

Haida Gwaii: Maternity Care



Summary of a Study of Local Birthing Services

About this report

In 2006, the Centre for Rural Health Research conducted a study on sustainable maternity services in Haida Gwaii, visiting the communities of Masset, Old Massett, Queen Charlotte, and Skidegate. The **goals** of this project were:

1. To explore community perceptions of the importance of local birth,
2. To examine the sustainability of the current level of maternity services in each community, and
3. To consider the potential for enhanced local maternity care services.

This **summary** outlines the results of the study and includes recommendations based on a) the findings from interviews and focus groups with 43 participants, b) community forums undertaken after data collection, and c) our systems understanding of sustainable models of maternity service in rural British Columbia from our larger program of research. Collaborators in this research included the Northern Health Authority, First Nations and Inuit Health, and the BC Reproductive Care Program.

Background & Context

In British Columbia, more than 20 communities have closed local maternity services since 2000. These closures are due, in part, to the challenges that rural care providers face in



Map 1: Haida Gwaii

providing local maternity services including: limited maternity training, stress, and lack of funding for being on-call for births. Many rural women must leave their communities to give birth, leading to stress, anxiety, significant financial expenses, lack of continuity of care, and separation from family and community. Recent pilot work suggests that babies born to women from communities without local access to maternity services experience higher rates of perinatal morbidity. Women from remote communities are often directed to travel to the planned referral community at 36 or 37 weeks' gestation to await the onset of spontaneous labour. Some women choose elective

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induction in preference to long waits away from home. Other rural women choose to remain in their home community and arrive in labour at their local hospital, regardless of the lack of local maternity services, which forces local care providers to provide emergency delivery care.

Aboriginal Maternity Care

Our recent research suggests that Aboriginal communities feel the impact of the loss of local birth services more acutely than non-Aboriginal families, due in part to the First Nations' historic and cultural importance of local birth as a community event that unifies families. Some women in Aboriginal communities have traditionally served as midwives, offering their expertise and cultural knowledge to assist local birthing women. However, the closure of maternity services in Aboriginal communities across Canada has left many traditional birth attendants feeling that their knowledge has been wasted, discredited, or ignored.

In Canada, Aboriginal women experience rates of infant mortality and stillbirth that are double the Canadian national average. Recent national initiatives to improve Aboriginal perinatal out-

comes focus on *the importance of keeping birth close to home* and including all key stakeholders in the decision-making process surrounding maternity care service provision.

How Safe is Rural Maternity Care?

There is evidence to suggest that low-volume, rural birthing services, when integrated into a regionalized system of perinatal care, can safely provide local birthing services to women – even without local caesarean section capability.^{1 2 3} Some low-risk pregnant women may even benefit from the “minimal intervention” approach to labour and delivery offered in rural birthing centres, suggesting that, for some women, birth in a rural service centre may actually result in better outcomes than birth in a larger centre. However, some care providers and decision makers continue to have concerns about the risks of providing maternity services in settings without local caesarean section. What has been missing from an overall understanding of the safety of small, rural services is a greater appreciation of the social stressors and consequent adverse outcomes related to separation from home and family during the time of birth.⁴



Haida Gwaii birth tunnel

1 Gryzybowski S, Cadesky A, Hogg I. (1991). Rural Obstetrics: a 5-year prospective study of the outcomes of all pregnancies in a remote northern community. *CMAJ*, 144(8):987-994.

2 Nesbitt T S. (1996). Rural maternity care: New models of access. *Birth*, 23(3): 161-165.

3 Cameron B, Cameron S. (2001). Outcomes in rural obstetrics, Atherton Hospital 1991-2000. *Aust J Rural Health*, 9 Suppl 1:S39-42.

4 Kornelsen J, Grzybowski S. The costs of separation: the birth experiences of women in isolated remote communities in British Columbia. *Can Women's Stud* 2005; 24(1):75-80.

Planning Rural Birth Services

In British Columbia, there is currently no systematic approach to planning rural maternity services and a limited evidence base to inform such decision making. Health planners are responsible for making decisions that meet the needs of rural populations within a context of competing social, political, and financial priorities, and often use an ad-hoc approach in response to a deemed local maternity health service problem. Our research has examined the systematic sustainability of small rural maternity services in British Columbia and we believe that, by defining population catchments for each service, and measuring the local need for maternity services based on size of birthing population, the vulnerability of the population, and its isolation, we can develop a quantitative guide to appropriate and sustainable services. We have named this measure the Rural Birth Index and calculated a score for each maternity service catchment. We have used our qualitative findings to parameterize the scores against existing and projected sustainable services, ranging from no local maternity services, to access to services provided by a specialist.

