the prenatal woman has delivered, a Post-Partum Referral is sent from Regional Health Authorities (Winnipeg Regional Health Authority in this study) back to the Nursing station, as they do to the appropriate public health office for any woman who delivers in Manitoba. In my experience, women may have returned home days, sometimes weeks, before the referral actually reaches the awareness of public health nurse or office. Still this centralized system of notifying public health offices regardless of jurisdiction offers some possibility of improving or completing the communication loop between sending and receiving communities or regional health authority. Although First Nations communities reside within regional health authorities, little if any provincial

programming is offered to residents living on-reserve, with the exception of the Provincial Prenatal Benefit Program[2].

Manitoba Health also directly pays physicians' services that are "medically required" and accessed outside of the community. Patients who are billed for insured services by physicians who practice outside the plan are entitled to reimbursement from Manitoba Health also for physicians' services, surgery / anesthesia and X-ray and laboratory services in approved facilities when ordered by a physician[5]. Of recent, the Public Health Agency added another layer of complexity to the "mish mash" of programs and services. Armed with the responsibility of disease control, prevention, surveillance, and emergency preparedness their precise role in "Aboriginal Health" and relationship with Health Canada's First Nation and Inuit Health Branch has not been clearly defined (Waldram, Herring & Young, 2006). There is no simple method of explaining the organization of financing of the health care system for First Nations, but generally for those residents living on-reserve, federal funded services are available and for those living off reserve, they are potentially able to access provincially funded services. Let us not make any assumptions that services are equitable in both systems, otherwise a paper of this topic would not be necessary. It must be clearly pointed out that health care services that are available on reserve do not mirror the services of those that are available off reserve; huge disparity and inequity still exists as indicated in the Assembly of First Nations 10 Year Report Card on the Royal Commission on Aboriginal Peoples (Assembly of First Nations, 2009)

First Nations and Inuit Health Evacuation Policy

Barclay, Andre & Glover (1989) wrote of child birth services among Aboriginal women in Australia: “there is an exchange occurring which has allowed professional penetration and control of an essentially social and emotional event. Professionalism can be seen as having ‘split’ birth from its family of origin” (p. 123). While this is also the case for maternal and child birthing in Canada, this “penetration” is even more marked for First Nations women living in isolated and remote regions of this country. Dawn Smith (2003) wrote that this disruption in care imposed by relocation to a southern center compromised the effectiveness of relevant community services and fails to address the root causes of poor health experienced by Aboriginal women and families as well as seriously compromising the efforts of Aboriginal people to achieve vitality in their family and communities.

Patricia Jasen (1997) traced the history of childbirth for First Nation women from the standpoint of race, culture and colonization, factors that are not examined any great detail in the study. Her paper is relevant however, because it lends context to some of the policies that eventually lead to the practice of evacuating all pregnant women at the end of their pregnancy today.

> By the early twentieth century, the medicalization of childbirth in Canada, as elsewhere in the industrialized world, was well underway. As authorities became preoccupied with alleviating infant mortality and as overall health among aboriginal people deteriorated, an assimilationist policy was directed towards bringing childbirth among these women under direct government control. Subjected, simultaneously to ideologies of both gender and race, aboriginal people underwent a particularly stark transformation in their reproductive lives (p 400).

Chamberlain & Barclay (2000) found three main categories of stressors for those women that left the community: (1) emotional stressors such as forced separation from

family, culture and community, (2) physical stressors such as difficulty obtaining assistance and lack of awareness of whom to contact for assistance, and 3) economic stressors for babysitting or to bring the partner along. In addition, they voiced concerns in regard to lack of choice in decisions around the birth of the baby, lack of support from family and the health care system, inadequate preparation or lack of information on what to expect when they arrived in the urban centre (Smith, 2003). The effect that these emotional, mental and physical stressors have on the unborn baby and evacuated women is a topic that has not been well explored in the literature, although stress itself during pregnancy has been associated with preterm birth (Ruiz, Fullerton, Brown & Dudley, 2002). More studies are required to assess the relationship of perceived stress with other maternal and infant complications in the context of the First Nation women, but common sense tells us that "uncertainty" can potentially compound the stress already experienced by the young prenatal woman having her first baby, as illustrated in our hypothetical example.

The negative effect that poverty and social economic status (SES) has on the adequacy of prenatal care has been demonstrated in the literature (Heaman, Gupton & Moffit, 2005), and women living in poorer neighborhoods have been shown to be more vulnerable to adverse pregnancy and birth outcomes (Zhong-Cheng, Wilkins & Kramer, 2006, Mustard & Roos, 1994). It is also well known that the majority of First Nation families living on reserve live in poverty; 23.6 percent of respondents reporting in the 2002/2003 Manitoba RHS an average household income less than $14,999/year, another 18.2 percent households reporting an income below $30,000/year and total of 60 percent households reported that they did not have gainful employment at the time of the survey (Elias, 2005).

Moving birthing services closer to home and practice of midwifery has been established in the far north in response to national policies of removing women from their communities to give birth (Couchie & Sanderson, 2007, Kaufert & ONeil, 1990, ONeil & Gilbert, 1990). The midwifery services and birthing centers have shown to be safe, and successful in keeping the family involved in the birth event (Houde, Qinuajuak & Eppo, 2003). Although a resurgence of midwifery is now underway through the legislation of midwifery in most Canadian provinces and midwifery educational programs, it may be a very long time for the province to provide adequate coverage of midwives. Even if moving birthing services closer to home may be realized sometime in the future, there will always be a need for some prenatal women to leave their community to give birth. Some communities may be too small or remote to have viable midwifery services in the near future; and there will always be those women who require more intensive medical care. The question remains then: "what can be done to improve childbirth experience and maternal care for women in *the meantime* and for those prenatal women who will always have a need to deliver near a tertiary care facility?" It is worth reiterating that this study is not at all meant to undermine efforts to move birthing close to home, it is entirely supportive of policy efforts to do so. It simply is seeking interim and short term solutions that may have some immediate impact for the women that are affected by the evacuation policy. The following chapter describes the study design and methods chosen to examine the experiences of women in Berens River, considering all the factors and environments outlined in this chapter.

Chapter Two: Study Design, Methods and Analysis

Study Design

The research centered on the experiences and interests of First Nation women, their families, and friends or significant others from the remote isolated community in Manitoba, utilizing multiple qualitative methods with what I have ascertained is partially rooted in institutional ethnographical inquiry; and framed within an ecological perspective that allowed for essentially three things:

1) Starting with a First Nation woman and family perspective, ground the real life experiences of the people who are and will be most impacted by the policies and practices of childbirth health care captured through semi structured in-depth interviews;

2) Validate their opinions, concerns and experience with the voice and input of their families, friends or significant others who have been impacted by current policies or who may be impacted by any change in the future through a community based focus groups and sharing circles;

3) Incorporate the researcher's position and emersion within the health care system both as observer and participant, and utilize this experience and knowledge of policies and practice to frame the inquiry; and explore whether the women have access to the goods, services, supports and resources they need to achieve a certain quality of life.

Mykhalovski and McCoy (2002) describe Institutional Ethnography (IE) as being rooted in feminist inquiry and particularly useful in exploring institutional process, but with one crucial difference: it does not empirically focus on 'experience' or 'culture' but instead, addresses the "processes" of social organization. Institutional ethnography is primarily concerned with exploring and describing the various social and institutional

forces that shape, limit and otherwise organize people's actual, everyday worlds. They continue:

> *[A]n important feature of IE is its critique of ruling processes that objectify people's lives. IE takes issue with standard sociologies that obscure the ground of experiencing subjects, instead of formulating a way of thinking about the social that preserves the particularities of people's lived worlds and their embeddedness in social relations. IE inquiry does not begin in the categories of formal sociological discourse. It begins with the actualities of people's daily lives and seeks to explore how those actualities are brought into being through coordinated sequences of activity (pp.19).*

Institutional ethnography, as described by Mykholovski & McCoy (2002) is a method of inquiry that investigates 'what actually happens' in the realm of practices and relations through which societies and people are governed. As such, it connects with social movements as a practical knowledge, one that can be used to understand how people's daily lives and troubles are organized both socially and institutionally. In the case of this study, the "process" being explored is the medical evacuation for childbirth policy and the connection to the practical knowledge is to that of my own - and my duel position as a practicing community health nurse in Berens River and as Co-manager and Coordinator of the federal Maternal and Child Health Program in Manitoba.

Institutional ethnography, much like other ethnographic approaches generally utilizes three distinct methods: interviewing, observation, and review of relevant documents or texts as data. Institutional ethnography departs from other ethnographic approaches by treating the data not as the topic or object of interest, but as "entry" into the social relations of the setting (Campbell, 1998). Like Campbell argued in *Institutional Ethnography and Experience as Data*, this study supports her claim about the validity of people's experience as data; and as a solid methodological technique to "make sense" of people's experience to which we can then draw broader implications from the methodical

analysis of this local experience. I have taken this one step further in that I also drew upon my own experience to augment the analysis and examination of the issue.

Data Collection Methods

This study therefore incorporated multiple data collection methods that allowed for a rich understanding of a complexity of these factors; personal, social, institutional and organization that are all related to the childbirth experience of the First Nation woman leaving home to deliver her baby – interviews and focus groups, participant / experiential observation and examination of textual and relevant documentation.

Marianne Hill (2007), wrote of the "the expansion of capability opportunities is an underlying objective of the capability approach … related goals such as righting basic social inequities or correcting ecological imbalances require changes in social institutions and practices. Such change in turn rests on the creation and spread of liberating knowledge and practices" (p 259). In this case the "liberating knowledge" will be that shared by the First Nation women themselves, and those most connected to the environments in their world that have the potential to influence the policies and practices that affect them. Higgenbottom (2004) further explained that study samples in qualitative research are not necessarily static or shaped by the original conceptualizations in the research design nor is it dictated by the need to establish generalizability.

The study therefore began with interviewing First Nation women who have experienced birthing away from home, combined with a focus group consisting of women selected from those interviewed and either a family member, significant other or someone whom they have chosen as being a major support in their lives. I have combined these two methods with an element of participant observation, both as observer and health care

practitioner incorporating both on my knowledge and experience of being both a product of a similar environment and as health care provider in both provincial and federal health care systems. Relevant policies, texts and documents were reviewed and referenced as well.

