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## The geography of belonging: The experience of birthing at home for First Nations women <sup>☆</sup>

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### ABSTRACT

The number of rural hospitals offering maternity care in British Columbia has significantly declined since 2000, mirroring trends of closures and service reductions across Canada. The impact on Aboriginal women is significant, contributing to negative maternal and newborn health and social outcomes. The present qualitative case study explored the importance of local birth for Aboriginal women from a remote BC community after the closure of local maternity services. Data collection consisted of 12 interviews and 55 completed surveys. The average participant age was 32 years old at the time of the study. From the perspective of losing local services, participants expressed the importance of local birth in reinforcing the attributes that contributed to their identities, including the importance of community and kinship ties and the strength of ties to their traditional territory.

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### 1. Introduction

The number of rural hospitals offering maternity care in British Columbia has significantly declined since 2000, mirroring trends of closures and service reductions that are occurring across Canada (Allen et al., 2004; Hutten-Czapski, 1999, 2001; Peddle et al., 1983; Nesbitt et al., 1990; Rourke, 1998) and internationally (Larimore and Davis, 1995). A convergence of factors has influenced this crisis in rural maternity services including structural-economic changes in rural communities (Cameron and Cameron, 2001; Halsey and Sullivan 2003; Galvin, 2003), health care restructuring (Kornelsen and Grzybowksi, 2005a), a changing context of care that supervaluates access to technology and specialists (Kornelsen and Grzybowksi, 2005a), and health human resource issues (Grzybowksi et al., 2007; Kornelsen and Grzybowksi, 2008). These changes are taking place despite an emerging body of evidence on the safety of small volume maternity services (Chaska et al., 1998; Peddle et al., 1983; Rourke, 1998; Rosenblatt et al., 1985) and the impact of these

changing patterns of access on maternal and newborn health. The closures of small volume maternity services and subsequent evacuation of women to give birth have been linked to increased perinatal morbidity and mortality (Larimore and Davis, 1995; Nesbitt, 1996; Nesbitt et al., 1990), as well as heightened stress, anxiety, and social vulnerability on the part of birthing mothers (Chamberlain and Barclay, 2000; Greig, 1990; Jasen, 1997; Kornelsen and Grzybowksi, 2005b).

A review of recent policy literature indicates that these service changes in British Columbia have been made in an ad-hoc manner in response to a local or regional sense of crisis (Kornelsen and Grzybowksi, 2005c). In these instances, decisions have been reactive and not necessarily based on a broad range of health indicators, let alone cultural considerations.

Although all rural women experience the impact of reductions in local maternity services, qualitative evidence suggests that these impacts are felt more acutely in Aboriginal communities. This is due in part to the historical place of birth in Aboriginal life where it was a community event that strengthened ties within families and nations (Moffitt, 2004). In Canada's far north, the systematic evacuation of women from their communities due to shifting policy and practice has led to severe psychosocial consequences, including the loss of birth as a community event to birth becoming an isolating experience resulting in feelings of loss of control for women (Jasen, 1997; Voisey et al., 1990). When speaking of their evacuation experience, northern Aboriginal women themselves express regret at not having family close by to

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share their birthing experience and anxiety about being away from their homes and children for extended periods of time (Paulette, 1990). 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, 1990). Additionally, with increased energy, time, and money devoted to the immediate intrapartum period, fewer resources were available for care and education services within the community, contributing to the diminishment of prenatal preparation and postnatal support (Stonier, 1990).

This qualitative exploratory study considers the implications of closure of a local maternity service from perspective of local First Nation women. Findings focus on participants' perceptions of the importance of place and community in giving birth. The experiences of women who left the community have been recorded elsewhere (Kornelsen et al, forthcoming).

## 2. Background

A number of First Nations communities in British Columbia have lost local maternity services in recent years, forcing women to travel significant distances to access intrapartum care. The decisions leading to these closures have been ad-hoc and typically without community consultation. The community of Bella Bella, also called Waglisla, has a current population of 1250 residents, almost all of whom are from the Heiltsuk nation, and is located on Campbell Island on BC's Central Coast (Map 1). The hospital in Bella Bella/Waglisla is governed by the United Church Health Services and receives funding from Vancouver Coastal Health, while the Heiltsuk Band Council has taken responsibility for the management of insured health care benefits, received from First Nations and Inuit Health (FNIH), a division of Health Canada. Historically, the Heiltsuk Nation always birthed in their home community. However, in 2000, the provision of maternity care in Bella Bella/Waglisla began to atrophy, and since 2001 it has been the policy for all women to leave the community at approximately 36 weeks gestation to give birth elsewhere (usually BC Women's Hospital in Vancouver).