The formula is:

$$RBI = (PBS \times APV) + IF$$

- **PBS** (Population Birth Score): The average number of births in a hospital's one hour catchment over 5 years divided by 10
- **APV** (Adjustment for Population Vulnerability): A social vulnerability score derived from BC Statistics, ranging from 0.8 (advantaged) to 1.4 (disadvantaged).

→ **IF** (Isolation Factor): The degree of isolation based on the following travel times to cesarean services:

Distance	Score
Less than 30 minutes	-3
31-45 minutes	-2
45-60 minutes	-1
60-90 minutes	1
90-120 minutes	2
2-4 hours	3
Greater than 4 hours	4

The RBI score for a community correlates to a recommended service level, as follows:

RBI Score	Recommended Service Level
0-7	No local intrapartum services
7-9	Local intrapartum services without operative delivery
9-14	Local GP Surgical services
14-27	Mixed model of Specialists and GP Surgeons
>27	Specialist service

We have calculated RBI scores for all rural community catchments in British Columbia with a population of 25,000 or less and a history of local maternity services. The RBI score aligns with existing service level in 33 of 42 small rural communities, and our research suggests that 6 of the remaining 9 communities have unsustainable and suboptimal levels of care.⁵

The RBI model should be used as a starting point for decision makers in a three-stage maternity service planning process:

Stage 1: Use the RBI to determine the appropriate level of maternity service for a rural community;

⁵ Grzybowski S, et al. Planning the optimal level of local maternity service for small rural communities: A systems study in British Columbia. *J Health Policy*. 2009 Oct;92(23):149-57.

Stage 2: Assess the feasibility of this level of service based on community characteristics (such as a review of existing facilities, availability of health human resources, consideration of transport, and economic issues); and

Stage 3: Consider the implementation of the appropriate level of service based on the Health Authority’s *planning priorities* (e.g. maternity care versus palliative care for a given region).⁶

Haida Gwaii: RBI Score

We have used the Rural Birth Index to calculate the optimal, sustainable level of maternity service for Masset and Queen Charlotte (see Table 1).

Community	PBS	APV	Nearest C-section Service	Surface Travel Time	Isolation Factor	RBI Score	Recommended Service
Masset	1.9	1.19	Prince Rupert	>240 min	4	6.3*	No local delivery services
Queen Charlotte	3.2	1.19	Prince Rupert	>240 min	4	7.8	Delivery Service w/o C-Section

Based on the communities’ population size, geographic isolation, and social vulnerability, it is evident that while local birthing services are sustainable in Queen Charlotte, the birthing population in Masset* is probably too small to sustain local services. However, if we stretch the one-hour catchment to include both communities based on their significant isolation, a combined score of

6 Grzybowski S, Kornelsen J, Schuurman N. Planning the optimal level of maternity service for small rural communities: A systems study in British Columbia. *J Hlth Pol* 2009 Oct;92(2-3):149-157.

* RBI score for Masset may be underestimated due to inaccurate recording of mother’s address at referral hospitals.

10.1 is generated, which would support local GP Surgery.

Haida Gwaii Demographics

Haida Gwaii is home to 4,812 residents, of whom 36.7% are Aboriginal, primarily of the Haida Nation. Approximately 2,300 residents, or 48% of the islands’ population, live within a one-hour drive of Queen Charlotte Islands General Hospital (QCIGH) in Queen Charlotte. The remaining residents live primarily in the northern half of the region in the communities of Masset and Old Massett.

At the time of this study (2006), Masset’s health centre offered no local birthing services, while the QCIGH offered birthing services without local caesarean section back-up. In total, Haida Gwaii has on average 50.6 births per year, the majority of which (over 75%) take place in referral centres on the mainland (see Table 2).

The nearest 24/7 caesarean section service and consultant obstetrician is at Prince Rupert Regional Hospital in Prince Rupert, 120 km away (approximately 2 hours air travel time in good weather). Although Haida Gwaii women can access local low-risk maternity care in Queen Charlotte, stress associated with the lack of local surgical back-up results in three-quarters of women delivering elsewhere.