Purposeful sampling techniques were used for the interviews to gain an in-depth understanding of the impact of institutionalized policies and practices from the women who have had previous and recent experience giving birth away from home. Every attempt was made to choose women who had experienced more than one birth away from home and those that had only one, as well as women who delivered at various periods of time so as to capture historical or new experiences in child birth. For example, a woman who had given birth in the past year may have had a different experience then when she delivered a baby more than a decade ago. The Community Health Representatives (CHR) and Community Health Nurses (CHN's) assisted in sharing information in the beginning about the research and referred them to me if they wanted more information. This was agreed as part of the original protocol, as the health care providers were the individuals most connected with the community.

Fourteen (14) women and one couple shared their stories and experiences of leaving home to give birth in semi-structured conversations and another fifteen (15) women participated in two sharing circles held four weeks after the initial interviews in Berens River, Manitoba. All data collection occurred over a six week period during the summer of 2009. A total of seven women consisting mostly of individuals who had come to the clinic for prenatal care participated in the first sharing circle. This group was purposely planned to correspond to prenatal day at the Chief Jacob Berens Nursing Station and jointly coordinated by the Canada Prenatal Nutrition Program (CPNP)

worker, who graciously organized a nutritious lunch for the participants. The second discussion group occurred one week later and had a total of eight participants. It was open to family members and anyone who was interested in hearing a brief overview of the preliminary findings of the interviews. This group therefore consisted of female staff of the health centre who experienced leaving home to give birth and members of Berens River. Participating in this group was the Health Director, two nurses and three individuals working in community programs. All interviews and sharing circles took place at the Health Centre. The interviews were conducted in the room identified for family counseling - a room beautifully decorated in calming colors of pale blue and green and adorned in traditional Ojibway ornament and paintings. It had a plush round carpet custom made in traditional Ojibway design that filled the room and a circle of chairs set to accommodate up to 20 people or more. Out of necessity, four of the interviews took place in an empty office adjacent to the family counseling room

The Chief Jacob Berens Health Centre is located along the Berens River and in the centre of the community. It consists of two wings: one identified for Primary Care and the other for community wellness programs such as CPNP and Brighter Futures. The CPNP and Brighter Futures workers volunteered to assist in organizing the focus groups and interviews. It is they who recommended the Health Centre be used for the hub of the research activity due to its central location ability to access the medical transportation services. They were also primarily responsible for planning the research to correspond to days when the women would be coming into the centre to access prenatal care.

Semi-Structured Interviews.

Two initial interviews were conducted jointly by me and Melanie Hegg, a research student that obtained a Network Environment for Aboriginal Health Research (NEAHR) grant to work with Dr. Rachel Eni at the Faculty of Human Ecology and on the Maternal Child Health evaluation. Melanie's research was to complement the work that was taking place in Berens River, but with a focus on the experiences of women from a community that did not evacuate women to give birth. Her research was meant to provide some comparison in a community where all "lower and moderately risk prenatal" women remained at home until delivery. Melanie and I travelled to Berens River together; we I set out at 5:30 AM on a crisp cool morning from my home in St. Andrews and set off by truck to Pine Dock and clambered aboard a small single engine plane at 9:00 to travel across the lake to Berens River. She and I jointly interviewed the first participant and then separated for the remaining.

Focus Groups (Sharing Circles).

The two rounds of discussions were held with a sample of the women who had participated in the first round of interviews including others identified by the women as fulfilling a supportive role in their lives. The focus groups were advertised in the community as a Sharing Circle, and took place as did the interviews in a manner that respected the culture and customs of the community. These groups had begun with an opening prayer, set in an informal atmosphere and began when enough people were gathered. The participants sat around a circular table and food was placed in the centre. All were invited to share the meal and were allowed to enter and leave the room freely. The focus groups/sharing circle followed up on some of the themes identified through the

interviews. It was also an opportunity to hear the collective voice of the community, as child birth policies and practices not only affect the individual, but their families, friends and ultimately the well-being of the community.

Participant Observation and Documentation Review.

A total of three trips were made into the community in the two months preceding the first round of interviews and focus groups. These trips were two, three and four days in duration. During these trips I worked as a community health nurse, participating in prenatal clinics, reviewing clinical practice guidelines, policy and procedures, prenatal checklists, Manitoba Prenatal record and other documentation required for the prenatal woman. During these visits, I thoroughly familiarized myself with the clinic routine, provided prenatal care, arranged prenatal appointments outside of the community and gathered information on the history of the community. Field notes and relevant copies of blank documents were taken during these exploration visits.

Analysis

At the end of each day of interviews, Melanie and I deliberated and debriefed on the interviews that had taken place during that day. The same evening, the taped interviews were transferred to the storage medium, reviewed, and some preliminary discussion between the two of us took place in regard to similarities and differences in the responses. At this point, ideas for making sense of the data already began to emerge while still in the field conducting interviews. A hand written journal was also kept of all encounters and events that had taken place from the period of time when I first contacted the community a year before to the time I boarded the plane and returned to the city when

all data collection was complete. Both the journal and the interviews were reviewed within days following the interviews and the questions on the interview guide were cross referenced for completeness. Some notes were recorded in the journal, either about questions that may had been overlooked during the interview or answers that I thought were particularly provoking. Preliminary data analysis began early in the study from this perspective, even before the interviews were transcribed.

Interviews and group discussions were audio recorded using a digital recording devise (WAV) and converted to MP3 Format using Goldwave software. From the transcribed interviews, I created notes on power point slides of answers to the numbered questions (similar to using index cards) that were later categorized and given a temporary "label" to describe the emerging themes. I was acutely aware that data collection was not yet complete and did not want these initial interpretations to overly influence the analytical processes that had yet to be determined, and I felt compelled to keep the data fresh in my mind. Fortunately, as the interviews were transcribed verbatim during the course of the next four weeks, these initial categories or labels were proving to be fairly representative. All this was necessary as the protocol developed with the community was designed to have some preliminary synthesis of the data provided to the community as a lead into the focus groups discussions in the second round of data collection.

The information provided to the focus groups was therefore introduced as "preliminary", but useful in beginning to open up the discussion. It was observed that when the presentation of the preliminary data was being made, that many nodded their heads in agreement and a few comments made to the effect that "yeah that's right", "exactly" and "wow that's how I felt". After the initial round of interviews, portions of the interviews were reviewed with one of the thesis advisors and the six members of

maternal child health evaluation team. We therefore had an opportunity to share thoughts about the experience and give the team an opportunity to ask questions. This sharing and debriefing session with the evaluation team provided another opportunity to interpret and make sense of the data, as many interesting observations were pointed out and the discussion that took place was considered prior to the second round of data collection.

All taped individual interviews and focus groups were transcribed into a Word document and cross referenced with audio recording for completeness and accuracy. All written transcriptions were read and reviewed several times until I was satisfied that I had heard every voice, variation and similarity without attributing any particular meaning. Once I was certain that I had completely listened to all the raw data of each individual and individuals within the focus groups, I began a process of organizing the responses to each of the questions. This was not a simple task, as the conversations sometimes were allowed to flow and the data had to be sorted and sifted through to locate various bits of data and attached to individual questions. Each response to individual questions were then compiled and categorized according to answers to the numbered questions and bits of information that did not fit any of the questions was moved to a “parking lot” to be analyzed independently from the questions.

Each individual question or subset of questions were then reviewed independently of each other and responses to the questions cut and pasted into separate and distinct Word documents organized by the numbered questions/subset of questions. Once the cutting, pasting and synthesis from all the interviews were compiled, each document was reviewed. Portions of text that somehow did not fit, or fit better with another question, but were part of the normal flow of the conversation, was highlighted and color coded according to the question that it was most pertinent to. This method seemed to make more

sense because sometimes during the course of answering one question, the answer to another occurred and then flowed back on track again with the original question. It is with this in mind that I decided to completely manually analyze the data; as opposed to the computer assisted program as I soon recognized that may have been some overlooking of many of the marginal or “parking lot” discussions that may have been missed by the computer program.

Once the individual questions were organized, I again reviewed the document for themes and categories. Without labeling as I had done in the preliminary analysis I took similar responses and assembled them in a column under a unique symbol using the standard symbols found in Word. Once I had completely sorted through the data and organized the responses under these symbols, I assigned each response an alpha and beta character to keep each response completely organized and could be easily retraced to interviewee. Once all the responses were organized in this column I then examined each individual category and attached a descriptive name that I thought fit each column. I then began a process of underlining and placing a form of notation beside those responses that I thought would be useful to highlight this particular point in the discussion of the findings section.

I completed a similar process for organizing the data in terms of the amount and level of effort required to implement the raw recommendations that were flowing freely from the interviews and focus groups. I organized these raw recommendations in regard to: a) those required at the community level b) those required outside the community at the pre-hospital setting, c) those required at intrapartum in the hospital setting, and then d) at the postpartum stage. I then compiled a matrix using my own experience within the health care system of each recommendation in regard to the level of effort and with what

level of the system that it fell within. These raw recommendations were much easier to work with, as the women themselves posed many solutions, which was paramount to this research. I then used these columns and matrixes to begin an outline of the major points of the findings of the research project. Each of these points can be found in the next chapter.

Themes identified by both the interviews and focus groups were brought forward, compared and cross referenced for similar themes and topics to ensure that the findings reflect accurately and represent the truth and authenticity of themes that are uncovered. The strongest convergence design required the separation and independence of one method from the other and performing a linking and comparing and assessing the degree of convergence (Green, 2007). In an effort to reduce researcher biases as well the transcribed text in both methods were analyzed until no new themes emerged.

Ethical Considerations

The physical, emotional and mental well-being of the participants was considered as some physical, emotional and mental discomfort was experienced by the participants. Every effort was made to minimize the physical discomfort of participants by conducting the interviews in the comfortable counseling room that had comfortable seating. A traditional elder was on standby but was not requested by any of the participants to provide for the emotional needs. All research participants were reassured of the confidential nature of their participation and interviews conducted in a secure location that respected their privacy.

Individual informed consent was obtained from all research participants as per the standards of the University of Manitoba Health Research Ethics Board as well as the

Canadian Institutes for Health Research (CIHR) *Guidelines for Health Research Involving Aboriginal People* in regard to community consent (CIHR, 2007). Written support for the research was obtained from the Health Director of the community and information sharing meeting with community leaders, the health director and acting nurse in charge. In keeping with the CIHR recommendations as well, the Manitoba First Nations Health Information Research Committee (HIRC) was consulted and indicated that community approval supersedes the HIRC process (personal communication with Dr. Avery-Kinew, 2008).

As part of the community protocol, I will also provide the community with a written summary of the research as well as another community presentation to provide them with an opportunity to validate results and obtain community approval prior to sharing results in any public forum.

