Winnipeg Regional Health Authority
Research and Evaluation

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Prenatal Connections (PNC)

Understanding the strengths and needs of women who temporarily relocate to Winnipeg for birth:

An action research study

Prepared for:

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Key Messages

This report is a first step to understanding the needs of women traveling for birth. It should be used to further develop the relationship between the Prenatal Connections service and women and communities. An evaluation of the service delivery and referral processes should follow.

For many participants in this research, traveling for birth has become normalized and women do not necessarily feel empowered to make decisions for themselves about their pregnancy and birth. In addition to providing education and information related to pregnancy and birth, health care systems and providers need to take measures to examine power dynamics and give power back to women and families who travel for birth.

Ensuring that their families are cared for at home and coping with being in Winnipeg alone or with limited social supports are significant challenges for women traveling for birth. Women need support while they are in Winnipeg to birth, and also support for their families at home. Further research is also needed to understand the long-term consequences of traveling for birth on breastfeeding, attachment and other outcomes.

Many women described complex pregnancies and medical concerns. To ensure that women's needs are met, cultural understanding, communication with women and between providers and coordination of care need to be improved.

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Executive Summary

The report of the Maternal and Child Healthcare Services (MACHS) Task Force (2008) identified that there were gaps in services and supports available to women who travel for birth. In 2010, the Winnipeg Regional Health Authority's (WRHA) Population and Public Health Program convened a steering committee to guide the development and implementation of a public health service for women traveling for birth.

Methodology

Objective: The WRHA's Research and Evaluation Unit was asked to lead a study to understand the strengths, resources and needs of women from rural or remote communities who temporarily relocate to Winnipeg for birth in order to design an effective and culturally safe range of prenatal services and supports to meet these needs.

Research questions: The following research questions were developed collaboratively with members of the WRHA Prenatal Connections Steering Committee:

1. What expectations do women and families who temporarily relocate to Winnipeg for birth have related to healthcare services and social supports?
2. What barriers do women who temporarily relocate to Winnipeg for birth face and how do they currently cope?
3. From the perspective of women traveling to Winnipeg for birth, their families and other stakeholders, what services and supports would be helpful?

Methods: This study used an action research approach including a literature review and qualitative methods.

Research challenges: Recruitment was a significant challenge in some parts of this research. Great effort was made to recruit sufficient women and families to participate in interviews in order to adequately give voice to the challenges and concerns of those who must travel for birth. Many of the women who did participate seemed somewhat uncomfortable sharing their experiences and therefore the interviews may not have the depth that is typically sought when conducting qualitative research. The recruitment of care providers was not a challenge.

Ethics: This study was approved by the University of Manitoba's Health Research Ethics Board, the WRHA's Research Review Committee and the Assembly of Manitoba Chiefs (AMC).

Literature Review

The following eight themes emerged from the literature: The normalization of traveling for birth, concerns about safety and security in the birthing community, the importance of social support, women's experiences of powerlessness and of a lack of opportunities for informed choice,

the importance of cultural awareness, perceived consequences of birthing away from home, coping strategies used by the women and suggestions for improving care.

Qualitative findings

Twenty-five women and 35 health care providers (HCPs) participated in the research. Based on the research questions, the following themes emerged:

1. What expectations do women and families who temporarily relocate to Winnipeg for birth have related to healthcare services and social supports?

   Women's expectations and the normalization of traveling for birth – For many women and HCPs, it seems that traveling for birth has become the accepted norm. Many women described traveling for birth as an ordinary experience or the safest option. However, women also described a range of negative emotions related to traveling for birth. Some HCPs described traveling for birth as 'normal' and worried about the risks of birthing in remote communities, while also recognizing the reluctance or fear that women may feel leaving their homes for birth.

2. What barriers do women who temporarily relocate to Winnipeg for birth face and how do they currently cope?

   Challenges managing daily life while in Winnipeg – Arranging care for children left at home was a challenge and source of worry for many mothers. Women staying at boarding homes were mostly positive about their experience; however accommodations were usually not covered for partners, or even for women in some circumstances. A few women expressed concern about their safety outside of the boarding home. HCPs echoed many of these concerns.