Community	2001-2	2002-3	2003-4	2004-5	2005-6	5-year Avg.
Queen Charlotte	14	9	17	10	10	12.0
Terrace	2	5	5	1	2	3.0
Prince Rupert	24	23	26	25	24	24.4
Other	14	10	14	9	9	11.2
Total	54	47	62	45	45	50.6

Study Methods

Research was undertaken in Bella Coola, Queen Charlotte/Skidegate, and Masset/Old Massett (the results of our Bella Coola study are reported elsewhere). These three communities were chosen based on the following criteria: population size, ethno-cultural diversity, geographic realities, “high outflow” of birthing women, and a range of existing maternity service levels (no local maternity care, local primary maternity care, local maternity care with surgical back-up).

This project sought to have participants identify the resources and activities that were necessary to meet the needs of rural parturient women – either locally or in referral communities. Two important goals of the research were (1) ensuring all voices – community and decision-making – were heard, and (2) respecting the importance of



an ongoing relationship between research teams and local community leaders and health service planners in order to ensure that the results of the research were integrated into community planning.

We conducted interviews and focus groups with key stakeholders (including care providers, allied health professionals, and community leaders) in each community. In a second visit, we returned the qualitative results and initial analytic findings to the communities to assess the accuracy of our understanding.

What We Learned

In the interviews and focus groups, care providers, allied health professionals, and community leaders explored the activities and resources they felt were necessary to support sustainable birthing services. They also discussed the barriers to a local birthing service, where relevant, and the characteristics of the support needed by women who were forced to travel to access maternity care. The findings are organized for each of the following participant groups: Queen Charlotte care providers, Masset care providers, Masset/Old Massett community leaders, and allied health professionals from across Haida Gwaii. Due to the limited number of community leaders who participated in data collection in Queen Charlotte/Skidegate (n=3) and the similarity between their stories and those of allied health professionals, we have combined their findings.

Furthermore, as we explored the vision held by various stakeholder groups with respect to appropriate maternity services, we found that different groups clearly articulated *values, assumptions,*

and *beliefs* about birth, and these were not always congruent. It is important to understand these perspectives, and how they differed between the three groups, as they provide the foundation for the activities and perceived barriers for sustainable local maternity care.

Queen Charlotte: Care Providers

Activities to Support Local Birth

Care providers in Queen Charlotte expressed a commitment to supporting local access to intrapartum maternity services. This was underpinned by an understanding of the importance of local birth to the community. To support local birthing services, care providers emphasized the importance of creating a stable complement of care providers who are skilled in obstetrics for a low-volume, low-resource rural environment. As one participant stated, “The stability of the staffing is the biggest threat to sustainability” (021, 107-108).

Specific strategies for retaining skilled care providers included 1) continuing professional development through ALSO/ALARM/NRP certification,



Labour / delivery room in Queen Charlotte Hospital

mock scenario training, and visits from traveling instructors; 2) increased funding for on-call maternity care for nurses; and 3) an improved work environment that supports collegial, interprofessional, team-based care. Many noted that the hospital already has a “solid core” or “steady group” of maternity care providers, whose stability and integration with the community have made local labour and delivery care possible.

In addition to recruiting, retaining, and training skilled care providers, several other activities were identified to support local birth for Queen Charlotte/Skidegate:

- Providing comprehensive prenatal care;
- Enhancing the hospital’s physical infrastructure;
- Enhancing access to and support for birth away from the community;
- Having a risk screening protocol for local birth;
- Developing an informed consent process for local birth; and
- Working with the community to collectively acknowledge the risks of local birth.

Barriers to Local Birth

Care providers in Queen Charlotte also identified barriers to sustainable local maternity care, focusing on challenges to retention of skilled providers and potential challenges to interprofessional collaboration with midwives. The barriers they perceived included:

- Care providers have difficulty accessing ongoing continuing medical education;
- New nurses often lack experience with maternity care;
- The loss of maternity care “champions” in the hospital could lead to closure of services; and

- The introduction of midwifery might not be sustainable due to the small size of the birthing population.

Activities to Support Birth Away

Although, in an ideal world, all low-risk women from Queen Charlotte/Skidegate would be able to give birth in their community within a supportive network of family and friends, care providers emphasized that there will always be women who need to leave Haida Gwaii to access a higher level of care, both in emergent and planned situations. Care providers noted some positive strategies for supporting women who give birth away:

- Strengthening the organization of emergency transport to Prince Rupert; and
- Supporting extended family to attend births off-island.