Study Limitations

The study was limited by the fact that only one community was involved in the research project; and the findings cannot be assumed to be true of all First Nation experiences and expectations in Canada, nor can it be assumed to be true of all women in this community. The general referral pattern for women leaving the community to give birth is for the women to leave by air to the city of Winnipeg and other referral patterns exist in the province. The data may also be limited by the fact that the researcher is not from the community and is an "outsider" to a certain extent, although I am a member of a First Nation of the same cultural group and has already established a long term working relationship with the community. On the other hand, this may prove to be useful to the researcher, given that there is already an established professional relationship with the

community working as a relief community health nurse in this community since 2005. There is also a need to acknowledge that my present position in the health care system as both a practicing Community Health Nurse in Berens River and as Nurse Program and Practice Advisor with the Assembly of Manitoba Chiefs Strengthening Families Maternal Child Health Program are positions of power and influence. However, every attempt was made to separate the roles and position myself as researcher during the interview and focus groups data collection trips and create a safe and ethical space for the women to share freely their thoughts and ideas without fear of repercussion or reprisal. The role of researcher was clarified at each visit to the community for the interview and focus group trips, at which time I did not function as a nurse. This was also clarified at the beginning of each interview with each interview participant.

Chapter Three: Findings

Finding their Voice

This section will attempt to bring together the collective voice of the women from Berens River accurately and respectfully, without adding too much narrative which sometimes can further overpower and drown the voice of the unheard. The women living in Berens River (and one couple), had a lot to say about their child birth experience. That was the very premise in which this study was built. “Give them an opportunity and they will speak. They will come up with their own and the best solutions” I had said to one of my most trusted confidants, advisors and respected colleagues, Dr. Rachel Eni in explaining my choice in doing this study. And that they did. Many who had not formally participated in the interviews but were involved in organizing, assisting, working or leading in the community had also contributed as well. All contributors, both directly and indirectly expressed that ‘it was about time’ that someone gave them an opportunity to have their voices heard and that is such a critical issue that required some fundamental change. I found some overall general groupings of themes that I could organize under two categories that I have labeled: Suffering, and Hope. Under each of these headings, I have organized further subthemes that emerged. Some of the subthemes fit more than in one of the categories, but I have listed them under the one that I thought most appropriate. The following will therefore highlight some of the major sub-themes under each of these categories.

Suffering

The women of Berens River spoke very clearly about the experience of birthing away from home and how this experience impacted them both emotionally and

physically as well having a negative impact on those most closely connected to them in their immediate environment. There was overwhelming agreement among those that left the community and their system of support behind that the experience was marred by negative emotions and symptoms as well as a great deal of internal suffering described in terms of loneliness and tears. They also described embodied physical suffering and three other areas in their immediate environments that were impacted. I have organized all broadly as the emotional impact, and the impact on the body, family, and finances. Each of these will be addressed in turn.

Emotional Impact.

Overall, the women from Berens River described their child birth experiences of being evacuated for birth, in terms of how they were impacted emotionally. Most women shared that the experience was not a positive one, although for the most part, the physical outcomes for both mom and babies were good. They expressed emotions of a negative nature such as being scared, lonely, worried, angry and sad and many of these manifested in outright expression of lamentation "I used to like cry at nights, cause I was so lonely. Like, there was no one; cause when you're pregnant you have like, um, emotions, like sad emotions, and you know you need somebody there to comfort you, when you're in that situation" (I-1). Another stated: "I was really lonely, like seriously, I was lonely, I was like crying. Yeah like that's another thing too - I was like crying a lot *after* I had the baby, 'cause no one was there" (I-3). These statements were also reflective of women who expressed these emotions as confounding the already volatile nature of emotions intrinsically associated with pregnancy, "I was very lonesome and during the last weeks of pregnancy all these hormones are quite high and it was like, the most awful thing you

could go through" (FG2). Some women described a sudden realization of these emotions once they had left the community "I didn't really actually start feeling about it until I was sitting in Winnipeg for like, for a few days. When I was away from home and I finally realized like, who is going to be there for me?" (I-1).

The experience was often described differently for those who were able to take a supportive person along with them, or had someone available in the city to support them while they were from home. The most common descriptor was not a true emotion in the popular understanding of the term, but more generally expressed as a sense of relief "If I didn't have this friend, I probably would have went about it alone. Ahum, not really having anyone there is a big thing" (I-7). One woman explained that she really wanted one of her three sisters to accompany her, but for different reasons all three could not accompany her. She expressed sheer relief that her grandmother had made the trip to be with her, but was not able to stay after the delivery of the baby:

> *And then my Granny came. YEAH! But then she told me she was leaving ……and she told me she was coming back out here. (Berens River) I was like 'nooooooooo, stay with me until I get out of the hospital' and she couldn't stay, she just had to go, and I just stayed there for four nights. I was so lonely (I-8).*

One of the participants described themselves as "fortunate" in having a midwife while they were in the city. She shared a different experience. Their stories were portrayed more positively. When asked about her experience of having a midwife she explained "I think I met her in 96 and I didn't really talk, I just listened, but it turned out that she became one of my best friends" (FG#2). More discussion about the experiences and support of a midwife will follow. Other overwhelming sentiments, in addition to feeling lonely or sad were that of extreme boredom and of nothing to do while waiting; "I was just kind of sitting there"; and, "waiting, just waiting" (C-1). This boredom was

sometimes compounded by self-diagnosed depression; “and I started to feel depressed, and there wasn’t like support with my family, so then I started, I think that’s why I kind of like, got get sick from it – from waiting too long” (I-1). Some directly expressed feeling stressed “It was a stressful time” (I-10) and of feeling upset “it’s ah upsetting” (C-1).

The Effect on the Body.

The women often told stories of how the separation from their families impacted them physically and associated this with ill health; “when I initially went, I went by myself. In the first week I couldn’t eat, I couldn’t sleep” and “my weight, I lost a quite bit of weight, in just that one week. Because we are very close, we do everything together; we read, play and do everything together. It was really traumatic for me”. She further added that that the family eventually joined her, due to this reaction she was having. She stated “them being there, my blood pressure went normal and everything stabilized, just because they were there” (FG2). Others also described the experience as “sickening” and attributed the negative emotions - loneliness, fear, worry and anger as manifesting in physical symptoms, loss of appetite and potentially harming their babies:

> *I must have hurted, like hurted my baby, because of my loneliness, and I didn’t want to eat. Like I ate at times, but everybody must know how it feels when you are lonely for somebody, and you don’t eat. And then I thought about it, like I shouldn’t have done that (I-10).*

The above statements are also significant in that they reveal an underlying guilt associated with responding in such a manner to the negative emotions and feelings they were experiencing and a need to alleviate the suffering simply by just being near to their families.

The Impact on the Family.

Most respondents who identified their partner as the most significant source of support during and after their pregnancies expressed anger, disappointment and frustration about not being able to take them along to share in the birth experience. They were very aware of and spoke very frankly about current policies and the system that does not allow them to take their partners or significant others with them when they left home to deliver their babies. One woman wrote: "I felt like, um, I felt like running away from there and coming home. Like, just jumping on a plane and coming home, cause I was so lonely, cause I never been away from my partner…. like that long. And then I asked if he could come and [they] said, *they didn't sponsor your partner* and I was like,….I almost came home, but in a way I was kind of afraid, you know". She shared how she experienced such an emotional hardship at being separated from her partner "and not having nobody there" that she seriously thought of "sneaking away" from the city but tried very "hard to hang in there" for reasons, she later explained, were related to the safety of both her and her child (I-6). Another woman shared how her partner was impacted by her having to leave:

> *Yeah, he was, he used to like, we used to like talk on phone and he was like… Maybe he was stressed because he was, he was lonely too, and he had to um, it was, 'cause we never been apart together – for so long; and he was getting lonely and frustrated. I don't know – it was hard for him too (I-1.)*

One woman spoke very frankly about the strain the separation put on her relationship with her husband. She stated that he was trying very hard to keep up with caring for the children, doing laundry, cooking: "I felt that he was going to leave me"(I-3)

The women who indicated that another person other than their partner were the most significant source of support during their pregnancy, also expressed similar sentiments in regard to the inability of this supportive person to be with them at the later stages of their pregnancy and at birth of their child. “I really wanted my sisters to be there, and they couldn’t be there”. When asked to speak a little more about why they could not be there she further explained “they didn’t have enough money to get on a plane. The ticket was like a hundred and eighty. And if my sister planned to come in, she would’ve had to bring her daughter and she only had enough for her [self]”. She further added in regard to who she relied on for support she replied “well my granny, [and] my sister, my other sister too – my older sister, I really wanted her to be there, and I wanted my mom. My mom was supposed to come too, but it didn’t work out” (I-2).

One of the major concerns expressed about going out to have a baby alone was the fear of being alone if something should go wrong. Some women expressed that this worry added another layer of suffering, and many asked rhetorically, “what if something should go wrong – then what?” A family member attending one of the focus discussions added “something CAN go wrong and the mothers, they are there by themselves, and if something goes wrong” and she shrugged her shoulders in resignation. She then concluded, “but if you have family there - you have someone there to support (you)” and spoke directly to the young women currently pregnant in the room (the young teenager was fortunate in that she was going to be accompanied by her mother during her confinement).

The experiences of the second and successive deliveries were often described differently than the first deliveries, and most often described in terms of the impact it had on the children they left behind. This appeared to be the most significant and disparaging

of all their concerns. They spoke of leaving their children with sheer passion, expressing fear in being separated from them, uncertain about their wellbeing, stress in finding suitable childcare, and most always concurrently - incessant worry. As one woman wrote, her stay was actually good with her first child because she had stayed with her sister. However, for her second one:

> *It was harder, because like, I had kids here. I was leaving and, like V., was kind of small, and I was having the last one. That's the hardest part there, my last one. Have to leave, like three more behind and not knowing what's going to happen 'cause' like, H. does drugs and he was drinking all the time too. Like I didn't know when he'd start. So I always have to phone home every day, or like twice a day. So, like, I was worried more.* (I-4).