Map 1

Vancouver and Bella Bella/Waglisla are approximately 600 km apart, and women travel between the communities by either a 2 h long, weather-dependent flight or a 14 h trip by vehicle and ferry. Since 2001 a small number of local deliveries have taken place in the community due to precipitous labours, and between 2001 and 2005, 53 deliveries occurred in referral communities. This cessation of service was due to a confluence of factors, including recruitment and retention of practitioners with enhanced skills to provide local access to cesarean section and the reluctance of physicians to offer maternity care without the availability of such services.

A lack of local maternity services negatively affects a rural community's perinatal health and well-being (Chamberlain and Barclay, 2000; Klein et al., 2002; Nesbitt et al., 1990) and can lead to prenatal stress and preterm delivery (Heaman et al., 2005; Norbeck and Tilden, 1983; Rondo et al., 2003; Sable and Wilkinson, 2000; Wadhwa et al., 1993), as well as financial strain and decreased social support for birthing women (Chamberlain and Barclay, 2000; Kildea, 1999). Studies in Australia, Canada, and New Zealand indicate that there are significant disparities between Aboriginal and non-Aboriginal peoples' perinatal health (Chalmers and Wen, 2004; Craig et al., 2004; Luo et al., 2004; Muggah et al., 2003; Simmons et al., 2004; Vancouver Coast Health (VCH), 2004, 2005), in addition to finding that rural Aboriginal women are more likely to receive inadequate prenatal care compared to their urban and non-Aboriginal counterparts (Baldwin et al., 2002; Heaman et al., 2005). Perinatal health statistics for people living in the Central Coast of British Columbia, including Bella Bella/Waglisla, are dismal, with local preterm birth and infant mortality rates nearly 3 and 5 times the provincial average, respectively (Thommasen, 2003). Some Australian Aboriginal women believe that regional centre birth and separation from traditional territory are the cause of infant mortality (Kruske et al., 2006). Positive attributes of local birth include support and family involvement (Chamberlain and Barclay, 2000; Iglesias et al., 1998).

National efforts for improving rural perinatal outcomes for Aboriginal peoples in Canada emphasize the importance of keeping maternity services close to home, with community members playing a significant decision-making role in the service planning process (Couchie and Sanderson, 2007; Royal Commission on Aboriginal Peoples, 1996). Successful examples of rural Aboriginal maternity care include birthing centres in the Canadian north. The Inuit birth centres of Nunavik, Quebec are staffed by Aboriginal midwives and attempt to maintain Inuit mothers' connection to the land and community by keeping birth close to home and integrated with Inuit culture (Douglas, 2006). The birth centres provide primary care (without local access to cesarean section), which has led to a significant increase in the number of local births, a decrease in preterm birth rates, and contributed to low intervention rates for women who do leave the community to give birth (Houd et al., 2003; Van Wagner et al., 2007). Such birthing projects in Arctic communities produce many psychosocial benefits including decreased family disruption, greater parent satisfaction, and greater community involvement with the newborn baby (Chamberlain and Barclay, 2000).

Listening to Aboriginal women's birthing desires provides the foundational knowledge for building their maternity care programs, authenticates their knowledge, and ensures that programs are culturally appropriate (Moffitt, 2004; Molina, 2001; NAHO, 2006; Smylie, 2000; Smith, 2003). FNHI and the National Aboriginal Health Organization (NAHO) advocate for approaches to service development that are grounded in Aboriginal culture, build on community strengths, and require care providers to be sensitive to Aboriginal peoples' socio-cultural needs (FNHI, 2005; NAHO, 2006). The importance of community involvement in Aboriginal maternity care planning has been emphasized by health decision makers responsible for the area in which this research took place (Timbers, 2005).