Barriers to Supporting Birth Away

Within the context of supporting sustainable care to women who access services away, care providers focused predominantly on barriers to evacuating women from the community. Many spoke of the challenges of inclement weather while others noted that ambulance attendants on the islands are afraid to support emergent deliveries, as many lack skills and experience with labour and delivery. However the most common challenge expressed by care providers was the social and financial impact on families of having to leave the islands to give birth, which some noted leads to poor birth outcomes (e.g. breastfeeding difficulties and higher caesarean section rates).

Risk Management Strategies

Care providers expressed that risk management strategies are central to safe, sustainable maternity care in Queen Charlotte/Skidegate. For care providers in this community, “risk” included both clinical and social dimensions – clinical risk to the mother and baby, social risk to the mother and her family of leaving the community to give birth, and social risk or stress to nurses and physicians of providing maternity care without surgical back-up. Care providers’ maternity care risk assessment management strategies are described below:

- Providing comprehensive prenatal education;
- Conducting careful prenatal screening;
- Informing women of the risks and benefits of local birth through a rigorous informed consent process (including the use of a signed form);
- Creating a woman- and family-centered birth environment; and
- Discouraging local birth for first-time mothers.



Queen Charlotte physicians Dr. Tracy Morton (left) and Dr. Jamie Chrones.

Barriers to Risk Management

Care providers emphasized that risk management is still a concern for them. Many spoke of their personal fears of attending births on island. A number of care providers had attended deliveries during which an infant had died. These traumatic experiences coloured their perception of the safety of local birth and their level of comfort providing labour and delivery care. Care providers' perceptions of risk influenced some women to bypass the local system of care. This was associated with some women:

- Attending only a limited number of prenatal classes;
- Having poor communication with hospital staff and community; and
- In some cases, giving birth outside of the system (e.g. unassisted home births, not traveling off-island when recommended).

Masset: Care Providers

Activities to Support Local Birth

Care providers in Masset/Old Massett communicated 1) a belief that local birth within the current system is unsafe and 2) that birthing women should be well-supported in accessing maternity services in referral communities. However, many care providers expressed a desire to make local birth a safe and sustainable option for women, in recognition of the social and spiritual importance of local birth to the community.

Participants emphasized that the most important factor should local birth be considered is the recruitment and retention of skilled care providers who are personally committed to supporting ma-

I know that I don't sleep particularly well two or three weeks before each delivery. (026, 77-78)

I think the biggest [challenge] is probably lack of staff experience and education, that's my personal feeling. (029, 484-85)

ternity care. Suggested strategies to make the care provider team more sustainable included:

- Recruiting care providers with maternity skills;
- Engaging in team-building activities;
- Improving the work environment; and
- Upgrading maternity skills.

Barriers to Local Birth

Participants noted that their current maternity care work environment is highly stressful due to the low volume of deliveries, geographic isolation, high turnover leading to lack of leadership and continuity of care. Many also expressed that they incur a great deal of personal stress related to emergent deliveries and unassisted home births. In addition



to these professional challenges, participants also suggested the following barriers to local birth:

- The care providers and community have different perceptions of “risk” in childbirth;
- Care providers fear litigation in the event of a bad perinatal outcome;
- Maternity skills are not a priority when recruiting care providers and locums;
- Introducing midwifery into the community might not be sustainable due to the small number of births and care provider resistance to the model of care as well as issues around homebirth; and
- The hospital's physical infrastructure for maternity care is outdated.

Characteristics of Birth Away

Within the current model of care (no local birth), women must leave Haida Gwaii to access maternity services, both in emergent and planned situations. Care providers in Masset/Old Massett noted some positive strategies for supporting women who give birth in referral centres, including creating better accommodation for women and their families. The predominant focus, though, was on the existing barriers to safe and sustainable access to maternity care in other communities. These barriers included:

- Intermittent access to emergency transport due to inclement weather and challenging geography; and
- Birthing women and their families incur significant social and financial costs in leaving the community to give birth.