Others described the effect that it had on the children that they left behind:

> *I had them crying when I phoned too, they wanted me to go home, or they wanted to come to me*" (C-1) and *Well they thought that maybe I wasn't going to come back. They thought that maybe the chances were that either me or the baby will die – those were the scariest parts for them. (FG2).*

One participant told the story of even after ensuring that the kids were in good care had left the community and was fortunate enough to bring her partner along, described what it felt like when they discovered the children had not been cared for as they expected them to. They spoke of an "incident" that occurred when they left them behind to deliver their second child:

> *We've ah, learned from this incident and tried to be more safe I guess, and try to find a more reliable house sitter. So um, I don't know, there's not much you can really do when, when you know. …when you are two hundred or three hundred kilometers away from your kids. You know you can't control the things that are going to happen to your kids….you just, just hope things will work out. (C-1).*

Another women stated: "I was worried for what kind of um treatment she was getting at home, from….like that's what I worried about the most – like how she was being treated, or if she was being fed" (I-1). One woman stated that they had no one to care for the

children they left behind and were left with no choice but to place their children in the care of Child and Family services:

> *I had to leave my, my other kids behind in the reserve. And the only person I had to leave with was my husband, 'cause I was in the city – I had to stay in the city. Anyways, he's an alcoholic, and I was always worried about my other kids and ah, I went through CFS workers in Berens River, and they had to replace my kids to CFS, like people keep them. That was a problem with me, every time, like I had a child. (I-5)*

Many of the women just simply stated that they were extremely "stressed out". Unfortunately, no studies on stress and on fetal functioning, birth outcomes or on child development could be found with a First Nation context or in the context of the evacuation policy, but it is very much needed.

The Effect on the Finances.

Those families that were able to take a supportive person along with them, either their spouses, or another significant often talked about the financial burden it had on the family. If a family member had travelled along, they described having to pay for them to travel to the city and pay for their accommodations out of their own pocket "I know, you don't have a place to stay, you need money to eat – your own money" (I-10). Some women explained that they chose not to stay in the boarding home, as they could not afford the cost to keep their partners in the boarding homes with them, and others chose to stay in a hotel where they did not have to pay extra for their partner or family members. Most complained that they were unable to bring these partners or significant others with them when they left the community, due to the decision that, 'they' (government), would not pay for their way out or for their accommodations. One respondent indicated that when her partner had made the decision to accompany her at his

own expense, they also had to pay for a babysitter back at home. She offered her own summary of the events - “it was tough.”

The Most Significant Source of Support.

When women were asked about who the most significant source of support was for them during and after their pregnancies the answers varied. Some women identified their partners, while others identified a close friend or family member such as the mother, sister, grandmother or aunt. Some identified that this supportive person sometimes changed with successive pregnancies, but one thing that was fairly consistent from the participants was the frustration, sadness or anger that resulted if the supportive person was not able to be there with them at the most critical time at the end of the pregnancy or at the birth of the child. As one women stated “so a few days after, after I got to Winnipeg, that’s when I realized that my grandmother wasn’t there. I just wished she could be there, and I started feeling sad” (I-2). Another woman responded that it made her very angry that she had to leave her partner behind. It is very interesting to note that not one of the respondents had identified a health or primary care provider as a source of support.

The Health System in the Community.

In regards to feeling prepared for leaving home before leaving the community, it was pretty much the same response “Nothing, nothing. They give you papers and ok, and mostly if there are any medical procedures and not really any of the extended emotional support and encouragement that mothers need, I guess, before they give birth” (FG2). In terms of the preparation they received, most women responded that they learned what to

expect from other women who had been out and no formal consultation had taken place in regard to the date that they were to leave. They were simply "told when to leave" by the nurse or clerk. The majority of responses indicated that the preparation amounted to "being told" when to leave and then being provided a copy of their "papers".

The Health System Outside the Community.

The women were also probed for some possible positive encounters with the health care system in their experience away from home. When questions were raised about the type of support they received beyond their medical appointments after leaving the community they did not have a whole lot to say. As a matter of fact they were quite unanimous in saying "there was no support". Most discussion ended there and further any probing didn't elicit any responses. Some participants indicated they had transportation to and from appointments by family members as well, or utilized the public transportation system on their own accord.

The participants also spoke very openly and frankly about their views on staying in the boarding homes in Winnipeg during the last weeks of their pregnancy and thereafter. These concerns were grouped into three broad themes: (1) fear, (2) discomfort and (3) disconnect. Each of these three will be discussed in sequence.

The first and most commonly mentioned of these themes that emerged in both the interviews and in the focus groups was fear. I further organized it into two types of fear: number one was a fear for their safety, and closely related to that was fear for their health. One woman spoke of being afraid of standing outside and waiting for a cab. A statement made by one participant represented a fairly good summary of the concerns expressed by most of the women when questioned why she had decided not to stay in a boarding home:

> *Because I was always told that just you could be there and no one else; no visitors. To me I always found it kind of creepy because all kinds of people stay in there and most times when I would be in the medical vans driving by, you would see some of the girls or women drinking; and being alone……. not knowing anybody. It was kind of scary and you know I just didn't want to go through that, someone asking me if I had money and getting mugged (M: yeah). And I thought, no way. Yeah I think that a place just for prenatal women going out to have babies and, like have family, there - then I would definitely consider a boarding home, but right now I would rather stay in a hotel (I-6).*

The second most commonly expressed fear was fear for their well-being, or the well-being of their babies and more specifically the fear of coming into contact with communicable diseases such as HIV/ AIDS and TB. One woman who stayed in the boarding home voiced "Well, this patient that was in my boarding home he had AIDS, and medical abscesses, like we had to watch what we shared – the utensils that he used. Yeah – I felt sick". Granted the fear of contracting a communicable disease in such a setting also speaks of a broader educational issue - what is important here is that their fears are perceived as real.

The women also spoke of some comfort issues in staying in the boarding homes in Winnipeg. Some women expressed discomfort at having to share a room with someone they didn't know, and lack of privacy and some spoke of the physical discomforts of being pregnant and staying in a place other than your home. Most women mentioned that they had nothing to do and were basically just "waiting, waiting…waiting", during their stay in the boarding home. Others voiced that they felt confined to the boarding home due to lack of transportation (for reasons other than medical appointments) or had anxieties about using the public transportation system. Some women mentioned how difficult it was to sleep due to the unfamiliar environment, or due to noise in the city. At least one of the boarding homes that were visited mentioned an "hourly check" policy and

the practice of opening each and every room to ensure that the residents were complying with boarding room policy of being a drug and alcohol free facility[7].

The women also spoke about difficulty connecting with their families back home and with resources or support in the City of Winnipeg while staying in the boarding home, or a general lack of knowledge with what might have been available to them. A number of women spoke about difficulty using the telephone to connect with their families, of long line ups to use the phone or about scheduled use that prevented them from contacting them on their own terms. There was difficulty making connections to other supports as well. One woman spoke about being in the boarding home and not knowing who to call in time of need:

> And you kinda like wonder 'who should I call?' It would be good if there was some kind of support. Like a lot of women go into labour in the middle of the night and there is nowhere for them to call and uhm, like a lot of times I was rushed. Like a lot of women uhm, they could get to the hospital without having to go through emergency like, I think that is how a lot of young mothers think, you know you have to wait till the last minute. Yeah. I think kind of a support system where they can ask questions (I-1).

The women who chose not to stay in the boarding homes spoke about some of their experiences in staying in private accommodations of relatives or friends that were far from ideal as well. They had voiced the same safety concerns as the boarding homes and of the neighborhoods where the residences were located, difficulty finding transportation to/from appointments, lack of access to a phone, and lack of one basic necessity: food (or the lack of money for food). The following excerpt is a fairly good summary of some of the sentiments with one woman who chose to stay in private accommodations:

> The positive was they could, my family, could come and visit any time, right? And the negative part is, maybe the home…the home owners would drink a lot, or

> no food, but or, so you have to try to…Or there's no phone – so that means you are putting yourself at risk going out to the pay phone to use, to use the phone (FG-2).

One woman spoke of having to sleep on the floor and difficulty trying to get up from the floor during such a late stage of her pregnancy. Two women did speak about the experience staying with family as being a positive one, mostly due to having a supportive person there with them:

> Well, my sister was there with me. Like, I stayed at her house and she like kept, she'd go, with me to the appointments with me. And we talked about like, what if I go into labor at night, what are you going to do with me? And she said 'Oh I'll put a sheet on the floor and I'll make you lay there until the ambulance arrives! (I-7)

Hope

Although the women from Berens River shared very openly about the toll that the evacuation policy had on them or on those most closely connected to them, they also spoke very optimistically about the future. They were very pleased about being asked what would improve their birth experience and excited that their voices would be carried to the outside world. It was very easy to summarize their thoughts under the broader theme of Hope, as this was exactly what their voices projected. These have been further broken into several subcategories.

Returning Birth Back to the Community.

The women shared their thoughts about to where they would prefer to have their babies. There was no question that the ideal scenario was to return birth back to the community. Most women, without hesitation, responded "here" or "in Berens". There

was one exception where one woman who stated that she had gestational diabetes and the city was the safest place to be. Interestingly, there was general agreement among the women about what that this support may look like in their community: there was preference to deliver their babies in a hospital or a similar facility, located within the community as it had been in the past. One woman offered a bit of context for this preference when I had inquired why this may be so. Apparently there had been at one time a hospital operated by the Catholic nuns in the community for many years and the babies were delivered there. Her grandmother, now in her 90's worked there a long time ago. (I had actually spoken to the grandmother earlier on in the year during a home visit working as a community health nurse and I recalled the conversation that I had with her. She had told me that the old hospital she had worked assisting the nuns in her late teens and early twenties in the hospital and that she had been scared of everything and avoided delivering babies. At that point, knowing that I was planning for this project I had asked her if she would like to talk to me when I returned later in the summer. Unfortunately, I was unable to do so, as she had moved into a long term facility in the city before I was able to interview her). I was able to determine when I was gathering historical information from other community members that this practice ended when the Nursing Station opened up in the 1950's. Berens River was one of the ports along one of the oldest fur trading transportation routes in North America from the Hudson Bay on route to Winnipeg in the 1800 and 1900's (personal communication with D, Berens, band member, 2009).

One of the major reasons for preferring a medically equipped environment was that it was perceived as the safest place to deliver a baby; and the nursing station in its current state is not properly resourced to deliver a baby. As one woman said:

> If I had a choice to have, like, if they had the right equipment - here. Like for the, for the delivery, it would be really nice like to have it, so we don't have to leave and all, and our family members could be there to support us, like, while we're delivering. I think that would… it would have been nice, like, I would have stayed home. (I-1)

One woman spoke very clearly about the need to bring back the role of the "traditional midwife", as one of the few that could recall stories of how things were before women were evacuated:

> Yup, when, my grandmother had many stories of women giving birth here in the community. And of course, they would have midwives, and they would know the medicines, what to give the women and things like that… things that we need to go back to and see again…ahm, what they did to the placenta and whatever they did, and however they did. (FG2).