For Aboriginal women, birth is an event tied to their traditional lands and identity (Douglas, 2006; INAC, 1996; Kruske et al., 2006; Wilson, 2003). The land is seen to shape cultural, spiritual, emotional, physical, and social aspects of the lives of Aboriginal peoples, and to provide plants and animals for food and medicine (Wilson, 2003). The land is seen as essential for maintaining good health and well-being; when Aboriginal peoples are separated from the land, they often experience isolation and dislocation. This has been demonstrated in studies on Aboriginal peoples' decision to access – or not to access – renal and palliative care outside of their communities (Anderson et al., 2009; McGrath, 2007). Chamberlain and Barclay (2000) found that the “research suggests that women are often aware of the physical risks [of childbirth] but they have an overriding need to have the support of their families and their communities at this time. The social consequences of major disruptions to family and community may, therefore, far out-weigh the risks.”

### 3. Methods

Results presented here are part of a larger case study on the implications of maternity service closures in Bella Bella/Waglisla. This paper presents findings from: (1) a written survey to document women's experiences of birth, locally or away; and (2) in-depth interviews to document women's stories of their experiences of birth.

Guidance for the study was provided by a community research advisory committee with representation from the Heiltsuk Cultural Education Centre, Hailika'as Heiltsuk Health Centre, RW Large Memorial Hospital, and Heiltsuk College, as well as a community-based research assistant. As a participatory research approach is the most appropriate to ensure that the research questions and design are responsive to the needs and concerns of the community (CIHR, 2007), advisory and community consultation was held throughout the research process. All women in the study were from a confined catchment area, and their maternity services were closed in the recent collective memory of the community. All authors had prior relationships with the study community. The principal investigators are non-Aboriginal researchers who had practiced as a physician in the community (AK) and had undertaken research in the community since 2003 (JK). The other investigators (PW, LW, DW) are Heiltsuk women from the Bella Bella/Waglisla community. We sought and obtained ethics approval from the appropriate University Behavioral Research Ethics Board and from the Vancouver Coastal Health Authority.

#### 3.1. Participants

Potential participants, women from Bella Bella/Waglisla who gave birth in the study time frame (1996–2005), were identified through existing records kept by one of the investigators (AK) while he provided care at RW Large Memorial Hospital from 1996 to 2001 and cross-referenced with a list of all women who gave birth in the study time frame based on the Hailika'as Heiltsuk Health Centre Members List. The two lists were combined to give a comprehensive record of all the women from Bella Bella/Waglisla who gave birth between 1996 and 2005. Signed, written informed consent was obtained from all participants.

#### 3.2. Written survey

The survey, designed to capture experiences of birth in and away from the community, was developed specifically for this

study and was based on the principal investigator's previous qualitative research conducted with First Nations birthing women in the province of British Columbia (Kornelsen and Grzybowksi, 2005c). The survey was reviewed by the whole research team and amendments were made where suggested. Additionally, the survey was pilot tested with six community members for clarity of concepts and readability. All suggested changes were included. The 21 question survey included items on basic demographic information (i.e. age, ethnicity) and on participants' experience with receiving prenatal and intrapartum care rated on a 3-point Likert-type scale. We generated three separate forms: one for women who birthed locally prior to 2001, one for women who birthed away prior to 2001, and one for all women who gave birth from 2002 to 2005. Four themes informed the question groups: access to care, social support, sense of safety, and ideal visions of birth.

The community-based research assistant recruited potential survey participants by phone, from local phone book listings, or in person from the Health Centre day care program to ask them if they would agree to fill out an "Experiences of Childbirth" survey. The assistant hand delivered surveys to all women who had given birth within 2 years prior to data collection and retrieved the surveys upon their completion. The survey participation rate was one hundred per cent for those women approached to fill out the survey, with a total of 55 surveys returned. Once data saturation was met, the research team stopped approaching women in the community to complete the survey. Due to the high rate of illiteracy in the community, a member of the research team was available for women to assist in filling out the survey. We classified each survey into one of three categories: (1) birth away before and including 2000; (2) birth away after 2000; or (3) birth in Bella Bella/Waglisla.

