Starting Strong: Exploring Experiences of Prenatal Care among First Nations Mothers

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ABSTRACT

Studies have revealed that Indigenous[1] women experience a higher incidence of negative birth outcomes and are more likely to receive inadequate prenatal care.(1)(2) Few studies have examined the opinions of First Nations women with respect to their prenatal care. The aim of this study is to use an individual, semi-structured interview-based qualitative approach to identify themes related to First Nations women's current experience, and their thoughts regarding prenatal care going forward. Themes related to overcoming barriers including transportation issues and appointment accessibility were cited. Privacy concerns and information-sharing revealed a desire for respect when accessing care (four participants). There was appreciation for the care received at the Nursing Station despite some of barriers described above. Going forward, there was interest in dedicated space and staff to deliver prenatal programming, and greater information sharing related to travel for birth and postpartum depression. A one-on-one approach was appreciated. This study contributes first-person narratives of the prenatal care experiences of women living in a northern First Nations community. As in existing literature, access to transportation, and appointment availability were reported as common barriers to prenatal care. Going forward, additional research surrounding perinatal outcomes and the barriers to accessing prenatal care among women who did not seek prenatal care would add additional context.

[1] Indigenous peoples is a "collective name for the original peoples of North America and their descendants." First Nations, Inuit and Metis people are all recognized in the Constitution of Canada and are distinct and unique peoples.(20)

INTRODUCTION

Adequate prenatal care is positively correlated with birth outcomes such as healthy birth weights and reduced mortality while inadequate care is identified as a risk factor for more negative outcomes including preterm birth. (2) It has also been found that many factors can contribute to receiving inadequate prenatal care. In addition to smoking, alcohol use and lower levels of education; lower socioeconomic status, increased stress, low self-esteem and Indigenous cultural background are all associated with inadequate care. (2) In Manitoba, the "most significant predictor of inadequate care among women giving birth in Manitoba, after controlling for other maternal characteristics, was poverty." (2) The Manitoba First Nations Regional Health Survey reported that 80% of First Nations peoples live in poverty, and more than 2/3 of women in their study reported an annual income of less than $20,000. (2)

According to the 2016 census, 18% of the total population of Manitoba identifies as Indigenous (First Nations, Metis or Inuk).(3) Almost two thirds of Manitoban First Nations people are under the age of 35 and the fertility rate is overall higher (averaging 2.2 children/woman in combined Aboriginal population versus 1.6 children/woman in the non-Aboriginal population) (3)(4) Unfortunately, the infant mortality rate is also doubled in the Aboriginal population and this is similar across the Canadian provinces. (1)

There is limited data available about First Nations women's perspectives about the prenatal care available to them or their current experience with prenatal care. This study will examine from a qualitative perspective, the experiences of women in a northern First Nations community with regards to their prenatal care, and to explore their priorities in terms of the care they receive. A qualitative approach allows for first-person narratives of prenatal experiences

and provides an objective account of the current experience of Indigenous women in this northern First Nations community and their potential needs going forward.

BACKGROUND

1) Disparity between Indigenous and Non-Indigenous populations in terms of prenatal care and outcomes

Numerous studies have shown statistically significant differences in the prenatal care received, and corresponding outcomes between Indigenous and non-Indigenous women in Canada. In Manitoba, one study using the Kessner Adequacy of Prenatal Care Index found that 15.7% of Aboriginal women received prenatal care that was deemed to be "inadequate" versus 3.6% of women in the non-Aboriginal group.(2) Aboriginal women were more likely to have their first contact with prenatal care later in their pregnancy and to receive fewer healthcare visits related to their prenatal care. (2) In British Columbia, a study that looked at First Nations populations found that those mothers were also less likely to have an ultrasound before 20 weeks' gestation.(5) This study questioned if disparities in perinatal outcomes were in fact "downstream consequences" of differences in these mothers' prenatal care as fewer prenatal visits may increase the likelihood of pregnancy-associated complications such as pre-eclampsia or intrauterine growth restriction. (5)