   Limited social support – Women reported feeling homesick and described waiting and being alone as two of the most challenging aspects of traveling for birth. HCPs recognized that women were homesick and questioned the policy of women traveling *alone* for birth.

   Misunderstandings about culture and language – Many women missed traditional foods, but very few identified challenges related to other aspects of culture or language. However, HCPs felt that for some women language was a challenge and that cultural misunderstandings did occur between women and providers.

   Health and health care challenges – Many women identified that they were coping with complex pregnancies, medical concerns or social issues on top of the stress of traveling for birth. A couple of women also identified issues related to coordination of care. HCPs recognized these health concerns and also identified concerns related to the health care system, such as communication between sites and providers.

   Choice and power – Many women made comments that demonstrated that they felt that their situation was outside of their control and that decisions were being made by someone else. Some also described subtle ways in which they were able to assert control and make decisions for themselves. Many HCPs found aspects of the system unnecessarily oppressive.

Perceived consequences of traveling for birth – The most significant consequences of traveling for birth identified by women and HCPs were family separation and strain. HCPs also wondered about long-term consequences related to breastfeeding and attachment.

Coping – Primarily women talked about family and community support, whether from near or far, as a way to cope with the challenges of traveling for birth.

3. From the perspective of women traveling to Winnipeg for birth, their families and other stakeholders, what services and supports would be helpful?

   What services and supports do women need? – The most common response to this question was that women want to have their family with them. Women and HCPs also identified the need for recreational opportunities, financial assistance, professional support and education, and improvements to accommodations. HCPs identified the need for assessment and treatment of medical concerns and coordination of care.

   What do HCPs need? HCPs identified three areas of need for themselves: Increased knowledge of available resources, improved communication and increased support for care providers in rural and remote communities related to pregnancy, birth and postpartum.

Discussion

The findings of this needs assessment highlight the complexity of the needs and challenges that women who travel for birth and their families cope with. It is important to understand the full spectrum of needs in order to provide the most appropriate services and supports to women traveling for birth. However, women who travel for birth are not a homogeneous group. The women interviewed for this study had diverse cultures, traditions, socioeconomic backgrounds and experiences and many were apprehensive about sharing their experiences.

Recommendations based on this report were developed and prioritized by the Steering Committee and cover 5 areas: The referral process and communication between providers; Service provision; Expansion of services; Evaluation and research; and Advocacy.

Conclusion

This needs assessment should be viewed as a first step to understanding the needs of women who travel for birth. It highlights the importance of building relationships with women and their communities to create an environment of mutual respect. This action research study will be used to inform the continued development of the Prenatal Connections service and to encourage the services provided by Population and Public Health to be grounded upon the perceptions and needs of the women and other stakeholders. An evaluation will follow. This research has also raised broader questions about the short and long-term impact of traveling for birth on outcomes such as attachment, breastfeeding, family dynamics and empowerment.

Introduction

In March 2007 the Maternal and Child Healthcare Services (MACHS) Task Force was formed, and in September 2008 it released a document that outlined recommendations to the Minister of Health. The recommendations encompassed three areas of need:

- Supporting access to services closer to home;
- Addressing service gaps and supports; and
- Promoting promising practice across Manitoba

One gap identified by the task force was services available to women and children who are required to seek care outside their community or region, and specifically for those women who are required to travel for birth. Many women living in rural and remote communities are required to travel to Winnipeg or other centres to birth or obtain specialized obstetrical care. These women typically spend two to eight weeks away from home. In Winnipeg, many First Nations and Inuit women stay in one of the community specific boarding homes, while others stay with family, friends or in hotels. In its report, the task force identified that:

- Currently, in the Winnipeg Health Region, public health nurses (PHNs) receive a postpartum referral for women who have travelled for birth, but there is no systematic way to identify women prenatally

- While away from home, women who travel for birth may not receive the same services and support related to their pregnancy as other women who permanently reside in an urban setting

- Women residing in the boarding homes report feeling lonely, bored, isolated, overwhelmed and fearful for their health and safety (The Maternal and Child Health Care Services (MACHS) Task Force, 2008)