### 3.3. Interviews

The women interviewed as part of this study were recruited by the community-based research assistant, who when distributing the surveys asked if women would be interested in participating in an interview. The research assistant then scheduled the interview to take place either at the community's Health Transfer House or in the board room at RW Large Memorial Hospital over the process of three days. Interviewees were recruited until data saturation was achieved (no new themes emerged from the data). The lead investigator and members of the research team conducted open-ended, hour-long interviews with 12 women from the community. The research team made efforts to minimize and neutralize potential power differentials between the team and First Nations interviewees and to establish safe interview environments in which women felt respected and their stories honoured (Meadows et al, 2003). Namely, interviewees were introduced to the study by a peer, the community-based research assistant; the study was accepted and supported by the community, as represented by the community research advisory committee; both the community-based research assistant and research advisory committee provided cultural guidance to the research team; interviews were open-ended to allow for women to express stories they felt were personally important, rather than to answer direct questions; interviews took place in locations familiar to the women; interview times were flexible to accommodate the women's needs; and interviewers positioned themselves in a physically non-threatening manner.

### 3.4. Data analysis: interview data

We tape recorded and transcribed all interviews into a word document. We used open coding methodology (Strauss and Corbin,

1998) to inform the four stages of our analysis: (1) immersion in the transcripts (reading and re-reading); (2) the development of themes and codes; (3) coding the transcripts; and (4) re-integrating the codes into an explanatory narrative. The principal investigator and project coordinator independently read and coded each transcript separately and developed code books (a list of derived themes and codes). We then compared the code books for congruency before coding the entire collection of transcripts. The researchers achieved almost perfect conceptual congruency regarding emerging themes and codes and some modifications were made to increase semantic congruency. We entered all coded parts of the transcripts into a qualitative data management program, QSR Nudist, printed code reports, and presented them to the research advisory committee in Bella Bella/Waglisla. The principal investigator and project coordinator conflated 53 codes into 23. The research team worked with the research advisory committee on interpretation and presentation of the findings within a culturally appropriate framework (CIHR, 2007).

### 3.5. Data analysis: survey data

The first round of survey data analysis, using the Statistical Package for the Social Sciences, consisted of generating frequency tables for all questions and running correlations for all fields. We highlighted statistically significant correlations and ran further statistical tests on these interesting questions. We cut and pasted tables into a word document and presented them to the research advisory committee in Bella Bella/Waglisla for comment and preliminary interpretation. During the second round of data analysis, we created frequency tables for all interesting fields as identified by the advisory committee and categorized them based on which birth category women fit into (birth away before and including 2000; birth away after 2000; or birth in Bella Bella/Waglisla). We then wrote findings from interviews and surveys into narrative form and presented them to the advisory committee for validation. Upon completion of the final community report, the Heiltsuk Band Council issued a resolution ratifying the project recommendations.

## 4. Results

### 4.1. Overview

Between 1996 and 2004, there were 144 births among the women of Bella Bella/Waglisla. Of the 55 women who completed the survey, 19 indicated that they had lived in Bella Bella/Waglisla all their life, while 32 had lived in the community for over 13 years. The average age of women at time of survey completion was 32 years old. Thirty-five survey participants gave birth away from the community and 20 gave birth in the community. For those who gave birth away, the majority birthed at BC Women's Hospital ( $n=15$ ), a tertiary care facility in Vancouver, British Columbia, or other hospitals in Metro Vancouver. All but one survey participant received prenatal care, which consisted of physician care, routine diagnostics, and specialist appointments where necessary. Of the 12 women we interviewed, 9 gave birth in Bella Bella/Waglisla, and 3 gave birth in a referral community. All of the interviewees who remained in the community gave birth before 2000, when local services, including caesarean section back-up, were available.

This paper represents findings from surveys and interviews with women who gave birth in Bella Bella/Waglisla at least once. Some women had also experienced childbirth in a referral community and were able to compare the experiences of birth

away versus birth at home. Themes that arose from the interviews included the importance of community support, the overriding belief that women should be able to give birth in Bella Bella/Waglisla, and the difference in experiences of birth before and after local services were closed. All interviewees described important ties to their family, community, and place that formed not only their home but also their identity, and which were made stronger through experiences of local birth. Each of these themes is discussed in detail below.