Beyond the prenatal care received, disparities also exist in perinatal outcomes and overall, those outcomes generally appear worse in First Nations populations.(6) Many studies and a report from the College of Physicians & Surgeons of Manitoba state that First Nations women experience higher rates of infant mortality. (7)(8) In 2008, First Nations women were 1.75 times more likely to experience perinatal death than their non-First Nations counterparts.(8) This difference appears particularly pronounced in the post-neonatal phase

with differences in the neonatal phase not reaching statistical significance. (9) There are also reports of higher rates of stillbirth in the Aboriginal population.(5)

Evidence surrounding other perinatal outcomes is somewhat equivocal. Many studies suggest that First Nations women are more likely to have macrosomia (defined as babies born with birth weights >4000g) however, once adjusting for other factors in those studies, statistical significance was not consistently met.(6) In addition, though there are increased likelihood First Nations women will deliver their baby prematurely (before 37 weeks), after adjustment for other factors, in one study Aboriginal ethnicity alone was not shown to be associated in a statistically significant way with either low birth weight, or premature delivery.(6) The reasons for these differences in outcomes is likely multifactorial with social, economic, medical and prenatal care factors all contributing.(6)

2) The barriers to accessing prenatal care

Numerous barriers to accessing prenatal care can exist for all women, and Indigenous women in particular. Those barriers can be considered more individual or personal, those related to program delivery and to the care providers involved.

Consider that while there is universal healthcare in Canada, and prenatal care is "free," costs associated with transportation to and from appointments as well as access to transportation; and the potential need for childcare for women with other children at home has been identified as a significant barrier.(2) Many women also identify simply not knowing where to access services as an additional barrier.(10) These kinds of barriers affect lower income women disproportionately and may not even factor in as a barrier across income levels.

Living in more remote communities can provide additional barriers as access to prenatal care is more limited in rural and northern areas.(2) In addition, in Manitoba, tertiary care centres, and medical specialists, are concentrated in the South, in particular, in Winnipeg.(7) First Nations mothers were more likely to live in rural and more remote parts of the province. (5) Manitoba data suggests that almost 44% of the Aboriginal population lives rurally with an additional 15% living in a "small" population centre.(3)

Program characteristics including long office waits, scheduling issues, and increased distance to appointments as well as healthcare system issues including lack of availability of prenatal care providers or consistency in care providers provide additional barriers. (10)

More intangible barriers also exist in accessing prenatal care for many First Nations women. Previous qualitative study suggest that many First Nations women felt dissatisfied with their prenatal care citing a more authoritative approach and a lack of cultural sensitivity as being factors contributing to this dissatisfaction. (2) In addition to feeling "judged for lifestyle choices," there are often reports of underlying mistrust and fear of the Canadian health care system deeply rooted in the history of the relationship of the Federal government with Indigenous populations and the legacy of the Residential Schools which "created an environment of distrust between Aboriginal and non-Aboriginal populations that is still being passed on to the next generation today."(11) There is a history of discrimination and judgment within the Canadian health care system which carries over into mistrust and reluctance to access its services. One mother described an experience of being criticized for being "unprepared" as she did not arrive at a hospital with supplies for her baby without health care providers understanding that for her community, the "cultural belief is not to buy anything for baby until he or she is born." This mother reported feeling "unsupported and embarrassed" and the

resultant shame and guilt add a further layer of reluctance to participate in the healthcare system.(11) A tendency towards information sharing and not appearing "busy" were seen as positive qualities in prenatal program care providers.(10)

The Wetaskawin program in Alberta identified issues with judgment and lack of cultural understanding, in addition to more individual or personal barriers such as the practicalities of transportation and childcare, and attempted to attenuate some of those barriers by providing child care, consistent care providers and an environment of cultural safety.(11) Following its implementation, there were fewer First Nations women presenting to hospital with inadequate prenatal care prior to delivery. Almost all of the women (98%) stated they would return to the program for future pregnancies and that they would recommend the program to their family or friends.(11)