A number of women spoke specifically about their preference to deliver their babies by midwife, and one woman had the experience of having a midwife to support her through all of her pregnancies and had this to say about her experience:

> She did prenatal care with me while I was staying with friends and family in the city. And she really taught me how to take care of myself, cause first time mom, we don't really know what to do, like for me there was no one really to show me to eat proper, to exercise, to not smoke, like I seen my whole life. Women smoke, and I thought it was normal but she help teach me that 'no it's not normal' and that it's really bad for a baby. I think she went above her duties of being a midwife into a mentor. This is where I really started to trust my nurses, doctors, because when you're in a hospital there are so many people looking at you, checking your blood and what not. I was never used of anyone touching me but she helped me to overcome that and to like just enjoy being pregnant and she would come with me to all my appointments and then when it was time to have my first baby she was actually there. (FG2).

The participants were not short of opinions and had a quite a lot to say about what would make their experience a more positive one. The almost unanimous response was that they would have had a different experience if they were able to have family present at the end of their pregnancies or during their deliveries. Most mentioned regrets at not having their partners there with them, but others mentioned their desire to have a

significant other such as a sister, mother, grandmother, aunt or close friend. Most women, who spoke about their worries at leaving their children behind for the second and subsequent deliveries, also mentioned their desire to have their children with them when they left for the city.

One woman who was further probed about how the experience differed from when she was able to have her children join her in the city and one where they were not with her, remarked: “yeah there was a big difference. I think I just functioned better, you know with them there and I think that if they didn’t come, there would have been a lot of complications with the pregnancy”. I believe it is very important to take note here what this comment says about how they feel the separation affects them. It not only has an emotional impact, but it clearly shows that there is an underlying belief that there is a strong bio-physical consequence for both mom and baby. Some women suggested if they were not able to bring their children along, they would appreciate if they were to obtain some support (including financial) at the community level in finding reliable childcare.

Advance Preparation in the Community.

Many participants were realistic about having all of their wish lists come true and spoke about some of the supports that could be made available to them prior to leaving the community: advanced and comprehensive preparation about what to expect while away from home awaiting the birth of their babies, prenatal classes, and network of prenatal education in the community that would include the advice of “elderly women” with knowledge about pregnancy and childbirth. One woman voiced:

> It could be in a form for example, an elderly women coming by and talking to you or it could be a healthy baby, or I don’t know, but it could be that they would come and give that support and that encouragement to the, you know, to the

> mothers to be. And to kinda give that information about anything, from fetal alcohol syndrome to uhm, drug addictions whatever, to healthy eating to being emotionally healthy in your pregnancy and not stressing out too much, because it is really hard, when your, when your pregnancy and you have all these emotions that you are dealing with, your up's and your down's and some women go through baby blues and there really isn't that support there. (I-11).

The Support in the City: Winnipeg Regional Health Authority.

As I mentioned previously, many women were reasonable about the support that could and would ever be available to them while in the community and very cognizant of the fact that they were "complaining", offered much insight about what could be done to improve their experiences. Many ideas surfaced and overt suggestions were made. I have grouped these into four broad categories: 1) access to educational support that includes prenatal, post-partum and breastfeeding support; that could also be satisfied by 2) Doula/Midwifery services and support; 3) other social support such as transportation, peer companionship; and finally, 4) a place to stay that is exclusively for prenatal women only. Each of these will be discussed in no particular order.

Educational Support.

We heard the women speak very candidly about the experiences of being lonely and of nothing to do but wait. They were equally candid about one solution that would be very simple: education and support that came to them such as prenatal classes, workshops and activities to support them through their last days of pregnancy. In addition to the prenatal education in the community before leaving home, they also mentioned that this support should be available for them while they are waiting the delivery of their babies in the city as well.

Doula/Midwifery Support.

Many women described a desire to have access to a supportive "labor coach" or support that was different from midwifery, if the spouse was either not able to travel with them or he did not feel comfortable being in the delivery room with them. They described other support that was more than just a labor coach, such as someone to talk to about what to expect during delivery; someone to accompany them on appointments; someone with knowledge of how they could navigate the support available to them in the city such as breastfeeding. Although many were not able to label the type of support they were describing, much of what they suggested could very well fall under the role of doula or midwifery support.

Breastfeeding Support.

The topic of breastfeeding arose spontaneously and a number of women voiced that there was a need for be more support around breastfeeding. One woman had shared that if it was not for "my granny I would not have known how to prepare my breasts and probably would have quit breastfeeding altogether" (I-4). Some women expressed gratitude of hospital staff that was able to assist them if they had experienced difficulties and others shared that they received no support at all in the hospital or at home.

A "Prenatal Only" Family Residence.

There was an overwhelming opinion that women that have no choice to relocate to the city to give birth should have their own place to stay and many were very specific that this should be a "prenatal only" boarding home. They mentioned many benefits to having a place such as on-site educational opportunities and activities; having an instant network

of peers and companionship with other prenatal women, less fear of strangers; isolation from contagious diseases and sick people. Many were quite specific that their experience would be much improved if this centre would have an option to bring members of their families such as their spouses or children and access to child care:

> Like, to have like what a separate, for like not for other patients, you know, just for like pregnant women. And to keep them busy, and to have activities, and with like the mothers and to like…just like a one building thing, so they could have their partners and maybe their younger children to be with them. Like to have a place, so say you go into labour and have, like a, like a little daycare in there, with you…for them to watch, like, your children. Like it'll be, I don't know, it's, and then maybe like when you're done delivering the baby the father could go back to the boarding place and watch the kid, the kids. (I-1)

So what could all of this information possibly mean for the First Nation women? What could it possibly mean for their families; for the community; for the present health care system and policies around childbirth; and for future generations of women and families from northern and isolated communities? We have heard from women in Berens River representing various age groups, new mothers, experienced mothers and their families that they have not had a good experience with the present childbirth system or with current government evacuation and transportation policies. We have heard that they desire support and services that are responsive to their needs; they want to be able to have their families present when they have their babies. We also heard that they want to have the option to have their babies at home with their families present, and with adequate resources and facilities. We have heard that they are not satisfied with the present support they receive at all levels of the system from within the community, outside of the community, and from institutions. We have heard that evacuation, medical transportation and health care politics govern their lives and there is no sense of control over an event so critical for the perpetuation of life, of knowledge and of culture. I was deeply saddened,

although not shocked that there was a lack of stories that could be recalled of a time when birthing was any other way, but I was also equally uplifted by the fact that there were many ideas that flowed freely; many of these ideas which I had been given liberty to share, organized and categorize, and transform to a language that policy makers could understand. The next chapter utilizes the knowledge and ideas shared freely by the women to propose a new framework of improved childbirth care that could potentially transform their experience, thus liberating them from the suffering that they have spoken about.

Chapter Four: Discussion

A Lost History

For the women of Berens River the experience of childbirth was marred by unpleasant memories of relocating to a foreign environment and very few could recall any stories of a time before evacuation. Some did recall hearing stories of delivering in the "old hospital" and of their grandmothers stories of a traditional midwife, but none of these memories were first hand. This may have been due in part to the sample of women chosen. All women were between the ages of 18 to 55, when most would have themselves been delivered outside of their community. The following expert was the only one that alluded to the time before when one recalled her grandmother's stories:

> Back then there was a lot of midwives around here, and when the Catholic mission came, that's where the Catholic mission was the nuns and that's where they put them, over at the Catholic mission. The hospital they set up, they set up a hospital there and that's where the women went and give birth and that were of course probably the nuns were doing it and that's the kind of stories she would tell about childbirth at that time. And, I guess there was more of a support there that was going on…children being born at home (I-11)

If this 94 year old grandmother could only remember the hospital environment as a place of birth, it is clear why the younger women would believe that a hospital or similar environment is only logical option for birth. The memories of a more natural state of birth are fading quickly as the older women are passing on. There is a very real concern that these may be too far back in the distant past to be resurrected. Berens River has a very long history of colonization, and two centuries of infusion of western practice. Fortunately, Ojibway communities (such as the one that I am from) have had a different history and still possess many of the memories of birthing on the land. It would be very important and with a sense of urgency that past beliefs and practices about childbirth be

explored in this community with a little more depth as a future project, as this study was focused more on the present. Those memories must be captured, along with those that remain in Berens River before all memory has faded. As well, it would be interesting to explore how beliefs and meaning that are attached to child birth have changed over time. Although these questions were not posed as part of this study, but many interesting impressions crept through without intending. In the 1970's Kleinman et al (1978) proposed a theory that medical and health care systems, regardless of how they are construed, are fundamentally social and cultural systems. He explained just how illness and disease are entirely separate entities that are also constructs of their cultural and social environments; meanings of symptoms and disorders are influenced by the culture and social environments that they exist in. It is unfortunate that we have witnessed in Berens River, a community with a long history of colonization, osmosis of symbol of meaning from the larger society that has transformed childbirth to the point where it has essentially become a "biophysical event" reflected in the sentiments that a medical facility is the only alternative for a safe birth.

There is something else that we should pay attention to that warrants exploration in a little more detail as well. Again a revisit of Kleinmen's model clearly explained in another work (Kleinman, Eisenberg & Good, 1978) that purported that there are three distinct concepts should be considered when symptoms and disorders are examined. These are: disease, illness and sickness. In short, 'disease" is the process - the impact on the body, self and society (the "what"), illness the experience of the disease of the individual and the family (the "how") and sickness is the understanding of the disorder (assuming it is the combination of the burden of both disease and illness) as well as the impact it has on outcomes at the macrosocial level. The meaning of illness, (and in this

case we consider birthing, such as the broader culture has treated it), Kleinman would have explained, is often ignored or dealt with indirectly in the biophysical model. These meanings, he argued, are always culturally shaped and have the ability to amplify or dampen symptoms. To the individual and family illness is "problem" and along with it the behaviors and difficulties it creates in their life and the lives of their family. The healer, regardless of discipline, uses this information to "recast", label and prescribe treatment through the theoretical lens of their particular form of practice, rather than trying to understand the illness from the perspective of the individual and family. In doing this, the clinician turns the attention of patients and families away from decoding their own meanings of illness and hinders the clinician in recognizing "disturbing, but potentially treatable problems in their life world. This "value transformation", he concludes, is a serious failure of modern medicine. Kleinman and his colleagues argued that by paying attention to the effect that cultural and social factors have on disease and its treatment, and to the cultural and social understandings of disease as well, we have the potential for much greater "effects on cost, access, and satisfaction" than changes produced purely in the professional and biomedical world alone (Kleinman, Eisenberg & Good, 1978). Even if we accept that the childbirth experience (as it has been treated in this century as a biophysical event) without seriously considering the "experience" we are missing some very important meanings and unfortunately at a considerable social cost. The cost unfortunately for the citizens of Berens River is further fragmentation the First Nation family. The message here for health care providers and players in the health care system is that there is a need to pay attention to the experiences of childbirth, especially those experiences that have been as devastating as those spoken about in this study. If we have it entirely within our control to change, and if we do nothing, then we are essentially

failing to recognize the potentially treatable problems that Kleinman warned we were failing to do. Our challenge today is to deconstruct the pervasive cultural and social meanings we have attached to this birth experience and loosen the professional penetration and control that has split birth from its family of origin that Barclay, Andre and Glover (1989) spoke about.