#### 4.2. Importance of community support

Most survey participants noted family members were present during labour and delivery, ranging from “10–20”, to “lots–too many to count”, and “half the village.” While only four (20%) survey participants who gave birth in Bella Bella/Waglisla noted that only their physician was present at the time of delivery, 16 (80%) noted their physician, family members, and/or friends were present. When asked why women should give birth in the community, all survey participants and interviewees focused on the availability of family support and the difficulties of being away from family. Women interviewed saw this extended network of support as part of a larger Heiltsuk commitment to relationships, caught perhaps most clearly by the phrase of one woman, “If you are here ... you are not alone” [006:445]. Stories of community members providing material and emotional support exemplified this sense of being part of a larger association. As one interviewee said,

And I couldn't believe the support – you get a lot of support here ... If something happens, something goes wrong in one family, the whole community pitches in and helps out to support them, whether it's financial or, you know, if it's death, there's going to be food sent over. [006:86–94]

The most consistent – and dramatically expressed – descriptions of community support were of support during the labour and delivery itself, which, for all the interviewees and for teen moms in particular, was marked by the presence of family and community members at the hospital:

When I came out, it was wall-to-wall people. I said, ‘What's going on?’ Everybody heard that [my baby] was born. And it was wall-to-wall people. It was so nice because my father-in-law was there, and I was holding my baby. He was the first and only grandson. [005:84–90]

Most interviewees recalled how friends and relatives would care for other children. This was seen to mitigate the stress of the immediate post-partum period and even help combat “the blues”:

I think it makes a big difference to have our babies here, because you have all that family support and you really do need it because some mothers go through the post-partum blues here, and just to have all the support. [006:423–427]

For many, the celebration of local birth took the form of an ‘uplifting,’ which involved having the hereditary chief, the community's leader, present the baby to the community and bestow a name, sometimes within the context of a potlatch, a First Nations ceremonial feast. Other interviewees described fondly how Elders and grandmothers provided guidance on natural, unmedicated birth, which was seen to be enveloped within a sense of caring. For some, the importance of this support exceeded concerns about giving birth in the community without immediate access to specialist care: “I would rather take the risk of having my baby here than to have all the high-tech equipment and be in an atmosphere that wasn't familiar.” [007:130–132]

Most interviewees also described positive aspects of the care they received in their community, emanating in part from the on-going relationships they had with the care providers. Women's confidence in the care providers' skills and abilities led to a strong sense of trust in the advice given regarding labour and delivery – including location of birth. As one interviewee noted,

[The doctor] told me, you know, about the different complications that could happen during labour and delivery and he said, ‘But you have nothing to worry about, so I think it is going to be okay to have your baby here.’ I said, ‘okay.’ I took his word on it and I was fine with it. [006:90–94]

Several women incisively juxtaposed their in-community experiences with observations of the experiences of women giving birth now in referral communities. As one commented,

I think it just all goes back to having... the family here. My niece is giving birth to another baby [out of the community]. I'm not going to be there. I've never seen any of her kids being born. All my nieces were born out of town and I've never seen any of them. I just wish they would have their babies here. [012:205–210]

#### 4.3. The importance of birth in Bella Bella/Waglisla

All of the women we listened to – whether they gave birth at home or away – expressed the importance of birth in Bella Bella/Waglisla. Our survey data found that 70% of participants responded “Bella Bella” when asked where local women should give birth. Of those who gave birth in the community, 15 (75%) felt it was very important that they birthed at home and 2 (10%) felt it was somewhat important (1 felt it was not important). In addition, when we asked if they thought birth was important to their community, 16 (80%) of the survey participants who birthed locally felt it was very important, 1 felt it was somewhat important, and 1 felt it was not important. Of the survey participants who birthed away after the closure of services, 19 (86%) felt birth was very important to the community while 3 (14%) felt it was somewhat important. For most survey participants and interviewees, the importance of local birth was tied to a sense of connection to history and to the Central Coast region, and gave rise to their identity as mothers but also as Heiltsuk peoples. As we discussed with one woman:

Participant: I was glad that [all my children] were born here.

Interviewer: What does that mean to you?

Participant: It felt good. You know, I was born here. I was born in the old hospital. My mom had all of us in the old hospital there. ... We are all from here. [009:44–51]

The sense of a continuation of history underlay many of the women's observations of the roles their mothers, grandmothers, or aunts played historically in supporting women through the process of birth. Almost all of the interviewees referred to a family member or friend who they described as a midwife.