3) The current state of prenatal care in Indigenous populations in Canada

Health Services on Reserves fall under the purview of the Federal government and prenatal care on Reserves is therefore delivered according to Federal standards. In Manitoba, more than half of First Nations peoples with registered status live on Reserve.(12)(3) Most women on Reserve, therefore, receive prenatal care at nursing stations, however one study found that as many as 10.6% of women received "inadequate care" which they defined as 5 or fewer prenatal visits with a healthcare provider.(2) "Beginning Journey: First Nations Pregnancy Resource" is a book available to Indigenous women that provides information more specific to the Indigenous population. Though it refers to Ontario in particular, it acknowledges that traditions and customs vary from community to community.(13)

A shift in thinking has resulted in a significant reduction in the provision of maternity and birthing services in smaller communities and has resulted in the consolidation of those services

in larger centres across Canada. In Manitoba, this means those services are available primarily in Winnipeg, Thompson or The Pas. This shift disproportionately affects rural mothers, and as many Aboriginal women live in more remote areas, has affected them disproportionately as well.(14) The realities of having limited options beyond travel include issues of transportation, and leaving other children and partners behind in the home community.

The Health Canada Evacuation Policy requires First Nations women to leave communities and travel to larger centres at 36-38 weeks to await the birth of their child. (12)(15) If a pregnancy is deemed to be high risk, the evacuation will be to Winnipeg where tertiary care is available.(12) Until as recently as 2017, evacuation meant a mother may travel alone unless she was less than 18 years of age, or experiencing medical complications.(16) Confinement necessitates leaving behind other older children potentially, results in stress, loneliness, and isolation and can also be a financial burden either via the necessity to travel for a partner or spouse, or more expensive contact with home while away or the need for child care services for example. (14) The children of these mothers also experienced sadness and distress.(12) There are also studies linking evacuation with depression, loneliness, isolation, experiences of racism and "disconnection" with family and community. (12) Qualitative studies in B.C. have also associated the need to travel for birth with increased perinatal mortality and morbidity.(12)

The origin of the evacuation policy was suggested in one article to originate from the introduction of an obstetrician into a reserve in 1892 and was related to a "concerted effort to abolish pre-contact maternity care practices, midwives, medicines, ceremonies and to shift labour and birthing into the hospital setting."(12) The process of "forced evacuation" has colonial connotations, and is viewed as a cultural loss to the community and the loss of "something that brings joy and happiness."(12) It also symbolizes the absence of choice for women, a loss of

individual control over birthing decisions, and leads to isolation from their community, their support system and their family.(12)

More recently, greater attention has been focused on the process of returning birthing to many smaller and more remote communities, both from the communities themselves, and from The Society of Obstetricians and Gynecologists of Canada. (14) Studies looking at the availability of First Nations doulas, and of reintroducing Midwives into more remote communities is ongoing. Programs in this community have been initiated to provide doulas to women in the community with transition to doulas in the urban environment when the women travel to give birth. They are then reconnected with their original doula upon their return to home.(17)

4) The current state of prenatal care in rural communities versus urban centres in Canada

The Society of Obstetricians and Gynecologists of Canada standards for prenatal care suggest visits with healthcare providers every 4-6 weeks initially in pregnancy, then every 2-3 weeks after 30 weeks; and every 1-2 weeks after 36 weeks' gestation.(2) In Winnipeg, the majority of women receive prenatal care from a combination of their primary care provider and obstetricians.

Variation in pregnancy outcomes and in prenatal care exist in Manitoba, but the differences do not follow simple urban-rural divisions. In Manitoba, the geographical regions associated with the greatest proportion of women receiving inadequate prenatal care were located in the northern regions of the province, but also in the inner-city neighbourhoods in Winnipeg (which also consist of a larger proportion of Aboriginal peoples).(10) The influence of North versus South geographical location differed for First Nations versus non-First Nations women.