Communication with the Community

Care providers in Masset/Old Massett emphasized that one of the most important strategies for sustainable maternity services is good communica-

tion between the community and the hospital staff. Many wanted to listen to and honour the community's perspectives on birth. This was particularly important with regard to the First Nations community in order to understand and better meet their cultural health care needs. Care providers expressed that, in the past, maternity services have been based on physicians' level of comfort and experience, rather than the community's needs. Some of the care providers communicated their fears about the risks of local birth at the *community forum* hosted by the research team to validate preliminary findings of the study. For many participants at the forum, this exercise represented the first time they voiced their concerns and heard different views on local birth. Care providers expressed that such strategies for communication lead to mutual understanding and better health care and should be replicated.

Risk Management Strategies

The importance of risk management was a central theme for care providers in Masset/Old Massett. Participants emphasized that they are resistant to the option of local birth within the current system



Suzanne Johnston (Northern Health, at left) in action at the community forum.

because of concerns regarding clinical safety for patients in the low-volume, low-resource hospital available. Concerns about the risks associated with local birth led providers in Queen Charlotte to place a temporary, one-year moratorium on local elective deliveries that ended in 2001. Some strategies care providers listed to reduce clinical risks to mothers, and social risks (stress) to care providers, included:

- Building community awareness of limited local services;
- Informing women of the risks and benefits of local birth;
- Early evacuation of birthing women with complications from the community; and
- Improving local prenatal education and support programs.

Some care providers also noted that maternity care provision can have significant social risks for care providers, who fear that the community would “blame” the hospital and providers in the event of a bad outcome.

Challenges to Clinical Risk Management

Care providers felt that there was a difference between the risk tolerance of the hospital staff and that of the community. The community, they perceived, had a higher tolerance for clinical risk, leading to challenges in providing what care providers perceive to be clinically safe maternity care. Community perspectives that represented potential challenges to a clinical risk management strategy included:

- A desire for the option of homebirth, leading to unassisted deliveries and birthing outside the system;

- Lack of trust in care providers' judgment;
- Social risks of birth away are more significant than clinical risks of local birth for some community members;
- Lack of community understanding of the stress that care providers incur in a low-volume, low-resource environment; and
- Poor communication between the community and care providers leading to limited informed choice for decisions in childbirth.

Masset/Old Massett: Community Leaders

Cultural Activities to Support Local Birth

Community leaders in Masset/Old Massett believe in the importance of local birth to the community and the need to reestablish local birthing services. Participants described the need for: 1) activities to improve the infrastructure and health human resource complement for local birth, and, in the absence of local birth, 2) activities to support women who must travel to give birth away from the community.

Participants suggested that the community and hospital should collectively acknowledge the importance of local birth to the culture of the commu-



Newly-graduated (2009) midwife Celina Laursen (left) poses with research team co-leader Dr. Jude Kornelsen

nity, and the “revitalization” and “renewal” that occurs when the community is involved in a local birth. Participants also wanted to express to hospital staff and decision makers some important cultural perspectives associated with childbirth:

- Forced evacuation of pregnant women from the community echoes the First Nations residential school experience; and
- There is a balance between life and death. Death is a natural part of life and the community acknowledges that occasionally, deaths may happen in childbirth.

To increase the hospital’s sensitivity to these perspectives, participants suggested the following activities take place:

- Provide cultural education to care providers;
- Train Aboriginal doulas and midwives; and
- Integrate traditional First Nations birthing practices and childbirth knowledge into local maternity services.

Barriers to Cultural Activities

Participants felt that the existing maternity care system did not honour the community’s perspectives on childbirth. Many felt that the hospital was clinically risk-oriented—more focused on the clinical risks of childbirth than the cultural risks of removing birth from the community. Some participants shared personal stories of receiving culturally inappropriate health care at the hospital. Overall, community leaders in Masset/Old Massett felt that the following barriers impeded local birth:

- Care providers’ lack of cultural awareness;
- The lack of integration of First Nations knowledge into the health care system; and

There’s nothing more positive than birth, in a hospital and nurses, they love when there’s a baby, so it boosts morale and the whole hospital...

‘Somebody’s had a baby, there’s a real infant to look after.’ I think everybody’s on a high when there’s been a baby. (035, 512-18)

- The lack of communication and understanding between the First Nations and non-First Nations communities.

Hospital Activities to Support Local Birth

Participants suggested that in order to support local birth (and culturally sensitive maternity care), more Aboriginal health care providers should be trained and hired. In particular, participants were interested to see midwives and doulas made a part of local maternity care. To facilitate interprofessional collaboration, some noted that existing care providers need to be educated on the scope of midwifery practice.