If we do not pay attention, Kleinman et al (1978) also warned of an ever increasing discord between contemporary medical practice and lay expectations. They explained that there is a discrepancy between what "patients" were experiencing and what the health practitioner was doing. If we accept for the moment that the "experience of childbirth" as the "illness" in the context of First Nation women who birth away from home, this discord is even more pronounced- considering that the birth of a child is one of life's major life events and not just a typical clinical encounter. The discrepancy between what health care providers (and health systems) are doing is just as true for the event of childbirth as it is for the clinical encounter. They argued for the value of looking at the meanings of the individual illness from the perspective of culture. In doing so, the practitioner would essentially break the cycle of a person's distress and dehumanizing treatment of individuals, families and communities (Kleinmen, et al, 1978). For the women of Berens River we can break this cycle as well by paying attention to the women who are central to the child birth event; by paying attention to their experiences and to those who have been impacted by present day policies. We can essentially return the power to them to redefine what child birth means to them and define how the biomedical world and their external environments can respond.

It is true that perhaps only the quality of individual lives may be improved and it may not result in actual saved lives or costs, but if we as a society truly want to improve

infant, maternal outcomes for First Nation women and families (as we thought medical evacuation might accomplish) we will fail miserably if we do not consider cultural meaning and at all levels of the woman's environment. We apply Kleinman's concepts to understand that she is dealing with much more than a biological event and there are consequences to the evacuation policy that do have an impact that emanate out of her immediate environment. As this study also took a critical gaze at this issue, there is also a need to acknowledge that it is not only culture that influences the "experience", but other factors in the larger political, social and economic environments that have come into play, factors such as professional regulation and control, and economic incentives that have shaped the way childbirth is viewed today. Regardless, paying attention to the social environment and to the emotional, spiritual and mental wellbeing of the individual may prove to have more of an effect on health outcomes than the evacuation policy ever hoped to do. Similarly, might not strategies to address the individual in a holistic manner ultimately lead to improved family functioning, and thus healthier individuals and healthier communities? It makes perfect sense to me. However, as an Ojibway woman, the challenge is whether we can remember the meanings we have attached to child birth, meaning that an entire community has essentially adopted from western medicine today as their own. In the community of Berens River, the biomedical model has had such a strong hold over child birth for such a long time; it would be a challenge to find what those meanings once were generations ago in this small isolated community. This may be a whole different project in itself, but the implications for the women of Berens River would still be the same – and that is to challenge the pervasive cultural and social meanings we have attached to the birth experience and to uncover the meaning and significance they had in the past.

Rediscovering the beliefs and practices of the past may be daunting, but it may be necessary. In order to change the way that child birth is practiced today - we may first need to change the way we think about childbirth. As Leanne Simpson (2006) asserts *in Birthing an Indigenous Resurgence*, that Indigenous Peoples must also undergo a re-'traditionalization' of thinking and of *living* based on our individual Indigenous cultural and intellectual traditions, and this resurgence is a necessary prerequisite to bring about the kind of radical transformation that will allow First Nation women to emerge from being subjugated beings to ones that are free to make decisions in their reproductive lives. I was somewhat surprised that I did not appear to uncover any overt resistance to "de-medicalize" the experience, although there was a strong desire to return birth back to the community, providing there were adequate medical facilities for this to occur. I suspect that having a hospital in their community for so many years and a long history of colonization may have influenced this perception. Is it resigned acceptance of oppressive policies that perhaps the women feel they have little power to change? Regardless, the first necessary step as Simpson suggested could very possibly be one of re-education and relearning of our traditions, practices and beliefs of the past for both mothers and scholars alike. Once the awareness is created, then perhaps the outrage and the collective resistance will follow in this small northern community.

The Family

The Royal Commission on Aboriginal Peoples (1996) brought to light the negative impact educational and child welfare policies had on First Nation and Aboriginal traditions and their role in eroding traditional kinship and family networks. I join others in arguing that medical evacuation policy has pretty much accomplished the same

(Hiebert, 2001). The RCAP called for broad sweeping changes to both the child welfare, educational and health care systems. The impact that the forced separation of children from their families of the residential school system and child welfare policies has long been acknowledged and these systems have been abolished or undergone significant change. Medical evacuation of childbirth has been flying under the radar for many years and not been garnered the attention of the media as child welfare policy or residential school legacy has. Yet, it continues to erode the social fabric of First Nations families, ignoring a most critical event that takes place concurrently with the physical event of childbirth and is most difficult to quantify – bonding. It is a fundamental building block of our human existence and has provided "fabric" that fosters healthy family development (Bowlby, 1988). This phenomenon begins in pregnancy and childbirth (Klaus, 1995). The third volume of the Royal Commission on Aboriginal People (1996) said it best in the opening paragraph in Chapter 2:

> We begin our discussion of social policy with a focus on the family because it is our conviction that much of the failure of responsibility that contributes to the current imbalance and distress in Aboriginal life centers on the family. Let us clarify at the outset that the failure of responsibility that we seek to understand and correct is not a failure of Aboriginal families. Rather, it is a failure of public policy to recognize and respect Aboriginal culture and family systems (p. 9).

This research project did not intend on focusing on returning birth closer to home. The benefits of doing so have been the focus of many other studies. The solutions posed in this paper are realistic, one of which is keeping the family unit together during the childbirth experience, recognizing that it is only second best to delivering their babies in their own homes; in their own communities; and with their own families. There is also a need to acknowledge and address the lack of breastfeeding support for women away from home in the critical first few days after delivering their babies. Keeping the family united

during the birthing experience, and supporting breastfeeding to facilitate bonding are very simple means of correcting many the harmful effects that government policies have had on the First Nations family.

Implications for the Community and Systems within the Community

Many of the ideas that emerged were concrete strategies and possible initiatives that have implications at the community level. The participants spoke about being prepared prior to leaving the community, having access to prenatal classes and education about childbirth and more health promotion activities about healthy pregnancies and families. One woman suggested that having a video done, specific to their community about what to expect when they leave the community would be helpful. Other suggestions involved having "Elder" women in the community mentor the younger prenatal women. Many women recognized that there was a need to address pregnancy and childbirth from a holistic perspective, considering the physical, mental, spiritual and emotional well-being of the prenatal woman and her entire support system.

Implications for me: Nurse, Health Care Manager and Researcher

In the beginning of this paper I had started with a personal story of my own family, of the land and how connected this subject was to my life. As I immersed myself in the health care environment in a duel role as a nurse providing care and as researcher, speaking to women, health care providers, leaders and community members, reviewing policies, clinical guidelines, interviewing and facilitating I could not help but to be profoundly affected. Sometimes the role of nurse and researcher blurred and blended together, so that I could not separate the two. As much as I tried to explain that I was

acting on one role and not the other, I was often approached by health care workers and patients alike to provide health care advice or care. In my role as nurse, I gained a whole new appreciation for the prenatal women, not as a patient, but as a person with feelings, fears, aspirations and dreams for her family. I noticed that my nursing care had changed, that as I sat and spoke to the women who were making plans to leave the community to give birth, I may have surprised them by actually spending some time listening and engaging them in a conversation about what they hope for themselves and the experience of leaving home. Cognizant that I was not in any position to change the world any time soon, I asked them to participate in decisions that they were not asked to before, but within the guidelines that were allowed by present policies. For instance, I had asked one woman who was to leave home at 36 weeks gestation, "so which day of the week would you prefer to leave?" She responded with surprise, "Do I have a choice?" Giving her that option brought a smile to her face as she chose the day after she was to get her child tax cheque so that she could then do some shopping before she had the baby. This change in dialogue between patient and provider is so small on the grand scale, but what it did provide for her was the option to participate in making a small decision in her care, and for me it meant so much more and brought such immense warmth to see her pleasantly surprised and then smile. At the onset, I may have struggled to understand what this information could potentially mean to my family and to future generations of women. I had many doubts and feared that perhaps nothing at all will change and the information will be bound in hard cover on a University shelf, and accomplish nothing but occupy space on a shelf or maybe if I was lucky, be cited once or twice in other studies. I am very excited to write that even as the study unfolded, much work and discussion has taken place in tandem with this research project and some progress has already been made in

this area. In 2007, as the Maternal and Child Health Nurse Program and Practice Advisor with the Assembly of Manitoba Chiefs, I was asked to take a seat on the Provincial Maternal and Child Healthcare Services Task Force (MACHS) that was commissioned by the Provincial Minister of Health, Theresa Oswald. I presented a Brief on behalf of the Assembly of Manitoba Chiefs to the Task Force to consider the gap in services to First Nation woman who relocate to urban environments to give birth. One of the recommendations was that the first step should be to consult with First Nation women in Manitoba. Unfortunately, the consultation process was not considered, but the opportunity to carry this out on a smaller scale presented itself as I was searching to focus my thesis. The MACHS released its report in 2008, among which were recommendations to make improvements for services and supports for women relocating temporarily to urban centers' to give birth, that were based the briefing note on the issue that presented to the task force. The Minister announced subsequently that some financial resources would be identified to begin to address the gap for prenatal women and a Relocation Initiative Working Group (RIWG) was convened in 2009 to which I was invited as a member. I was asked to present the preliminary findings of this research project in September 2009, and discussion and dialogue is ongoing with this working group.

Implications for Future Generations

For what could this study and its findings possibly mean to me and my family and all my other First Nation relations? Most of my family of origin resides in Hollow Water and one of my family members actually lives in the community of Berens River, but still many of my relations spread throughout isolated communities in Manitoba. Leanne Simpson (2006) wrote to which I wholeheartedly agree that "self determination begins in

the womb. If more of our babies were born into the hands of Indigenous midwives using Indigenous birthing knowledge, on our own land, surrounded by our support systems, and following our traditions and traditional teachings, more of our women would be empowered by the birth process and better able to assume their responsibilities as mothers and as nations-builders" (p.29). For my aunts, and all First Nation women who keep the memories and stories locked up within, it may mean that many may be asking them to share more. For our northern and remote communities, it may mean that we all need to join the collective voice and efforts to bring about the necessary change. For me as researcher and manager, the experience does not end with the completion of this study. As Ojibway mother, it may mean that my children and my grandchildren may have to take up the cause and it is our hope that once collective voice has garnered enough strength, our children may one day be birthed in their own communities on their own land, or near their homes. For the sake of our First Nation women, children and families the process of self-determination should begin as Simpson suggested – "in the womb".