For all women, living in the North was associated with an increased risk for macrosomia. The effect of North-South location on infant mortality showed differences between the First Nations and non-First Nations group. Infant mortality was higher in the North versus the South, for both groups. However, women in the First Nations group had higher rates of post-neonatal mortality in the South than non-First Nations women (as much as 4 times the rate of their non-First Nations counterparts).(7) Infant mortality rates were therefore higher for First Nations women both in North and South geographic locations while this only held true in the North for non-First Nations women. The study concluded that "North-South place of residence does matter for adverse birth outcomes, but the effects may differ by ethnicity" with non-First Nations women having stronger trends of negative birth outcomes with residence in the North.(7) The writers acknowledge that their study was unable to address more "individual-level factors" that may impact on perinatal outcomes including access to prenatal care.(7)

A neighbourhood's socioeconomic status also appeared to play a role in prenatal care and pregnancy outcomes with some differences between First Nations and non-First Nations groups. One study examined the relationship of neighbourhood socioeconomic status (using measures such as income, unemployment, education and the percentage of lone parent households in a geographic area) to look at pregnancy outcomes in both First Nations and non-First Nations populations.(9) This study found that First Nations women were more likely to live in neighbourhoods with lower socioeconomic status ,and had higher risk of infant mortality (within the first year of baby's life) than the non-First Nations population. (9) However, in these lower income neighbourhoods, both First Nations and non-First Nations populations experienced similar rates of infant death. When adjusted for neighbourhood socioeconomic status, "the disparities in infant and post-neonatal mortality between First Nations and non-First Nations

were attenuated."(9) It was noted in this study as well that income and unemployment held the closest relationships with infant mortality while all four of the above factors in non-First Nations populations appeared to contribute equally to the increased rates of infant mortality. In general, low socioeconomic status in a neighbourhood, or for individuals is associated with poor health outcomes.(9)

5) Summary

Little evidence exists as to what components of prenatal care may be most helpful to improve perinatal outcomes, though trust and non-judgment appear to be common themes in promoting improved use of available prenatal care. (2)(10) Studies that have looked at motivators versus barriers to prenatal care have identified socialization, information gathering, and health benefits for both mother and baby as having a positive influence on prenatal care utilization.(10) Programs such as the Aboriginal Prenatal Wellness Program in Wetaskiwin (Alberta) has shown that culturally safe, integrated prenatal care targeted to Indigenous women can increase women's participation in the healthcare system and improve neonatal healthcare outcomes.(11)(10) Health care that is restricted by the "Euro-Canadian biomedical model, and that excludes Aboriginal ways of health and wellness can only result in health outcomes that are less than optimal."(12)

More broadly, a 2007 survey of Canadian women in 2007 sought to explore women's perceptions of their prenatal experiences. The Canadian Maternity Experiences Survey was undertaken by the Public Health Agency of Canada in an attempt to identify areas of strength and weakness in the current Canadian system. In this survey, almost half of women reported having "the same caregiver both prenatally and at birth" and a large majority identified this as being important to them. In addition, most women identified satisfaction with their prenatal care.(18)

In this study, fewer prenatal visits did not correlate with increased frequency of negative perinatal or maternal outcomes, however, fewer than 5% of women in the survey received fewer than 6 prenatal visits. (18) One limitation of this survey, however, is that it did not look at the Indigenous population specifically, and they were therefore unable to determine if this survey accurately reflected this population's experience of prenatal care.

There are many studies and articles that have attempted to look at the need for more targeted prenatal and infant care for underserved groups including Indigenous women and those living in communities with lower socioeconomic status.(9) This qualitative study of the experiences of women in this northern First Nations community will attempt to examine their perceptions of, and needs, related to their prenatal care using first-hand accounts obtained through interviews.

METHODS

An individual, semi-structured interview-based qualitative approach was selected to address the research question. With the permission of the community's health services director, participants were selected from the community with assistance from the Prenatal Nutrition Program Coordinator/Indigenous Doula Program Coordinator.

Eight participants were approached by the Canada Prenatal Nutrition Program Coordinator with an invitation to participate and subsequently signed informed consent documents agreeing to participate in the study. All eight participants completed the interview process.