Cultural and emotional ties to the land were also concretely expressed through multiple women's unsolicited comments in both interviews and surveys on the importance of having Bella Bella/Waglisla on their children's birth certificates:

I would want my grandchildren to be born here, like other kids. This is where we're from! You know, looking on the birth certificates, they say ‘Vancouver, BC.’ You know, they're not from Vancouver. We're from Bella Bella! So when they are born in Vancouver, does that mean they are from Vancouver? [012:271–279]

This sense of community also motivated some women to return to Bella Bella/Waglisla from away in order to participate in the rituals of Heiltsuk birth:

Our culture has always celebrated life. Our children got their first traditional name at birth: it was their child name. At 10, they get another name. As an adult, another name. As they become older, another name. So there was tradition. We've always celebrated life. And uplifted our children. [007:255–260]

For some interviewees, the timing of birth within the life cycles of others in the community was a poignant reminder of the inter-connectedness of life and death. When a child was born in the community soon after the death of an Elder, the concurrent mourning and celebration was marked either formally (such as at a potlatch) or informally, through marking the passage of time by the growth of a child.

For some, the absence of birth within the community, like an unbalanced mobile, shifted the weight of experience to death:

I think it's a huge void for people not to be born here, because all we see is death. You've probably heard that before. We're in a small community and it's constantly death, death, death, death. When you don't have birth here, and they're born outside, you know, it's different. There has to be a balance. There's end of life and beginning of life. [007:58–65]

#### 4.4. Comparison of services: before and after

Several women had given birth both in Bella Bella/Waglisla before services closed and in a referral centre after closure. The contrasting experiences led to observations of the differences between the two locations from both the perspective of individual experience and the larger community context. Interviewees spoke of the sense of comfort arising from familiarity of their own surroundings in contrast to the alienation felt in the new environment. As well, many interviewees noted contrasting levels of community involvement in the birth:

We've always celebrated life. But rather than the whole community waiting for the baby to be born, and family members [being] up all night and people in the hospital, you know, it's toned down to, you know, this baby has come home and we need to recognize and acknowledge this baby and celebrate the baby's life. Whereas if the baby's born here, it would be a whole different thing. [007:267–272]

This woman went on to describe the details that give rise to birth as a cultural event in the community and the concomitant sense of loss when it occurs away:

Let's say that they're coming off the plane and [the mom] is there and her mother and the grandfathers go meet them ... There's like two people meeting them, meeting the new baby. While if they delivered here, there would be like 50 people. So to me, it feels like a loss ... Eventually they will have a baby shower or a tea or whatever, but that's basically it. There's like a disconnect. It's like, 'Oh ... they had a baby,' and you know, 'How's the baby doing,' versus 'how are you recovering? You were screaming away in there – I didn't know you could swear like that.' There's a disconnect. [007:290–302]

Almost all interviewees expressed a preference for birthing at home for convenience ("I just find it easier to have babies in your hometown rather than having to fly out and then fly back" [011:75–77]) and the support they received. The women who chose to leave the community when local services were available

– and those who would have left anyways after they closed – expressed an appreciation for being close to specialist care should any complications arise. This group of women did note, however, a lack of continuity of care with their care provider leading to, in some instances, the sense of having received impersonal care.

The loss of antenatal services in a community often leads to diminished services in the prenatal and post-partum period as care providers become less current with this aspect of practice. The loss of attendant services after the closure of the maternity service in Bella Bella/Waglisla was noted by several of the interviewees. As one commented:

When I was pregnant with [my first child] ... once a month the health centre would drop off all these different kinds of fruit, potatoes, vegetables, milk ... That was something I really appreciated. But they didn't do that [for my second pregnancy]. That stopped. [004:96–103]

## 5. Discussion

The findings from this study illuminate the social significance of local birth for Heiltsuk women. The importance of family and community support for parturient women in the perinatal period reflects qualities of culture and well-being which must be understood differently for Aboriginal women and non-Aboriginal women, and, for Aboriginal women, understood in relation to the importance of their geographic home. In her article, "Therapeutic landscapes and First Nations peoples: an exploration of culture, health and place," Wilson (2003) notes:

The identity of indigenous peoples, whose concept of self is rooted in the context of community and place, differs strikingly from the identity of many Euro-Canadians whose concept of self is frequently encapsulated in independence of the individual." (p. 9)