Policy Implications for Health Care Systems

Again, I return to the proposed framework that was developed with the assistance of the women of Berens River to reiterate that these suggestions propose an interim solution; and more work is needed in the policy arena. In order to fully appreciate the proposed new framework, it is necessary to revisit how health systems are currently structured as it pertains to the prenatal women leaving home to give birth. In Manitoba there are currently three levels of government (local/community/band, federal and provincial) and multiple layers of health systems (community, provincial and federal) with coexisting, sometimes parallel health services that the prenatal women moves within

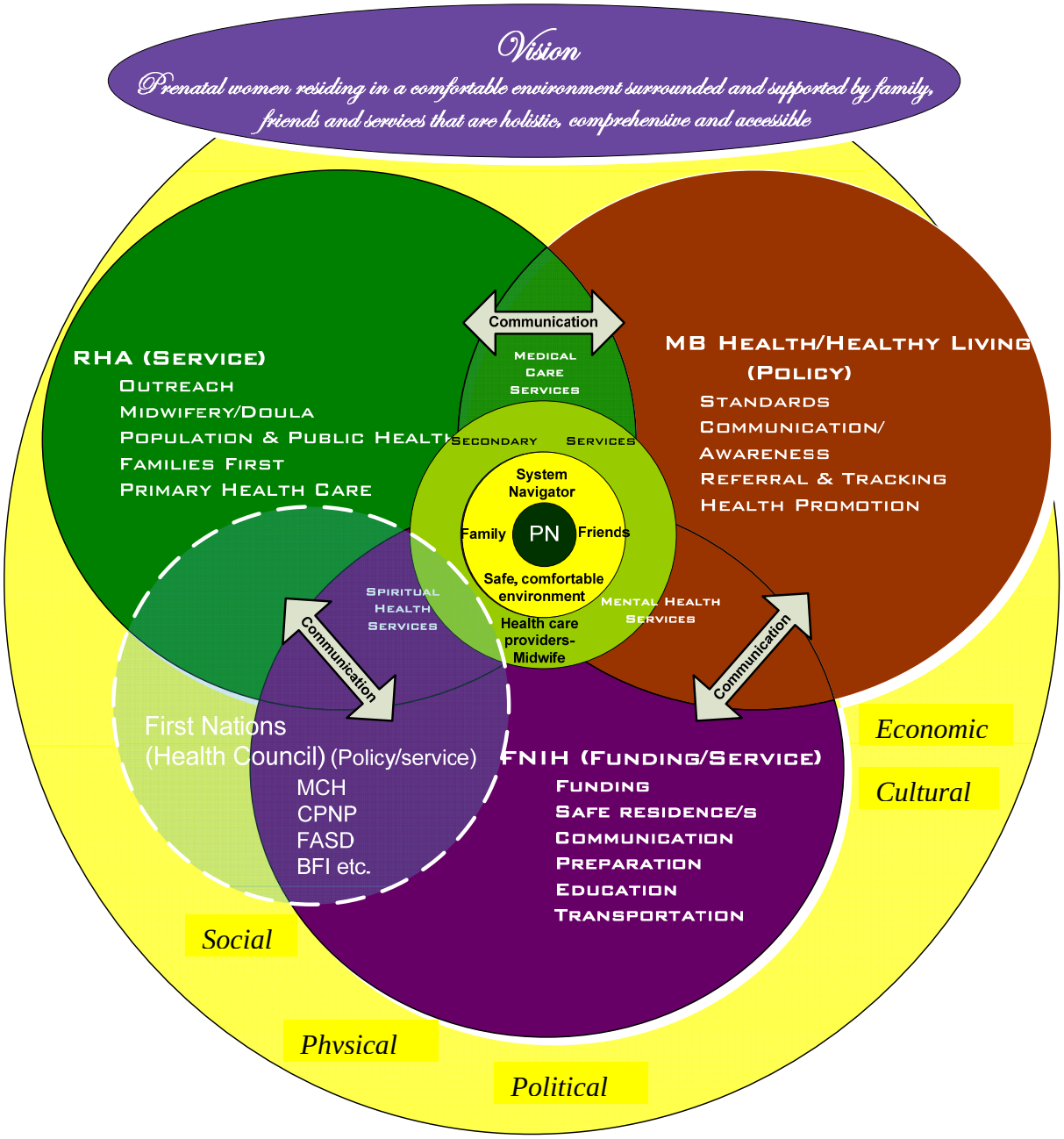
but does not necessarily access during the course of her pregnancy. In Berens River, prenatal care and support is accessed at the band operated Chief Jacob Berens Nursing Station and delivered by advance practice Community Health Nurses or from visiting physicians. The Chief Jacob Berens Nursing Station derives its funding from Health Canada, and has adopted Health Canada's Clinical Practice Guidelines in Adult and Pediatric Care[3]. Among these clinical guidelines is the "confinement policy" that is essentially a policy of maternal evacuation at 36 or 38 weeks gestation or sooner. The decision of when to send the prenatal "out for confinement" rests on the nurse or physician in the community sometimes in consultation with an obstetrician or other specialist involved in her care. In my many years of experience in the north, and confirmed by the women of Berens River, they are never or are rarely consulted in this decision. Once the prenatal woman leaves Berens River she travels to Winnipeg and resides within the Winnipeg Regional Health Authority's jurisdiction until she is ready to return home with her baby. If her pregnancy is especially high risk, she may be admitted to the Winnipeg Antenatal Home care Program[8]. If the pregnancy is determined to be low risk, she may access prenatal care from an obstetrician affiliated with either of the two teaching hospitals in the City of Winnipeg. The prenatal women carry with her when she leaves the community her prenatal records that consist of her prenatal visits and any relevant laboratory results or they are faxed directly to her obstetrician. The usual means of communication between the hospital (WRHA), nursing station or obstetrician occurs via letter, discharge summary or sometimes telephone call, but often the paperwork is not received in a timely manner. There are no direct communication links between the Winnipeg Regional Health Authorities Population and Public Health Division and the Nursing Station.

As mentioned in the introduction of this thesis the history of health care on reserve has a long history that warrants its own chapter. What is important to understand for the purpose of this study is the role the federal government has in providing health services to registered Indians living on reserve. Since the introduction of universal health care in Canada, the federal government's role in the health system has primarily been regulatory, establishing national standards, administering transfer payments to the provinces, setting priorities/funding health research, public health including health surveillance and health promotion on a national scale and direct service provision to special groups of people. Among these special groups are members of the military and registered First Nations living on reserve. In some cases, through transfer agreement with individual bands and tribal organizations health services are administered and delivered by First Nations on reserve (Waldram, Herring & Young, 2006). As far as I am aware no such broad framework exists that sets out how federal, provincial or regional systems communicate, coordinate or collaborate on health service delivery to the First Nation resident who moves between or within systems, and definitely none exists for the prenatal women. I therefore propose the following framework for the improved childbirth care for First Nation women who must and will leave home for some time to come.

It must first be emphasized that First Nation, Métis and Inuit women have spoken for many years through researchers such as John O'Neil, Patricia Kaufert and others as well as in various Maternal Health forums that moving birthing close to home though the promotion of midwifery and in-community birthing has and still is, unequivocally, a top priority and the direction they would like to see for Maternal Child Health policy and programming. This stance was very clear in The Aboriginal Women and Girl's Health Roundtable hosted by The National Aboriginal Health Organization (NAHO) held in

April 2005 and the subsequent publication “Celebrating Birth” Aboriginal Midwifery in Canada (NAHO, 2008). This position was also supported by the women from Berens River, Manitoba who talked about their desire to deliver their babies at home. The reality is, however, that there is a great deal of work in both policy and education that needs to occur before every woman in Manitoba is to have a choice on where they deliver their babies and the type of care they receive. This model therefore proposes a short term policy solution only, and the work on moving birthing closer services closer must continue in the broader policy arena.

A Framework for Improved Child Birth Care for First Nation Women in Manitoba: A Family Centred Approach



RHA – Regional Health Authority
FNIH – First Nations and Inuit Health
MCH – Maternal Child Health
CPNP – Canada Prenatal Nutrition Program
BFI – Brighter Futures Initiative
PN – Prenatal Woman
MB - Manitoba

Diagram 2: The Framework

The Framework: Brief Description

The framework as proposed places the woman at the centre and intersection of all three existing health systems, federal, provincial and regional, and framed within her social, economic and cultural environments. Most support and services are not new, but the link connecting all three systems is new. This link will involve the development of a communication loop connecting all three systems, by way of a reverse referral process between the First Nation community and the Regional Health Authorities Central Registry Services. The referral process from central registries to public health units throughout Manitoba is already in place. When a woman is discharged from the hospital a referral is sent to the public health office based on her home postal code, but the reverse referral does not exist when she leaves the community. New human resources may be necessary to facilitate this communication in a role I have termed "System Navigator", connecting the prenatal women to all supports and services that could potentially be available to her. First Nations community health systems are connected by way of a dotted line, as these services are available to her while she resides in the community at this point in time. The shaded and dotted line also contains the proposed First Nations Health Council[8], a First Nations governing health body, which is currently under development.

Communication Loop

Each and every woman that delivers a baby in the Province of Manitoba receives a referral to the Public Health office in her community, or nearest public health office from the regional health authority central services where she delivered.

The Prenatal Record used by physicians and nurses practicing in Nursing Stations already contains an Informed Consent that reads:

"***I understand that providing information is necessary to assist the physician/midwife in planning care throughout pregnancy, childbirth and postpartum. My personal information will be kept private but may be shared with other professionals directly involved in my care except _____. This information, with all my identifiers removed may be used in health care research. I understand I can withdraw or revoke this consent at anytime in writing***"[4]

The Prenatal Record will require some minor modification or the addition of another box or form that requires another interview with the woman at a later date in the pregnancy prior to confinement. This box could potentially include educational information to be checked off and cover such topics as: plans for baby, child care for children staying behind, clothing and items to take for mom and baby, and a space for the address and phone number of where she can be contacted in the city. This information would be vital for the "System Navigator" to be able to locate her in the urban center. This particular form and information would travel to Central Registry in the WRHA via fax or e-mail shortly after the interview in and around the time she leaves the community and the referral then sent on to the System Navigator.

System Navigator

I have named this particular role a System Navigator for lack of a better word, but essentially will assist the prenatal woman in connecting to support and services while she is away from home. This individual or individuals could potentially function as the connection between the community and the prenatal woman in the urban environment. This person would potentially receive the referral and initiate contact with the woman. This support would essentially act as an outreach and connect the women to existing

support and services. The existing services could potentially include midwifes, prenatal classes, lactation consultants, exercise classes and doula services. This role could potentially be expanded to include coordination and bringing the woman together for group care and education.