Inclusion criteria were adult women living in the community who received prenatal care within the previous twelve months. The study attempted to include women from a variety of perspectives including women after their first delivery, women with more than one delivery,

women under the age of 25 and women over the age of 30. Exclusion criteria included women who received prenatal care more than twelve months prior to their interview.

Written, informed consent was sought from all participants. Each interview was held via telephone, and consent was reviewed verbally prior to the interview commencing. Participants were informed that the interview call was being recorded using an iPhone app for transcription purposes. Digital recordings of the interviews were transcribed using a transcription service and anonymized. Basic demographic data identifying age groups and gravida were obtained but no other identifying information and that information was deleted from the transcripts. Any written records used only participant number as identifier.

The anonymized transcripts were reviewed multiple times by the primary investigator and research supervisor to identify themes related to the current experience of women and their prenatal care; to identify any common themes within their perceived needs and any gaps in prenatal care and to identify the participants' priorities in terms of the care they receive. Transcripts were further analyzed using NVivo, a qualitative analysis software.

RESULTS

Eight First Nations women participated in interviews of approximately 15-20 minutes in duration. Four of the women who participated were under 25 years of age; three were over 30 years of age, and one was between the ages of 25 and 30. Five women had sought prenatal care for previous pregnancies; for three women, this was their first pregnancy and first time accessing prenatal care services.

After numerous readings of transcripts several themes emerged. The quotes in the text below are all from the interviews with participants included in this study.

5) Overcoming Barriers

Many women discussed overcoming several barriers in order to access the prenatal care that they received. Issues related to appointments and transportation were the most commonly cited barriers that women overcame to access prenatal care.

Appointment-related Issues

Prenatal care is primarily accessed through the community's Nursing Station. In addition to prenatal and public health, the Nursing Station provides a variety of services from primary care for minor injuries and illnesses to initial management of more serious traumas. Five participants cited various issues related to prenatal appointments. While many women state they had scheduled prenatal appointments, incoming more urgent matters may draw the nurse away from their prenatal appointment and result in long and difficult waits to see their care provider, often with other small children in tow. "…it's prenatal and public health together, the workers, it's a long wait." Many described the lack of availability of doctors on a regular basis, stating "the doctors are real busy here." The impression by many participants was that there was a limited number of nurses involved in prenatal care at the Nursing station and therefore limited availability of appointments, especially when the Nursing Station became busy with other issues.

Other access related concerns came up such as opening hours, with some women describing that the "Clinic is not always open." Others reported that the community was often "short staffed" resulting in issues related to the availability of appointments and contributing to longer wait times. Issues with staffing also appeared to result in cancellations with one participant saying that the nurse "would always cancel my appointments and then rebook them. When that date came, she would cancel again and rebook."

Difficulties with appointment scheduling and cancellation also resulted in financial hardship for some women who either used all their sick time or were unable to access their appointments for other work-related reasons. "I was missing too many work days, and I started getting deducted." One woman describes having to drive to Thompson (a 5 hour round trip) for all her prenatal appointments as there was inadequate staffing available at the Nursing Station at that time, whereby her appointments were either cancelled or staff were not available. She was grateful to her physician in Thompson, who agreed to see her at times on weekends as she had used all of her sick time before baby was born.

Transportation

Three participants described either access to transportation, or the need to travel long distances as another barrier in accessing care. In addition to the distances required to travel for doctors' appointments or to deliver their baby in Thompson, transportation could also pose a barrier within the community itself. To access community transportation, one participant states that "you have to call about 30 minutes early for the transportation to come to your house." "Sometimes I can't go when I don't have a ride." Prenatal classes that came with "a pick up" were a popular topic of conversation and were widely described as a way to improve access to prenatal education.

6) Respect and Dignity in Care

Themes of respect and dignity, including the importance of privacy and information sharing, emerged as a major theme especially in the perinatal period.