To address these gaps in service, 3 recommendations were made. In summary, the recommendations were to:

- Ensure that expectant women who relocate from First Nations, Inuit, Métis and other rural/remote communities to give birth have access to a coordinated system of prenatal and social supports

- Develop human resource capacity within Manitoba regions to act as contacts and service coordinators for women travelling for birth

- Develop resources to inform women of the services available to support them in the birthing community (e.g. Healthy Baby groups) and support them to access these services (The Maternal and Child Health Care Services (MACHS) Task Force, 2008)

In September 2010, the WRHA's Research and Evaluation Unit was invited to a meeting of the WRHA's MACHS Relocation Initiative Steering Committee (now known as the Prenatal Connections Steering Committee). Subsequently, in preparation for evaluating any Public Health services provided prenatally by the WRHA, it was decided to first undertake a needs assessment to assist in the development of public health services for women who travel for birth.

Methodology

Objective:

The purpose of this study was to gain an understanding of the strengths, resources and needs of women from rural and remote communities who temporarily relocate to Winnipeg for birth in order to design an effective and culturally safe range of prenatal services and supports to meet these needs.

Stakeholders:

The primary stakeholders and users of this needs assessment will be the WRHA Prenatal Connections Steering Committee and the WRHA's Population Public Health Program.

Research Questions:

The research questions were developed collaboratively with members of the WRHA Prenatal Connections Steering Committee. The following three questions were the primary focus of this needs assessment:

1. What expectations do women and families who temporarily relocate to Winnipeg for birth have related to healthcare services (obstetrical care and public health nursing) and social supports?

2. What barriers do women who temporarily relocate to Winnipeg for birth face and how do they currently cope with these issues? Consideration was given to the following elements identified by the Steering Committee:

    a. Culture and language – Cultural safety and language access

    b. Health and wellness -- Physical, emotional, mental and spiritual health, nutrition and access to food, prenatal medical care (physician or midwife), public health prenatal services, postpartum period and return home, system navigation

    c. Social supports - Support networks (including family and other resources), accommodations (including safety and security), leisure, finances, transportation

3. From the perspective of women traveling to Winnipeg for birth, their families and other stakeholders, what services and supports would be helpful to address these issues?

WRHA public health nurses (PHNs) have been providing services to some women traveling for birth since the spring of 2011. Three further action research questions were included in the proposal in anticipation that the women may also be able to provide feedback about the services provided. However, data related to these questions were very minimal and therefore the following questions **were not addressed** by this research (but will be addressed by the subsequent evaluation):

4. From the perspective of the women, families and other stakeholders:

    a. In what ways does the WRHA public health service meet/not meet their needs?
    b. How could the service be improved? (Considering both the content and the delivery)
    c. What additional services/supports would be beneficial?

5. Does the WRHA public health service facilitate access to appropriate community resources?

    a. What community resources are being accessed?
    b. What are the barriers and facilitators to clients participating in these programs?
    c. Do the programs meet client needs?
    d. What, if any, alternatives are proposed?

6. What impact (anticipated/ unanticipated, positive/negative) has the WRHA public health service had on:

    a. Prenatal experiences?
    b. Birth experiences?
    c. Postnatal experiences?
    d. Other?

Methods:

Action research is a "systematic approach to investigation that enables people to find solutions to problems they confront in their everyday lives" (Stringer, 2014, p. 1). It focuses on understanding complex, real world settings (Stringer, 2014). This study involved a literature review to understand the broader context around women traveling for birth, in addition to qualitative methods. Qualitative methods are used to gain an understanding of a situation from the perspective of participants.

Literature review

Literature was obtained and reviewed using scoping review methods (Arksey,H., O'Malley,L., 2005). Key words were isolated and searched though the Scopus® database. Articles were reviewed for relevance and reference lists were scanned to ensure that relevant articles were not missed. The literature was then synthesized and findings were written up according to themes and categories. This process was done on two occasions, early on in the study and once at the end to ensure that any recent articles were also included.

