

# The Costs of Separation

## The Birth Experiences of Women in Isolated and Remote Communities in British Columbia

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*Cet article est le résultat d'une enquête qualitative des expériences d'accouchées dans les communautés éloignées de la Colombie-Britannique. Les résultats donnent une plus haut taux de mortalité causée par l'obligation pour les femmes de quitter leur communauté pour accoucher.*

There has been a precipitous decline during the past few years in the number of rural communities across Canada offering local maternity care services (Hutton-Czapski 2001, 2000; Rourke). There have been several contributors to this trend including health service delivery restructuring, difficulties in physician retention and recruitment in rural communities (Statement of Maternity and Newborn Care in Canada), and the trend towards the "medicalization" of childbirth in industrialized countries (Wieggers). Communities that have lost services now join other small rural and remote communities where, due to health human resource capacity, geographic isolation, and economies of scale, local birth has not been part of the health services infrastructure for several decades. Pregnant women in these small communities face significant challenges to accessing care, which in many instances leads to stress and anxiety during the childbearing year (Kornelsen and Grzybowski 2004b; Chamberlain and Barclay).

There is a growing understanding of the physiological consequences of stress during pregnancy, with research focusing primarily on the relationship between stress and preterm labour (Mackey and Boyle; Misra; Hedegaard *et al.* 1996; Cooper *et al.*; Wadhwa *et al.*; Mackey, Williams and Tiller; Hedegaard *et al.* 1993) and, as K. Marieke Paarlberg *et al.* note, the role of psychosocial stressors as determinants of obstetrical problems. Specific events correlated with stress include family disruption, a partner who is regularly absent, and financial insecurity due to job loss, transfer or no money at all (Moutquin), as well as the overall social or cultural context of a pregnant woman (Moffitt). Carol Hogue *et al.* describe,

Stressful life events have been defined as exposure to out-of-the-ordinary, demanding events ... that have the capacity to change the patterns of life or arouse very unpleasant feelings." (35)

One such stressful life event for rural pregnant women is leaving their community and family to give birth. This may be particularly relevant to Aboriginal women, many of whom live in small often marginalized communities in rural environments. Historically birth in Aboriginal communities was a community event and

as such, strengthened ties within families and nations (Moffitt). More recently there has been a systematic evacuation of women due to shifting policy and practice including immigration restrictions on foreign-trained nurse-midwives who traditionally staffed remote outposts (Jasen). The consequences have been severe, leading away from birth as a community event to birth as an isolating experience resulting in feelings of loss of control for women (Jasen; Robinson; Voisey *et al.*). There are also implications for the community. In describing the Pauktuutit (Inuit Women's Association) perspective, Martha Greig notes that the loss of self-sufficiency and competency is felt by older women as well, for those who acted as midwives in the past believe their own knowledge has been discredited, wasted, and ignored.

When talking of their evacuation experience, northern Aboriginal women themselves express regret at not having family close by to share their birthing experience and note the difficulty for women to focus on giving birth to a newborn when they are anxious about being away from their homes and children for extended periods of time (Paulette; Voisey *et al.*). In a comprehensive overview of the unintended consequences of maternal evacuation from the far north, Jennifer Stonier lists the detrimental health effects on women (e.g.,

loneliness, worry, anxiety, loss of appetite, increased smoking behaviour) and those on the children and family left behind (increased rates of illness and school problems for other children of evacuated women and the loss of understanding of the birth process among men). Stonier also describes that with so much energy, time, and money devoted to the immediate intrapartum period, fewer

social and economic realities of life in rural, remote, and small urban communities. Data collection was carried out in eleven rural and remote communities of mixed Aboriginal and non-Aboriginal populations in British Columbia chosen to represent diversity in cultural and ethnic sub-populations, size, geographic features, and distance to nearest hospital with cesarean section capability in usual

had given birth up to 24 months prior to the onset of the study and whose primary residence during this time was in one of the research communities. A total of eleven women were interviewed, all of whom gave birth outside their community. All interviews except one were audio tape-recorded (one participant expressed a preference not to be recorded) and transcribed. Extensive field notes were also taken by both authors following each interview. Seven women in three communities were video-taped. All data is included in the analysis. Ethical approval for the study was sought and received from the appropriate Behavioural Research Ethics Board.