Privacy

A majority of participants (five) described that at times prenatal care privacy was difficult to maintain. One woman reports knowing her nurse socially which created an uncomfortable

dynamic due to the personal nature of the appointments. Some women described reminders about appointments being shared over the local radio instead of personal phone lines. "You know, when you have an appointment, sometimes they don't call your personal phone. They announce it over the radio…and they say call the nurse's station. Or come to the nurse's station…" There were also feelings from some participants that information was not always kept "confidential like they should" and with reference to their personal information, "Yeah, everyone knew about it."

Further issues with privacy were mentioned once women arrived in Thompson. While awaiting their hospital admission, women are often sent to a hotel unless they have family available to stay with in town. One participant described the atmosphere at the hotel as "shady" and that it didn't "feel comfortable…you don't have much privacy…there's people in the hallway and other pregnant girls who look like they hate being there."

Issues continued once admitted to hospital. "There was no privacy." Conversations about personal matters were largely public, even about more personal topics. "When they (the doctors) come in the room, they're talking to you and then everybody can hear. They should be discreet, or they should, I don't know, if there's something that can be done."

Information Sharing

Participants described appreciating when information was shared freely, and questions were answered openly and honestly. Four participants either attended or had heard about classes offered in the community. However, women who were aware of prenatal classes stated that they found out about them via the radio, or Facebook. No one reported hearing it directly from the prenatal nurses at the nursing station, with one participant reporting hearing about the classes directly from the Community Prenatal Nutrition Coordinator. Most women who were aware of

the classes were for the most part interested in additional information and would have liked the option. "They have classes, you know, they have classes about this, about when you're pregnant they offer classes like cooking classes and stuff like that. But no one ever told me about it. No one told me that I should go and that would have been really helpful if they did."

Information sharing by clinicians was reported as a valued aspect of care. "…they told me everything, like…they told me what this and that meant. They didn't try to switch the things around. They told me what exactly what it was about. That's what I liked about it." Many participants in the study enjoyed having a venue and opportunity to ask questions and be heard by their care providers. "I would ask a lot of questions, so they always answered them pretty well." However, many participants stated that they would prefer to receive more information in a verbal format versus just written information, "they don't really talk to you about anything. Just hand you a pamphlet, a book and send you on your way."

Racism and Bias

Few women described being faced with bias or racism during their prenatal care although questions were not specifically asked regarding same. However, there was mention that at the hospital in Thompson one participant was approached about birth control immediately after the birth of her child. She was left with the impression that this had to do with her cultural background versus some kind of routine practice but was uncertain, "I don't know if it's just Native women coming in and having kids if they ask, you know, you should get on birth control…they kind of insisted…and I told them, I said no."

7) Appreciation and Flexibility

Care in the Community

There was significant appreciation for being able to access much of the prenatal care women received in their home community despite the occasional inconveniences and barriers discussed above. Many women specifically appreciated the staff at the Nursing Station, many of whom they knew from previous pregnancies and trusted. "They do a good job taking care of your pregnancy…it's a bit familiar to you, now, those same people." One woman also stated that the Nursing Station would phone to follow up if she missed an appointment to make sure she was rescheduled, "they called me, and I told them I would be there again, then they re-booked my appointment…yeah, they called me." With regards to her care one woman stated, "I liked it. They helped a lot." Many women expressed that the care they received at the Nursing Station was genuine, "The nurses were there to help." Participants also stated that they always felt they could return to the Nursing Station with additional questions or concerns.

In terms of content, there was appreciation for the medical aspect of their prenatal care such as blood glucose monitoring and blood pressure measurement and the reassurance it provided. "…all those appointments took away the worry." They appreciated the frequent checks on baby and receiving additional information from other professions such as dieticians to help with meal planning and eating well. In addition, participants appreciated learning about more practical aspects of preparing for baby, such as when to change diaper sizes, how to eat well, and information about common infant issues such as cradle cap. It was widely reported that these appointments at the Nursing Station eased their mind and provided reassurance that the baby was developing well and was healthy.