Qualitative methods

The following is an enumeration of where and with whom we collected perspectives on the needs of women travelling for birth:

- Semi-structured interviews and one focus group with women and/or family members who travelled to Winnipeg for birth. Women were interviewed at one of four local boarding homes (Kivalliq Inuit Centre, Ekota Lodge, Norway House Boarding Home and the Swampy Cree Receiving Home) or at Women's Hospital (n=17). One focus group was also conducted at the Kivalliq Inuit Centre (n = 9).
- Semi-structured interviews with care providers in Winnipeg, including physicians, nurses and others (n= 22).
- Semi-structured interviews and email consultations with health care providers in the referral communities of Northern Manitoba (n= 5) and Nunavut (n=8).

Interviews and the focus group with women were audio-recorded with the permission of participants. Detailed notes were taken during all other interviews and transcribed immediately following the interview. The researchers completed all data analysis. Notes were coded and the categories that developed were used to identify themes.

Research Challenges

The initial research plan included interviewing 30 women who traveled away from their home community to give birth in Winnipeg. However, due to scheduling and access issues the FrontStep research team was only able to interview 7 women individually and conduct one focus group. Following the completion of the first draft of this report, it was decided by the Steering Committee that another attempt should be made to strengthen the voice of the women and further understand their perspectives. An additional 10 interviews were conducted during this second wave. These 10 interviews resulted from the interviewer visiting Women's Hospital or the Kivalliq Inuit Centre 1-3 times per week over a period of about 12 weeks. Most women who were offered the opportunity to participate in an interview chose not to. Despite this attempt to increase the quantity, depth and richness of the data, interviews with women likely only scratched the surface of their experiences related to traveling for birth. This is in contrast to care providers, most of whom were very comfortable expressing their experiences and opinions, positive or negative.

It is also important to mention that the initial plan included interviewing the grandmothers of women who traveled for birth which did not come to fruition due to transitioning of staff. Finally, three managers from boarding homes in Winnipeg were contacted to offer their perspectives regarding the needs of women who travel for birth and were given the option of interviewing in person, over the phone, completing and faxing back a paper and pencil questionnaire, or filling in an internet based questionnaire. However, all declined to participate.

Ethics:

The study was approved by the University of Manitoba's Health Research Ethics Board, the WRHA's Research Review Committee and the Assembly of Manitoba Chiefs (AMC). Participation in this research was informed and voluntary, and consent was obtained from all participants. Information that could potentially identify a participant has been removed or masked.

Literature Review

The research literature was searched to find those articles that examined the experiences of women from rural or remote communities who travel away from their home communities for birth. The literature in this area comes from Australia and Canada. Almost all of the studies were qualitative and they varied in terms of quality.

Twenty two studies were included in the literature review. Five qualitative studies examined the experiences of Australian Aboriginal women travelling for birth and seventeen Canadian based studies focused on the experiences of Inuit women in Nunavut, women in rural areas of British Columbia, and women from Northern Manitoba. These studies go back as far as 1988. Eight themes emerged from the review of the literature:

- The normalization of traveling for birth
- Safety and security in the birthing community
- The importance of social support
- Informed choice and power
- The importance of cultural awareness
- Perceived consequences of birthing away from home
- Coping strategies
- Suggestions for improved care

The normalization of traveling for birth

Normalization is a term that has been defined as "the process by which individuals are shaped, regulated, and conformed to a certain set of standards and ideals for human thought and human conduct" (Lee Sinden, 2013, p. 61). In two separate studies, women indicated a fear of birthing locally as opposed to away, as they believed it was safer to leave their home community and birth in a location with more medical resources and amenities (Kornelsen & Grzybowski, 2004; Kornelsen, Kotaska, Waterfall, Willie, & Wilson, 2010; Telford Gold, O'Neil, & Van Wagner, 2007). Kornelsen & Grzybowski

(Kornelsen & Grzybowski, 2004) caution that this fear may be the result of viewing traveling for birth as 'normal' and having never experienced anything different. The authors highlighted this issue to illustrate the difference in opinion between women from communities where women have birthed elsewhere for a number of years compared to those who had just recently lost the option of birthing in their home community. The sense of danger in birthing locally was higher among those who had been birthing away from home for a number of years (Kornelsen & Grzybowski, 2004).