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resources were available for care and education services within the community, contributing to the diminishment of prenatal preparation and postnatal support.

Although the experiences of women in the Canadian far north have been well-documented (Chamberlain and Barclay; Jasen; O’Neil and Gilbert), we do not have a clear understanding of the experiences of women in remote or isolated communities in other parts of the country where health services context, geography, and access to services may differ significantly from their far northern counterparts which tend to be more isolated. This paper will consider results from a qualitative study on remote and isolated rural pregnant women’s experiences of leaving their communities to give birth. An understanding of women’s experiences leads to a greater understanding of the importance of attending to the psycho-social needs of isolated and remote pregnant women, and their families.

## **Methods**

The goal of this exploratory, qualitative study was to investigate rural pregnant women’s experiences of obstetrical care in the context of the

conditions of road and air access in winter months. Three of the communities were very small, isolated, and remote (total population of the communities is under 1,000) and although they met access to services standards set by provincial policy documents (access to obstetrical services within four hours air travel [Mate]), they were over nine hours from such services by car. Furthermore, these communities had not supported local birth for residents for over 30 years. We hypothesized that the longstanding lack of local services would contribute important insights to our program of research into the experiences of women from rural communities no longer able to access services in their home community. For this reason, transcripts were analyzed separately and results disaggregated from the larger study.

## **Data Collection**

The isolated and remote communities were all primarily Aboriginal with a small non-Aboriginal birthing population. Permission was requested by the research team from the Band and Health Councils to undertake the research within the communities. Once permission was received, face-to-face unstructured interviews were undertaken with women who

## **Data Analysis**

The analysis was carried out in two phases using a modified approach to grounded theory which included the use of traditional procedures such as the coding of emerging data, the use of techniques for ongoing comparative analysis, making connections between themes and sub-themes and memo writing as a form of reflexivity (Charmaz). In phase one, both authors independently coded the transcripts and field notes and identified emerging themes. Upon comparison there was a high degree of thematic congruence between the independent coding. Phase two involved collaboratively articulating the meta-themes of separation, social disruption and costs.

## **Theoretical Framework**

The narratives of participants in this study were grounded in stories of social disruption and separation and the costs associated with such separation. As experiences of stress and anxiety were common to many of the women we spoke with, the results are considered from within current literature on psychosocial determinants of stress in pregnancy.

## **Results**

The women in these communities are advised to travel to the referral

community where they will give birth at, or close to, 36 weeks gestation as lack of local maternity health services resources precludes local birth. Where possible the women are accompanied by partners or family members for part of their stay in the referral community (which may last up to six weeks).

Participants in this study conveyed narratives around their birthing experiences that were underscored by the themes of *separation* at the time of birth and the *social disruption* and other *costs* associated with this separation. These themes emerged through the following discussions.

### **Deciding on a Referral Community**

Several factors came into play for participants when determining where they would give birth, including geographic proximity, familiarity with the community (“When we leave here to go shopping people go to [community] so it’s like, automatic to go there. We know where everything is.”), physician referral patterns, reputation of the community and, most importantly, the presence of family and friends. Although the presence of family and friends in the referral community often mitigated the financial burden many of the participants faced, it did not diminish the anxiety most participants felt being away from their home community and their other children.

Although most participants traveled to the nearest referral community for birth (nine hours by car) some traveled farther if they needed more specialized care or chose to relocate to a larger community where extended family or friends resided. These participants felt the effects of being further isolated from their home communities and felt daunted by the contrast between their experiences in a small rural community and the urban environment. As one noted,

*I’m Native—I’m a big chicken to be in [the big city]. There was a shopping mall across the street—I*

*wouldn’t even go to it. I just stayed in my hotel room.*

### **Experiences in Referral Communities**

Due to the sustained high outflow of women from the study communities, an informal protocol had been established around accommodation alternatives and referral to appropriate care which included access to care

*[My husband and I] got a kitchenette so that we could cook for ourselves, but I just found it hard because you don’t have everything you need there. Like if you were trying to make something you need some certain spice for you’ve got to go out and spend five bucks for a bottle of spice that you’re going to use one night. So a lot of times I said “to heck with it!” and ended*

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**“It was pretty hard. I think it’s best if they go with you cause it’s hard, cause then your mind is on one thing. You’re worried about the baby you’re having and the kids you left at home.”**

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providers sensitized to the conditions and challenges faced by women coming from the remote, isolated communities and the availability of accommodation that supported extended families.