Prenatal only Boarding Home

Until such time there is universal coverage of midwifery and birthing in every community in Manitoba, prenatal women who have to leave home to give birth could benefit from a safe place where they can stay with other prenatal women. The women in this study voiced that this facility should be family centered, comfortable and accommodating to spouses and families. Currently there are several boarding homes in the City of Winnipeg and no scan has been conducted in other regions. A prenatal only boarding home will remove the fears of being vulnerable to communicable diseases and foster informal networks of support between prenatal woman, and provide a space for education, support and cultural activities that could potentially come to them. The women had indicated that this space should be near one of the hospitals where most of the deliveries take place, or could be co-located near the birthing centre planned for the City of Winnipeg. The women were very clear that this place is necessary to address their physical, emotional and spiritual needs.

The Escort Policy

The escort policy of the Non-insured Health Benefits of Health Canada must be reviewed. The woman have voiced through many forums that the effects of the evacuation policy in combination with the escort policy has detrimental and compounding

effects on their health and well-being in addition to overall family functioning. We have heard how critical that the significant other and support person share in bonding experience that occurs in childbirth. Uniting the family in this critical life event would address one of the Royal Commission on Aboriginal Peoples recommendations of rebuilding the fractured family that it attributed to residential school and child welfare system policies, (Canada & RCAP, 1996). The case has been argued that the Evacuation policy and escort policy continues to impinge this healing process.

The Effort

Many of the ideas that surfaced had implications beyond the community. It involves both federal and provincial Health Care Systems and a coordinated effort by all to address the well-being of the women and families from a holistic perspective, which considers her physical, mental, spiritual and most importantly, her emotional needs. Many of the concerns they raised about the care that they received (or did not receive) while away from home resulted from the women crossing multiple lines of jurisdiction: regional, provincial and federal. Federal responsibility for the prenatal women must extend beyond just providing transportation once she has left the community and must consider the consequences of leaving her emotional system of support behind. I have argued that the evacuation policy serves to perpetuate "assimilationist" policies, a policy also motivated and supported by the government for financial reasons. What is significant about this study is that we have heard from the women what it has cost them, both emotionally and physically and at what cost it has been to their families. Provincial and regional authorities must recognize that the women who have left their communities, already isolated and marginalized for generations are also their responsibility. It is not

enough to say, yes it is our policy to reach these women – some actual effort and resources must be committed to doing so. Addressing the needs of the First Nation women who still must leave home to give birth will require the cooperation of multiple levels of government, multiple health systems and a new spirit of cooperation between the individual, community and the macroeconomic, political and cultural systems she lives in.

Chapter Five: Conclusion

The existing system of childbirth care and support for the prenatal women from Berens River has been described in great detail by the women of Berens River augmented by what I experienced and learned in my role as Community Health Nurse and Manager of Maternal Child Health Program**.** Their words, as well as written and unwritten policies have been described in this paper in detail in the multiple environments and at multiple levels that they exist. This system involves family, friends, health care providers, elders and community while she resides in Berens River. This support essentially stops at the door when she leaves the community, and the support system is left behind. Once the woman goes "out for confinement", the support provided by FNIHB amounts to transportation and lodgings as she now resides in the Winnipeg Regional Health Authority's jurisdiction (unless she is experiencing complications and enters the "antenatal" program). Theoretically, she should be able to access prenatal support while she is in Winnipeg, but as the women have indicated they encounter many barriers, such as transportation, safety, lack of information about where to obtain the services and lack of communication between provincial and federal health systems. The prenatal women do obtain prenatal care, and access specialized health services, which are covered by provincial health services. The voices of the women of Berens River have been brought together to proposed a new framework to support child birthing services within and external to their community. Their vision involves additional support at all levels of the prenatal women's environment and ultimately a return of birth to the community and a return to traditional teachings. Their ideas involve both short term, immediate and long term solutions. The two broad objectives of this project has been accomplished: to give a voice to the women in Berens River to speak about their experiences in childbirth and

give them an opportunity to influence policy decisions at all levels of service delivery. This project has also the potential to inform service delivery planning for Maternal and Child Health Care. All of the information collected have been synthesized and a new vision for a system of childbirth health care for First Nation women has been proposed that acknowledges the voice of the women, respects the cultural beliefs and practices of the community and the ultimate goal of reclaiming birth. This framework proposes multiple level solutions and cooperation across jurisdictions. These findings may also be used to inform service provision for maternal and child health care for First Nation and women in remote communities. The interviews have engaged women and families in a dialogue that was intended to generate awareness of social and political forces that have had a negative impact on the women in Berens River and other First Nations communities. It also allowed an opportunity for the "sufferer" to challenge the hegemony of these health care systems and contribute actively to the development of a new framework of childbirth care and support that involves multiple levels of effort and policy action. I have proposed a new framework whose centrality is the First Nation woman and her family, connected to all levels of her environment and health systems through the practice of midwifery and doula support and proposed a communication process that is not affected by the "stop at the door policy". This framework does not propose to disrupt the level of support that is working well in the community, or to propose any radical change to borrowed and internalized beliefs about a "medicalized" birth, but to begin a gradual process of re-education, improving communication, introducing a new level of support and improved services in the City of Winnipeg, all the while recognizing that the ultimate aim is to have babies in their own community. I have represented this framework in a graphic format, shaped by the feedback of the women of Berens River and attempt to

explain how each system and level may be connected and improved. This framework lends itself well to policy and discussion forums.

Overall, one of the goals has been achieved: to have rich data based on the experiences of real people, and obtain their insight on how the system of services can be improved from their perspective - rather than creating solutions from a top down approach typically employed by government. It is also an opportunity for policy makers to take pride in the fact that their decisions are based on information obtained directly from the people it affects the most.

Ultimately, this research has the potential to build a model of childbirth health care that leverages existing services and realities and could potentially result in supports and services that address a huge gap of services and inequity of care. It was based on an ecological framework that considers all levels and interactions within the First Nations woman's environment and most importantly, based on the input from women who live in an isolated community and are evacuated for child birth. This process may also prove to empower women in this community and decision makers to initiate the necessary change under their control. For the possible solutions to the gap in services experienced by women who move away from home to deliver their babies, the First Nation women have been given a voice. It is hoped this work not only acknowledges the voice of the First Nation prenatal women, but of all individuals who are intimately and indirectly connected to them.

Miigwech!

Notes

1. This estimate is based on the 1465 births reported by FNIH for First Nations women living on reserve in 2007 and Regional Health Survey that indicated that 76 percent women reported that they had to leave the community for childbirth. Several attempt to obtain information from Health Canada First Nation and Inuit Health resulted in an e-mail from the Health Surveillance Division that indicated that information is not captured.
2. Women with high risk pregnancies from First Nation communities may enter the Winnipeg Regional Health Authority Antenatal Home Care Program. They are visited in the homes by skilled antenatal nurses in the WRHA area. Women from the north may be admitted into the Antenatal program if their condition can be managed in the home, but must remain in the WRHA area.
3. First Nation and Inuit Health Branch, Clinical Practice Guidelines for Adults. Clinical Practice Guidelines developed by Health Canada and panel of experts that outlines scope of duties for Community Health Nurses who work in Nursing Stations in an expanded role. They include Assessment, planning and interventions for common medical conditions and recommendations for care.
4. Manitoba Prenatal Record, endorsed by the College of Physicians and Surgeons is a documentation and legal record for all prenatal clients in Manitoba. The record is utilized by Community Health Nurses working in First Nation Communities who provide prenatal care as well.
5. Manitoba Health physician and insured services at http://www.gov.mb.ca/health/mhsip/index.html#eligible. Information on Healthy Child Manitoba found also at www.gov.mb.ca/healthychild
6. A blue instruction card is included in the documentation that the person who leaves their community carries to access services in another regional health authority. The blue card includes a number to call to obtain assistance for transportation to and from appointments, guidelines about when to be ready and some broad instructions about preparing for medical appointments and tests.
7. I toured two boarding homes in Winnipeg; one in particular shared with me some of the policies in regard to meal times, hourly room check's etc.
8. Assembly of Manitoba Chiefs received a resolution from Chiefs in Assembly in August 2009 to move forward with First Nations Health Council, and in process of creating a strategic plan for implementation of an agreement to take control over health services for First Nations in Manitoba.
9. For AMC Position papers visit. www.mantibachiefs.com and Assembly of First Nations visit www.afn.ca.

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Appendix 1

Interview Questions:

Warm up questions:

1. Please tell me how may babies you have had, or if this is your first?
2. Please tell me where and when you delivered your baby/babies?
3. Are you able to tell me where you stayed while you were awaiting the last few weeks to deliver your baby?
4. On average, how long were you away from home during these times?

Focused Interview Questions: (For the prenatal, each question will be reframed with "please share with me what you have heard…..).

1. Please share with me your experience delivering your baby/babies away from your community
2. What can you tell me about your experience in the place were you had stayed?
3. Please tell me about who or what was your most significant source of support during the last weeks of your pregnancy or pregnancies?
4. Are you able to tell me if you felt you had a choice of where you could deliver your baby?
5. Please tell me about your experience in <u>how</u> you had been prepared by the Health care staff in your community about leaving home to deliver your baby?
6. Please tell me about any support and services you had available to you while you were away from home awaiting the birth of your baby?
7. Please tell me about what supports or services you may have <u>liked</u> while you were away from home awaiting the birth of your baby?
8. Please share with me any stories, memories or information about the way babies were born a long time ago in your community?
9. Please tell me what you feel the ideal scenario would be, should you have a choice in <u>how</u> or <u>where</u> your baby/babies are to be born?
10. Please share with me any thoughts, ideas or concerns about what it may be like delivering a baby in your own home community?
11. Please tell me where you feel is the best place to be to deliver your baby?

Focus Group

The women may have had an opportunity to think about some of the questions that were asked during the one to one interviews, so the focus group can begin with opening up by asking participants if they have anything else they would like to share, or add after having some time pass between the interviews. The purpose of the sharing circle will be explained, and the research question re-iterated:

Given that the moving birthing services closer to home may be many years in the future, or not at all possible for this community [or for FN women in Manitoba] what do you feel is needed today to improve current child birthing practices and the maternal and child health care for the women who have to leave home to deliver their babies?

The researcher can follow the discussion that flows and introduce some of the themes that had emerged through the interviews as points of discussion. Some other focused discussion can take place around question 6, 7, 8 and nine above.