Half of the women interviewed expressed a desire for more class or group-based education to expand on the medical aspect of the prenatal care they received at the Nursing Station. One participant enjoyed the practical aspect of some of the prenatal classes that have recently started in the community, expressing interest in cooking and sewing.

Connections with care workers were also valued. One participant describes that her usual physician who had been following her throughout her pregnancy was not the doctor to deliver her baby, however, "she did come to check up on me a couple of days after, so I was happy to see her and that she came to check on me." Consistency in care at the Nursing Station was another topic, with preferences for seeing someone familiar throughout the pregnancy for various reasons. "I think it does kind of matter to me. Knowing, so they don't have to read over your chart…" "I like having the same nurse knowing about my pregnancy." This was not consistently reported, however, with some participants being receptive to other care providers as long as they were able to answer their questions.

Care Provider Background

There was no clear preference for the type of medical provider delivering care though there was appreciation for having a familiar "friendly face" delivering the care regardless of their educational background. A few women did state they would prefer to see a doctor who was more experienced if there were any more significant issues. "As long as it's somebody that'll answer my questions, I'm alright with that." Others did find some greater benefit from seeing a physician, "I guess I was more satisfied because it was an actual doctor that was seeing me."

While there appeared to be flexibility regarding the educational background of the care provider, there was mention of a lack of choice. One participant, who, while she appreciated the care she received from her doctor, did not feel that there was any choice available to her. "…I

don't know if people feel like, can I have a different doctor…they don't really give you a choice. They kind of just say, this is your doctor."

8) Moving Forward

Dedicated Space & Home Visits

The interviews with participants did reveal some hopes for the future in terms of the prenatal experience in their community. Suggestion was made that a dedicated staff and space for prenatal appointments would be preferable, mostly due to the interruptions that are a reality of the Nursing Station being both primary care and prenatal care at the same time. Dedicated staff, not beheld to the changing needs of the urgent and primary care resources at the front desk, may reduce appointment changes and cancellations and decrease wait times.

In addition, the availability of home visits was appealing to some women who cited difficulty accessing transportation as a barrier to accessing prenatal care. "I would actually like to see the nurses coming to the house…'cause sometimes not a lot of people have rides." While they acknowledged that some assessment and treatment might need to take place in the clinic setting, education and the basic aspects of the appointments would be more convenient in the home, especially if there were other children to look after in the household.

Information Gaps

Mention was also made of a desire for greater time spent explaining and navigating the process of leaving the community to give birth. One woman described receiving an envelope of information regarding her travel to Thompson but was unsure how to navigate the more practical aspects such as transportation and reimbursement from the Band Office. "They totally just send you. They send you without…I guess they just assume you'll know." She would have appreciated more time spent explaining the process and more step by step instructions and

information related to this. "The community…is expected to know everybody and how things work."

There was more than one mention of the preference for verbal versus written communication. Receiving a paper handout was less welcomed than conversation. "Maybe, like, having one-on-one talking with me, letting me know these things, instead of me reading about it on my own." Additional information about postpartum depression would have been welcomed by some participants, "I wished they would have talked to me more about postpartum depression."

DISCUSSION

Analysis of Results

The results of this study and the background literature appear largely consistent. Barriers to accessing care were cited both in the literature and by participants with particular emphasis on the struggles related to transportation, the need to travel long distances at times along with the corresponding economic burden of this travel, and issues related to appointment scheduling and availability.(2)(10) Participants in this study added additional detail to some of these barriers in their community, such as the Nursing station's multipurpose role as both destination for prenatal as well as urgent care; and some of the staffing issues that are associated with smaller, rural centres. In addition, participants discussed the financial burden of time off work to access appointments either in Thompson, or due to long community wait times. Distance to appointments was mentioned as a barrier, though only in instances where due to staffing or other issues, travel was required to Thompson. In this northern First Nations community, prenatal services are usually available at the Nursing Station, which reduces some of the travel that is

associated with barriers in rural communities cited in the literature. However, barriers were still cited with regard to appointment scheduling and cancellations at the Nursing Station.