However, despite addressing these logistical concerns, the women in this study struggled with their displacement from their communities and families. As one participant noted,

*That was rough cause it was my first kid and staying in a hotel, I didn’t like that. Cause you had to stay in a hotel the whole time you were there and you go there for a whole month, one month before you have your baby so you’re there like when you’re eight months [pregnant].*

Although some participants commented favourably on the availability of accommodations that were conducive to a family-centered experience (including rooms for other family member and facilities for cooking) many still experienced the challenge of a disrupted routine and being away from resources that they were familiar with. In some instances, this led to health consequences. As one participant expressed,

*up ordering out.... And a lot of women I’ve heard say, like, I gained 15 pounds my last month when I was in town cause you just get into that habit of eating whatever....*

The level of satisfaction of experience in the referral community was directly related to whether or not participants already had children, as the reality of either bringing children to the referral community or leaving them behind precipitated stress and anxiety. Most participants with school-aged children made arrangements for them to stay in their home community with family or friends. Aside from the logistical challenges of securing care for the children, leaving part of the family behind led to a sense of bifurcation for many of the participants. As one noted,

*[I couldn’t take the older ones] cause they go to school but [the baby] was born in February so I had to leave them after the holidays. It was pretty hard. I think it’s best if they go with you cause it’s hard, cause [then] your mind is on one thing. You’re worried about the baby you’re having and the kids [you left at home].*

This often led to the desire to

return home as quickly as possible, sometimes even before the birth due to the stress and anxiety of being away. As one woman commented, "At the end of it I just got to the point where I said, if I don't have this baby this week I'm going to leave anyways." This participant recognized the consequences—having an unassisted birth in her home community—and went on to juxtapose the risks of staying in the referral community and returning home.

*[My doctor] got in touch with a specialist ... and I just told him it can't be healthy for my baby either for me to be depressed because that's how I feel. I feel depressed. I don't want to be here and ... [the doctor] said, "well if she's that far along and she is depressed and she wants to go home ... then let her go."*

### **Financial Costs**

Aside from logistical challenges and a sense of separation from usual mechanisms of support that leaving the community precipitated, almost all participants noted the financial consequences of giving birth in a referral community. Although Aboriginal women are compensated for travel, accommodation and food, many noted incidental costs that they were responsible for. As one participant noted,

*Yeah, [I talked to my daughter] every night. It cost a lot of money. A lot of phone cards. She had a hard time with her homework. And I used to help her with her homework over the phone.*

Other non-Aboriginal participants observed inequities in access to services for rural women. As one commented:

*I think they should pay for us to go away. It's not fair. You know it's a lot of money then just added stress that you don't need.... For somebody who doesn't have extended health [care benefits], even*

*if you do have extended health it's expensive to have to put it out of pocket first and get it back later.*

### **Social Costs**

Beyond financial costs incurred, the social costs of leaving the community were the high levels of stress and anxiety experienced by most of the participants. One participant related her concerns over the stress she was experiencing in the referral community to the health of her third baby, drawing on her previous two pregnancies:

*I was concerned with my baby ... from me being so stressed out.... With my first son I wasn't stressed out through my pregnancy and he was fine. My second son, I had a very stressful pregnancy and by the time he was about, well, from the time he was born, we couldn't restrain him. He would sit in his car seat and he would cry and then by the time he was about 18 months he was a real handful. He had a lot [...] you could tell there was a big difference in him. So at the end, towards the end [of my pregnancy] when I was really stressed out, I was worried that [my anxiety might have the same effect as it did on the second one.*

She went on to describe some manifestations of stress she experienced during the time away from her community, such as loss of appetite.