Safety and security in the birthing community

In the literature, safety and security included both emotional and physical safety and security. Leaving one's home community and being transplanted into a strange location with little or no familiar connection to other people can bring about various negative emotions. In both the Australian and Canadian literature, women reported experiencing a range of negative emotions while traveling away from home for birth, including feelings of loneliness, alienation, boredom, anger, anxiety and fright (Dietsch et al., 2011; Kildea, 1999; Kornelsen & Grzybowski, 2004; Kornelsen et al., 2010; O'Driscoll et al., 2011; O'Neil et al., 1988; Phillips-Beck, 2010; Watson, Hodson, Johnson, & Kemp, 2002; Watson, Hodson, Johnson, Kemp, & May, 2002). Watson and colleagues (Watson, Hodson, Johnson, Kemp, & May, 2002) explored the perspective of Health Care Providers (HCPs) working in a birthing community and found that HCPs observed the pregnant women to be distressed, homesick, bored and worried about their other children at home. More specifically, Phillips-Beck's study (Phillips-Beck, 2010) found that women expressed feeling confined to the boarding home due to lack of transportation, and/or anxiety around using public transit. In the majority of the literature these emotions resulted from being in a strange location and feeling disconnected from family and friends back home.

The women's sense of personal safety while in the birthing community varied between studies. In Kildea's (Kildea, 1999) study, women reported concern about their personal safety and having to share a room with a stranger, and stated they would have preferred to stay somewhere with other prenatal women. Conversely, Watson et al (Watson, Hodson, Johnson, & Kemp, 2002) found that women felt secure because the accommodations were located within the hospital campus in a secure environment.

The importance of social support

Various Canadian and Australian authors found that there was little or no support for women while temporarily living in an urban centre (Chamberlain & Barclay, 2000; Dietsch, Shackleton, Davies, McLeod, & Alston, 2010; Dietsch et al., 2011; Kildea, 1999; Kornelsen & Grzybowski, 2005; O'Neil et al., 1988; Phillips-Beck, 2010; Watson, Hodson, Johnson, & Kemp, 2002; Watson, Hodson, Johnson, Kemp, & May, 2002). Separation from partners and family members prior to and during birth was difficult for both the women and their families (Dietsch et al., 2010; Dietsch et al., 2011; Phillips-Beck, 2010; Watson, Hodson, Johnson, & Kemp, 2002). If the women wanted a family member to join them in the birthing community it was an out of pocket expense that was difficult for many to manage (Chamberlain & Barclay, 2000; Dietsch et al., 2011; Kornelsen & Grzybowski, 2006; Phillips-Beck, 2010). While in some cases women were able to bring escorts, it was noted by Watson and colleagues (Watson, Hodson, Johnson, Kemp, & May, 2002) that HCPs expressed concern that some escorts did not fulfill the needs of the women.

The stress of arranging childcare and worrying about children back home was common (Chamberlain & Barclay, 2000; Kornelsen & Grzybowski, 2004; Kornelsen & Grzybowski, 2006; O'Neil et al., 1988; Phillips-Beck, 2010), and the financial cost and support required as a result of birthing away from the home community could be substantial. Additional costs may include: travel expenses (as mentioned above, if the partner or support person joins the mom to-be), missed work, phone calls, and intrapartum (during birth or delivery) transport by ambulance, all of which are often difficult for families to afford (Chamberlain & Barclay, 2000; Kornelsen & Grzybowski, 2004; Kornelsen & Grzybowski, 2006; O'Neil et al., 1988; Phillips-Beck, 2010).

Physical separation also resulted in families feeling emotionally separate prior to and following the birth of a child. Women reported a sense of loss from the comfort that comes with familiar people and places. Due to this separation, women reported a strong desire to return home early (Kornelsen & Grzybowski, 2006). Taken together, these issues made for a very difficult time for many of the women birthing outside their home community.