Others noted that prenatal education should be provided to the community more regularly, and should be open to both expectant mothers and fathers. If local birth becomes possible again and families choose to stay in the community, they should be well-informed of the birthing process and the limits of local services.



Barriers to Hospital Activities

Community leaders indicated that a significant barrier to local birth is recruiting and retaining care providers with maternity skills. It is hard for the hospital staff to have confidence providing local birth without a stable team of trained physicians and nurses. Consequently, at the community level, women see multiple care providers throughout their pregnancy, leading to a lack of continuity of care.

Giving Birth Away from Masset/Old Massett

Within the current system of no local birthing services, community leaders felt that the biggest challenges centered on the financial and social stress that families experience in leaving their homes to give birth. Some expressed that First Nations and Inuit Health (FNIH) provides too little funding for patient travel. As a result, individual families bear a large portion of the costs of transportation, accommodation, and food for their time in the referral community waiting to give birth, which can last up to six weeks. Participants recounted incidences in which the community took it upon themselves to fundraise for families, through bingo nights and bake sales to support extended stays for women and families away from home. Birthing women also experience the social stress of being separated from their families during their time in the referral community.

All Islands: Allied Health Professionals

Activities to Support Local Birth

Allied health professionals working in Haida Gwaii expressed support for local birthing services in both Masset/Old Massett and Queen Charlotte/Skidegate. In order to make these services sustainable, participants suggested activities that focused on 1) valuing the importance of local birth; 2) supported health human resources; 3) enhanced local physical infrastructure for birthing services; and 4) improving the process of care for birthing women.

Specific suggestions for sustainable local maternity care included:

- Celebrating local birth as a community event;
- Supporting health human resource innovation, including integration of midwives, doula care, lactation consultants, yoga instructors, ultrasound technicians, and Elders knowledgeable in birth traditions;
- Building a women-centred birthing centre and an island-wide operating room for cesarean section and other surgeries;
- Bridging hospital and community models of care through culturally sensitive prenatal education and outreach prenatal care.

Barriers to Local Birth

Allied health professionals recognized a variety of barriers to sustainable local maternity care, including the lack of funding to support health human resource and infrastructure innovations. Some also noted that existing care providers may be resistant to the introduction of midwifery due to the low number of births on Haida Gwaii and medical care provider fears about home birth.

Birth Away from Haida Gwaii

Participants recognized that some women will continue to choose to, or for medical reasons find it necessary to, leave Haida Gwaii to have their babies in a referral centre. For women who plan to give birth away from the community, participants felt that the following activities could make their experiences less socially and financially stressful:

- Increased funding to support food, accommodation, and transportation expenses; and
- Have doulas available in referral communities.

For emergency transfers of women to referral centres, participants felt that there should be increased communication between the Haida Gwaii care provider team and care providers at the referral hospital. Improved communication was also recommended for women returning home post-partum.

The most significant barriers to accessing appropriate care away from the community were limited funding for women's travel expenses and lack of funding for escorts. Participants also spoke at length about the social stress that



On the road South from Masset / Old Massett

I think it's important that the mother is able to have that choice as to whether or not she wants to deliver here or to go off-island. I think 99% of the time half the mothers want to deliver here. (018, 489-92)

women experience when they leave their family and community to give birth.

Risk Management Strategies

Allied health professionals emphasized that care providers and the community need to collectively create risk management strategies that address both the clinical and social risks to childbirth on Haida Gwaii and at referral centres. Suggested strategies include:

- Recognizing that birthing women can experience adverse social outcomes and that the impact can be significant;
- Transforming the culture of local birth in Haida Gwaii so that the hospital and community acknowledge a shared awareness of the possibility of a bad outcome;
- Educating the community about the clinical risks of local birth and birth away; and
- Educating care providers about the social risks to the family and community of birth away.

Informed Choice

Participants also discussed the importance of informed choice for birthing women. Many emphasized that birthing women should be ultimately responsible for making decisions about their ma-

ternity care, with support from care providers and the community. Some said that if a woman makes a choice that her care providers deem unsafe (e.g., unassisted home birth), her choice still needs to be respected.