*Actually I did lose [weight] but I think that was the stress... I was eating, but I wasn't eating lots. I just kind of ate to keep myself going. I was just stressed out. I had a lot of anxiety about being there so I lost [weight] in my last month.*

Another participant spoke of the adjustment period with her family when she did return home after giving birth away:

*When I got home it was hard because the kids ... were so excited*

*to see the baby and see their parents, you know, by the time you had to bring ... [the baby] into the house, really you haven't been there for so long and you've only been caring for yourself for a month and then you come home and you've got three kids.... You know it's hard you go from almost nothing to overload just overnight.*

### **Discussion**

Despite the social consequences of being separated from their home communities and support structures, many participants in this study had positive impressions of the care they received and their arrangements in the referral communities. Participants in this study expressed the belief that their physiological needs were met through a stable protocol involving evacuation to referral communities one month before their expected due date. They described the efforts made by health care providers within their local communities to secure appropriate care in referral communities and accommodation that met their needs and that of their families. Yet, experiences of stress and anxiety around leaving their communities were common to most women in this study due to the social disruption and sense of separation/isolation evacuation precipitated. These experiences were especially acute when the women were separated from other children who remained behind in their home community.

Effects of stress on health in pregnancy have been most closely related to pre-term delivery (Moutquin; Misra *et al.*; Mackey and Boyle; Mackey, Williams and Tiller; Cooper *et al.*; Hedegaard *et al.* 1996, 1993). This literature is part of a growing body of work investigating the psycho-social determinants of stress and the physiological implications of stress on health (Mate; Elstad). Thematic to this larger work is an understanding of the importance of social relationships in mitigating stress (Kornelsen and Grzybowski 2004b).

This was intuitively both understood—and experienced—by women in this study who expressed anxiety over loss of such support when they were separated from their social networks. Many tried to reassemble a sense of community within the referral setting either by having family accompany them to the birth (often a difficult undertaking due to the time away from the community this entailed and the associated costs) or choosing the location for birth based on the presence of family. Although leaving the home community at the time of birth was seen causally leading to stress and anxiety for many participants, underlying the action was a sense of loss of control: participants did not have the choice to stay nor any input regarding the timing of their departure.

Although we currently lack adequate evidence to determine policy around the size and isolation of a community that would justify maternity care (Kornelsen and Grzybowski 2004a), there are practical limits to the size and location of communities that suggest when local care may not be feasible. This may be the case for the isolated and remote communities participating in this study. Nevertheless there are significant social consequences experienced by women in this study when separated from their home communities to give birth. These consequences may be mitigated by attending to providing and maintaining antenatal support within the communities that would prepare women for evacuation in a collaborative way and involve women in the decision-making processes around their care. As Carol Hogue *et al.* note:

A sense of control or mastery has been shown to reduce psychological distress and positively affect physical health, as well as to buffer the negative consequence of stressors on mental and physical health. (32)

Mitigation of stress may also in-

volve securing family-centered accommodation for all women leaving isolated communities so they can benefit from the community and social support that is integral to their lives during one of the most joyous—and potentially vulnerable—experiences they will have.

Overall, participants from the isolated communities in this study did not express a desire to birth locally, due in part to perceptions that it would be unsafe because of the lack of local caregiver support, technological resources, and transport challenges (should emergency transport be necessary). This was a significant difference from women in communities that had recently lost, or were facing imminent challenges to, local birthing services (Kornelsen and Grzybowski 2004b). Differences in safety issues around access to technology and transport provide only a partial explanation of this difference. A more compelling influence may be the loss of a cultural vision of local birth. The lack of a community-based birthing narrative woven from the contemporary experiences of local women has a profound influence on what alternatives are believed to be within the realm of possibility. When the cultural narrative around birth is exclusively one of experiences outside their home communities, the ability to imagine anything different disappears.

Methodological limitations of this study include small sample size, one geographic area, and limited recruitment due to geographical challenges of distance between the research team and the research communities. As in all qualitative research, selected participants are able to articulate more compellingly than others. Care was taken to adequately represent narratives contributing to each theme among all participants.

## Conclusion

In spite of 30 years of lack of local birthing services and an established evacuation protocol, women living

in remote rural British Columbia described significant stressors and costs associated with birthing in referral centers. Participants in this study identified barriers to achieving adequate social support away from home that would help to mitigate the stress they experienced. The psychosocial needs of the pregnant women from these communities must be attended to in order to ensure positive outcomes for birthing mothers, their newborns, families, and communities.

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