Informed choice and power

The literature discloses that women experienced a lack of freedom and choice, as well as a loss of empowerment when they were required to leave their home community to give birth (Dietsch et al., 2010; Dietsch et al., 2011; Kildea, 1999; Kornelsen & Grzybowski, 2004; Kornelsen & Grzybowski, 2005). The literature from Australia described that the women felt devalued, disrespected, judged and even bullied by care providers (Dietsch et al., 2010; Dietsch et al., 2011; Watson, Hodson, Johnson, & Kemp, 2002). In their study Watson et al. (Watson, Hodson, Johnson, & Kemp, 2002) found that women felt they were not given critical information by staff regarding themselves or their baby, and reported that explanations about medical procedures and tests were lacking. Similarly, care was described as fragmented and characterized by unhealthy relationships and a lack of clear communication and understanding between women and care providers in the Canadian literature (Kornelsen & Grzybowski, 2005; Telford Gold et al., 2007). Families traveling for birth in Chamberlain's (Chamberlain & Barclay, 2000) study felt that decisions were made by HCPs without input from the woman or family. In Kornelsen, et al.'s study (Kornelsen & Grzybowski, 2005), Canadian women also expressed feeling that they were not provided with information about medical policies and services, including what to expect in hospital and around prenatal education.

Across the Australian and Canadian literature, women indicated that birthing away from family and friends led them to feel a lack of confidence in their ability to parent. Women in Australia reported feelings of fear that their baby would be apprehended or that their ability to mother was being judged in a negative manner by the hospital staff (Dietsch et al., 2010; Dietsch et al., 2011). Similarly the Canadian literature described how being away from home without the support of the community threatened the women's sense of competence around birth, self-esteem and identity in general, and contributed to feelings of being inadequate as a parent (Kornelsen & Grzybowski, 2005).

The importance of cultural awareness

In 2002, an Australian study was conducted to obtain the perspective of healthcare professionals (HCPs) in communities women travel to for birth (Watson, Hodson, Johnson, Kemp, & May, 2002). The authors used a survey tool to understand HCPs opinions about the maternity experiences of indigenous women in acute care who had travelled for birth. HCPs indicated that the women were not prepared for being away from home. They also mentioned that the women seemed unprepared for what it would be like in an acute care environment, including a lack of understanding about the roles of the hospital staff. The authors found that meeting the needs of the mothers was difficult because of language or cultural barriers. These barriers made standard procedures difficult, such as obtaining informed consent (Watson, Hodson, Johnson, Kemp, & May, 2002).

In much of the Canadian literature, concern was raised over the medicalization of birth and its departure from being viewed as a social event (O'Neil et al., 1988). Traditionally, childbirth was viewed as a community celebration where all members eagerly awaited the arrival of the new baby (Kornelsen et al., 2010). In Canada and Australia traditional birthing practices may be preferred, such as specific positions during labour (Kildea, 1999) and assistance from elders and family members (Kornelsen & Grzybowski, 2005). Studies conducted in Canada found that this separation of birth from the community was concerning particularly in regard to losing traditions, decreased support (social, financial and emotional), and the mother and child's sense of belonging (Chamberlain & Barclay, 2000; Kornelsen et al., 2010; Telford Gold et al., 2007). In particular, loss of traditions such as ties to the land and the bond that forms between an Inuit midwife and the children she helps birth (Kornelsen & Grzybowski, 2005; Kornelsen et al., 2010; O'Neil et al., 1988) and the issue of land claims among the Inuit were mentioned as concerns resulting from children being born outside of their home communities (O'Neil et al., 1988; Sillett, 1988).

Perceived consequences of birthing away from home

Having to leave their home community to birth resulted in unforeseen health consequences for some women and their families. Phillips-Beck (Phillips-Beck, 2010) found that some women experienced high blood pressure while away from home and others were unable to eat or sleep. Kornelsen & Grzybowski (Kornelsen & Grzybowski, 2004) found that women unexpectedly gained weight while in the birthing community as a result of not having access to cooking facilities and thereby having to rely on restaurant food. In both studies the negative health consequences experienced by women and their families decreased the perception of safety and security in the birthing community. Aside from health consequences, separation for birthing resulted in some families experiencing marital strain and even family break-up (O'Neil et al., 1988) and other studies reported difficulty reintegrating mom and baby into the family upon return (Chamberlain & Barclay, 2000; Kornelsen et al., 2010)

Coping strategies

Kornelsen & Grzybowski (Kornelsen & Grzybowski, 2006) highlighted some of the coping strategies that women used to either avoid having to travel for birth, or reduce the time spent in the birthing community. The strategies included: elective inductions to minimize wait times in the urban centre; women arriving at their local health centre in advanced labour and in turn the local care provider ruling out the option of transfer to the urban centre; or seasonal timing of birth to prevent the possibility of winter driving.