This study is limited, however, in its assessment of some of the perinatal outcomes often discussed in the literature. The participants in this study all sought out and received prenatal care, therefore there was no information gained regarding women who did not seek care, or who received inadequate care. Additionally, the interviews did not ask questions related to socioeconomic status including income, or perinatal outcomes such as macrosomia, prematurity or perinatal death. Having said this, mention of babies born greater than 4kg and of early delivery came up incidentally during the interviews. The interview did not include any questions regarding perinatal death or stillbirth, or any previous experiences related to these outcomes.

In terms of adequacy of care, many studies measured adequacy in terms of the Kessner Adequacy of Prenatal Care Index and used the number of prenatal visits and time of first prenatal visit to measure prenatal care received.(2) This study did not attempt to look at care adequacy, and did not ask specific questions to quantify the number of prenatal visits participants received before the birth of their children. Therefore, no comparison is possible between prenatal care satisfaction and the adequacy of care as measured by the number of prenatal visits using this measurement tool. All of the women in this study accessed prenatal care consistently throughout their pregnancy and were, for the most part, interested in receiving care. As such, this study does not address the literature related to reasons for not accessing care nor does it capture the viewpoints of women who may have received inadequate care.

Though not explicitly asked in the questionnaire, discussions that did arise regarding evacuation prior to birth were consistent with literature referring to isolation, loneliness and unhappiness. Participants cited lack of choice related to where and when they were boarded, and

a lack of information and direction about the processes especially for first time parents.(12)(14)(15) As expected, every participant left the community to give birth, travelling either to Winnipeg or Thompson.

The Contribution of this Research

Qualitative data examining the perspectives of First Nations' women about their prenatal experience is limited in the current literature. This study adds first person narratives about prenatal experiences for women living in the this northern First Nations community and records the voice of women in that community with regards to their prenatal care, their values, and hopes for the future regarding prenatal care. In addition, this study adds discussion about the challenges faced in accessing care, and the values held in high regard in the prenatal experience. The perspective of First Nations women is "often absent within the literature related to maternal and child health."(12) The emerging themes from this research may help to inform prenatal care going forward, giving validation to much of the care already in the place in the community, while acknowledging some of the barriers and needs that could be addressed in the future.

Next Steps, Further Research

This study relied on interviews with a small sample of eight women in a single northern First Nations community. A larger study with additional participants, or from various communities, may identify additional themes or add more robust evidence to some of the themes described above. The small sample size provides a snapshot only of a much larger population of women. Additional research into women's attitudes and interests in local midwifery or doula programs may also be of value due to the impromptu discussions that occurred in this study related to the interest in additional prenatal education and around travel to major centres in preparation for birth versus availability of services within the local area.

Further interviews with women who did not access care would be beneficial as further research on this topic. This study only discussed prenatal care with those women who had accessed care in their community and as such did not address the barriers or experiences of those who chose to not access care during their pregnancies for various reasons. Further research could examine the reasons and barriers behind not seeking prenatal care in an attempt to further explore some of these themes.

In terms of more quantifiable data, while the Maternal Experiences Survey attempted to look at the prenatal experience of women using their own words, it did not consider the unique perspectives or experience of First Nations women.(18)(19) An examination of this data with an Indigenous focus would be a valuable addition to the literature and would add context to the qualitative data in this study.

CONCLUSION

Limited data exists regarding the unique prenatal experiences of First Nations women in Canada. Using a semi-structured qualitative interview approach, this study contributes first-person narratives of the experiences of women living in a northern First Nations community with regards to their prenatal care. Themes of overcoming barriers, respect, and appreciation all emerged from interview data. As in the existing literature, access to transportation, and appointment availability were reported as common barriers to prenatal care. Details regarding perinatal outcomes were not included in this study, nor does this study address the unique perspectives of women who did not access prenatal care and the reasons for this. Going forward, additional research surrounding perinatal outcomes and the barriers to accessing prenatal care among women who did not seek prenatal care in the community would add valuable context to this study.

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