The idea of providing a *context* for the experience of birth that extends beyond medical needs (e.g., the hospital as a context of birth) has not been given consideration within current health planning. The context expressed by the women in this study was one of family, friends and community but extended to the recent historical context of birth in Bella Bella/Waglisla, evidenced through the many references made to either giving birth in Bella Bella/Waglisla – or others who had – and the symbolic importance of the place name recorded on the birth certificate. For women who birthed locally, these qualities led to a sense of belonging-through-birth. Snyder et al. (2003) refer to the loss of possession, kinship or belonging as "cultural loss" (p. 107).

Although we easily understand the therapeutic value of places (i.e., hospitals) and systems (transportation and referral systems) in contributing to health, it may be instructive also to consider the value of therapeutic *networks*. Smyth (2005) and Laws and Radford (1998) describe these as networks through which people receive support and care, though they are separate from traditional biomedicine approaches, involving families, friends, therapists, and kinship groups. This encourages us to think of health as an integration of the physical, psychosocial, and spiritual realms and thus of the importance of the context of health care provision.

The social relationships that women in this study identified as being important to birth occur primarily within the geography of Bella Bella/Waglisla (although some extended outside of the community), which suggests an inter-relationship between social relationships and place. Snyder et al. (2003) describe this inter-relationship by noting that for indigenous peoples, "relationship to land or resources involves an intimate bond or sense of place,

that take on the characteristics of kinship ties and belongingness, which are inalienable” (p. 108). Wilson (2003) takes this idea further to suggest that beyond merely *shaping* identity, the land is *part of* Aboriginal identity and shapes all aspects of their lives, a notion that Oneha (2001) suggests is consistent with all indigenous peoples on the planet. This gives rise to the sense of spirituality associated with the land by Aboriginal peoples (Royal Commission on Aboriginal Peoples, 1996), which in turn leads to the natural interweaving of culture and geography. When culture and geography are separated, however, Snyder et al. (2003) note that cultural knowledge and practices may lose meaning and change the nature of social relationships, which may have disastrous consequences:

Because so much of what constitutes a culture is woven into spatial patterns and localized meanings, to move a culture would be tantamount to destroying it. Much of what is valuable to the culture is embedded in the place.” (p. 109)

Despite the growing literature on the importance of community – both geographic and social – to both Aboriginal culture and health, this understanding has not been reflected in health services delivery policy. This is due to several reasons including fiscal constraints and the dichotomization of clinical and social concerns, with clinical management (including ensuring access to care) taking precedence. This is evidenced by the devolution of patient travel subsidies and lack of escort support from First Nations and Inuit Health (Health Canada) for women who must leave their communities to give birth. However, as the growing body of literature suggests, the social morbidities associated with this policy are significant and may have an impact on the short- or long-term health of rural parturient women and their families.

In some instances it may not be possible or feasible to support local birth due to low volume, lack of recruitment and retention of care providers willing to include maternity care within their scope of practice, or the desire of women to be closer to specialist care should it be necessary. In these instances the role of geography and culture need not be overlooked but instead used to inform appropriate practices to support women throughout their child-bearing experience.

## 6. Limitations

This study focuses on the birth experiences of women who belong to a specific geographic and First Nations community. Consequently, care must be exercised in adapting findings to other rural and Aboriginal environments. 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.

## 7. Conclusion

This qualitative exploratory study articulates the experiences of women giving birth in the rural First Nations community of Bella Bella/Waglisla. Findings reveal the importance of community support, the overriding belief that women should be able to give birth in Bella Bella/Waglisla, and the difference in experiences of birth before and after local services were closed. Central to participants' birth experiences were the ties to their family, community, and place. This web of kinship ties, which form their identity, were made stronger through experiences of local birth.

This project was guided by the principles of participatory research, an approach that ensures community participation in research design, methods, data collection, and analysis, as well as

shared power and a culturally responsive framework (CIHR, 2007; Kaufert et al, 1999; Strickland, 1999). The recommendations that emerged from this study, which were formally ratified by the Heiltsuk Band Council, emphasize the importance of community involvement in the decision-making around allocation of resources for maternity care and the importance of place and community in giving birth (Kornelsen et al., forthcoming).

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