Suggestions for improved care

In one Canadian and two Australian studies women described what could improve their experience. In the Canadian study, midwifery or doula support was mentioned as a potential aspect that could improve the experience of the women (Phillips-Beck, 2010). Women discussed the desire to be able to bring a partner or support person with them. Considering the financial weight of traveling for birth, the women also indicated that having financial support for childcare, or having the option of bringing their children with them would reduce this burden. It was also suggested that having a specific residence for prenatal women and their families would improve the women's experience. Finally, the women indicated that education and support on issues such as what to expect before leaving home, prenatal classes, and breastfeeding support would be welcomed (Phillips-Beck, 2010). The Australian literature by Kildea (Kildea, 1999) and Watson and colleagues (Watson, Hodson, Johnson, & Kemp, 2002) found that women felt it would be helpful to have education about mothering skills and what to expect when admitted to hospital. Kildea (Kildea, 1999) noted that women preferred support that encapsulated the traditional birthing practices such as labouring positions and having family members present for the birth. Additionally, having access to Aboriginal staff and/or interpreter services, and having a friendly hospital environment were suggestions made by the women regarding how services and care could be improved (Kildea, 1999).

In summary, as evidenced by the existing literature, the need for a sense of safety and security, family support, feeling respected, as well as recognizing the importance of culture and tradition are critical for women birthing outside of their home communities. Along with the findings from the needs assessment, the findings from this literature review will be discussed later in this report. The overall findings will be used to inform the delivery of services offered to women who must travel to give birth in Winnipeg. In what follows, we will provide an outline of the findings from interviews conducted with women who traveled to Winnipeg to birth and their care providers in Winnipeg, Northern Manitoba, and Nunavut (Kivalliq).

Qualitative Findings

This section will present the findings from the interviews and focus group with women traveling for birth, as well as interviews with care providers and other stakeholders. The findings are organized by research questions and further divided into themes emerging from the interviews with women and themes emerging from care providers and others.

Participants

Women: A total of 16 participants were met in interviews and 9 participants in a focus group. All focus group participants were from the Kivalliq region of Nunavut. Those who participated in the interviews were from Kivalliq (n=7), Manitoba (n=7) and Northwestern Ontario (n=2). All participants were mothers with the exception of one father. However, throughout the report, all participants will be referred to as mothers so that the one father is not identifiable. Women were interviewed from 6 of the 8 communities in the Kivalliq region of Nunavut. The Manitoba women came from six (6) different communities, some of which are accessible only by plane or winter road. The other communities are, at minimum, a 4 hour drive from Winnipeg. Only one woman who participated in the focus group and two women who participated in interviews were in Winnipeg for their first baby. All of the women in the focus group were prenatal. For the interviews, 10 women were prenatal and 7 women were postpartum.

Health care providers and other key stakeholders: Twenty-two participants resided in Winnipeg, five in Northern Manitoba (representing 5 different communities) and eight (8) in Nunavut (representing 7 of 8 communities in the Kivalliq region).

What expectations do women and families who temporarily relocate to Winnipeg for birth have related to healthcare services (obstetrical care and public health nursing) and social supports?

1. Women's expectations and the normalization of traveling for birth

Inquiring about expectations related to traveling for birth was challenging because for many, it would seem that traveling for birth is now accepted as the norm for women in the Kivalliq region of Nunavut and rural and remote areas of Manitoba. Traveling for birth from rural and remote communities is not a new phenomenon and dates back to the 1970s or earlier depending on the community (Parkin, 2000). It is estimated that approximately 1100 women a year relocate from First Nations communities and other rural and remote regions of Manitoba to give birth in urban centres, including Winnipeg (Phillips-Beck, 2010).