One barrier to informed choice that participants identified was the consent form for local delivery. Many participants felt that the form “scares” women into choosing to deliver off-island. Others perceived that physicians are reluctant to hand the locus of control over to birthing women without a consent process. However, some noted that given more evidence and education about the risks and benefits of local birth, women will be able to make better informed decisions about their care.



A newly-constructed longhouse on Haida Gwaii.

Values, Assumptions, Beliefs

Findings from this study were underpinned by the participants’ values, assumptions, and beliefs about childbirth. Generally, medical care providers believed in the precedence of clinical safety, access to technology, and informed consent, due to the assumption that bad outcomes will always happen. In contrast, community leaders and allied health professionals, believed that birth is a safe

and natural event and that social risks should be prioritized in informed choice decision making. A summary table is provided (above right), followed by a detailed description of individual participant groups’ values, assumptions, and beliefs.

Care Providers	Community Leaders & Allied Health Professionals
Birth is only normal in retrospect	Birth is a safe and natural event
Precedence of safety and clinical approach to risk management	Family and community connections to birth process are primary
Bad outcomes will happen	Outcomes are influenced by the psychosocial state of the mother
Importance of access to technology and specialist care	Social risk factors are privileged in decision making
Importance of informed consent in decision-making process	Importance of informed choice

Community leaders and Elders also conveyed three core beliefs about birth in Masset/Old Massett:

- Local birth is important to the culture of communities;
- Hospital services are important to the economy and stability of the community; and
- Birthing services are important to the stability of all hospital services.

Despite differences in attitudes, values, and beliefs, when participants were asked what they wanted the *impact* of a local birthing system to be – the ideal outcome – all participant groups expressed four common goals for a local birthing service:

- Establishment of sustainable local maternity services;



Focus group participant and daughter.

- Good maternal-newborn outcomes (safety);
- Satisfaction with the model of care for all parties (women, families, community, care providers, decision-makers); and
- Community education about birth.

All participants acknowledged that even with local, low-risk deliveries, activities were also needed to optimally support women who needed – or chose – to leave the community for care.

Recommendations

Haida Gwaii's challenges in maternity service provision are similar to those found in many other rural communities across the province. Based on this research, we have developed a set of recommendations that will assist families, care providers, decision-makers, and all other interested par-

ties to make informed decisions about maternity care, both on and off-island.

1. Communication is key

- **Maintain an open dialogue** between all maternity care stakeholders (women, families, care providers, allied health professionals, community leaders, decision-makers, etc.) to ensure a community-based decision-making process around local maternity service models of care.
- **Acknowledge and accept the risks and benefits associated with birthing in rural communities** and establish partnerships with care providers, administrators, women, families, and other community members to generate an open risk management strategy.

2. Support women and families

- **Develop support mechanisms for women who must leave their communities** to give birth by:
 - Subsidizing *accommodation* for women and their escorts in referral communities;
 - Recognizing *the importance of social support* for women leaving their communities (funding for multiple escorts based on needs criteria);
 - Providing sustained *adequate funding* to both Aboriginal and non-Aboriginal women who must leave their communities to give birth; and
 - Providing *access to Aboriginal liaison workers* and doulas at referral hospitals.
- **Ensure equitable access to prenatal care** by addressing barriers to interprofessional care (between physicians, nurses, and midwives) and by exploring innovative, culturally-

appropriate, and alternative models of pre-natal care and education.

- **Provide doula training to Aboriginal women** and acknowledge the contribution of informal labour support.

3. Support health care providers

- **Provide interdisciplinary, continuous professional development** for local care providers (on-site), including access to courses such as Advanced Life Support in Obstetrics (ALSO) and Advanced Labour and Risk Management (ALARM).
- **Explore the potential for new, inter-professional models** of maternity care service provision, such as physician-midwife shared care models.
- **Develop new models of remuneration** for care providers that recognize the increased responsibilities of rural practice and the burden of 24-7-365 on-call schedules.

4. Institute mechanisms to encourage high-quality care

- **Establish and maintain an open process of clinical care evaluation** within a quality improvement framework, which is mirrored at the catchment, regional, and provincial levels.

About the Centre for Rural Health Research

The Centre for Rural Health Research (CRHR) consists of a network of researchers whose aim is to evaluate, from multiple disciplinary and professional perspectives, the challenges facing the provision of rural health care. To date, the Centre's research has focused predominantly on developing a comprehensive understanding of rural maternity care in British Columbia.

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