Although all women in the Kivalliq region of Nunavut (aside from Rankin Inlet) are expected to leave their home communities to give birth, women who are classified as being at "low risk" are given the option of going to Rankin Inlet or to Winnipeg.

Women's perspectives

When asked what she did to prepare for leaving her home community one woman from Northern Manitoba responded: "*Nothing, the children know mom will be gone." (Mother of 3, Northern Manitoba).* Most women did not have a definite answer about what their expectations were related to traveling for birth. However, for many, this was not their first time coming to Winnipeg to birth, and they were familiar with the process.

> *I know what to expect and I feel relaxed. (Mother of 6, Northern Manitoba)*

Two women described how their experiences were quite different from their expectations.

> *They kept telling me when I'd come to my appointments I'm high risk, I'm high priority, and then when I would get here it's just like everything just kind of stopped and it wasn't going anywhere, and they weren't doing anything and no one was telling me anything. (Mother of 1, Western Manitoba)*

> *I thought it was gonna go a lot faster, because when I, when they, in Rankin they said that we had to go down I thought you know they had an idea that the baby was gonna be a lot quicker than it was. (Mother of 1, Nunavut)*

Others describe their experience of leaving home as an everyday experience.

> *It wasn't a huge burden, huge, it wasn't fun, but it wasn't a huge burden to come down either. (Mother of 3, Northern Manitoba)*

> *Well, I was just happy I was here cause I wanted to go shopping. (Mother of 4, Nunavut)*

> *It is easier to get Pampers in Winnipeg; they are more expensive back home. I'm getting a shipment of Pampers, baby clothes, and baby wipes shipped to [home]. (Mother of 2, Nunavut)*

Similar to the findings in the literature review, fear of birthing locally had some women preferring to birth in the city.

> *I would tell others it's good to come to Winnipeg to have their baby, because they are equipped for emergencies. (Mother of 3, Northern Manitoba)*

> *There was the option to stay in Rankin and have the baby there but … mom was quite, was more worried that I should have the first baby down there where there was better medical service. (Mother of 1, Nunavut)*

Although some women may see traveling for birth as an opportunity to stock up on needed supplies, or as the safest way to birth, this does not mean that it is easy for anyone.

When I was a first time mom, I was very scared and very young to have my first baby. (Mother of 5, Nunavut)

I packed my clothes. I didn't want to come to Winnipeg, it's hard to leave. (Mother of 2, Nunavut)

I was seventeen when I had my first baby and I was confused and alone, it was very hard. (Mother of 5, Nunavut)

Health care providers' perspectives

Many health care providers seemed to have also normalized traveling for birth. Some described it as an opportunity for women to stock up on food and other supplies that are much cheaper than at home. Others speculated that some women liked the break from their responsibilities at home.

It is just normal, how it's always been, you have your baby in Winnipeg and then you come home. (HCP Nunavut)

They just cope with it. It's just normal for them, they know that they will not be pregnant forever. (HCP Nunavut)

A lot of women want to go to Winnipeg for shopping. They may not want to go the day we tell them they have to go, but they are wanting to go down for a bit. (HCP Nunavut)

HCPs also described the risks they perceived of birthing in the community.

It is not that we can't deliver a baby here but if there are complications we don't have a chance of saving them. We have delivered babies in all of the communities but if there are complications it is dangerous. (HCP Nunavut)

On the other hand, HCPs observed that many women were reluctant to leave their home community to birth.

They experienced anguish when they were sent away for birth. (HCP Winnipeg)

Some of them like going to Winnipeg but most don't like leaving the community. I would say a majority of them don't like leaving the community. (HCP Nunavut)

Normalization is the process through which people are molded to behave according to society's standards (Lee Sinden, 2013). The normalization of traveling for birth may be reflected in the perspectives of women and HCPs described above. Some HCPs very directly described traveling for birth as 'normal' and 'how it's always been'. Although it has not in fact always been the norm to travel for birth, for many women, it has been so since before they were born. Some women and HCPs also described traveling for birth as the safest option. If over time traveling for birth has become generally accepted as the safest way to birth, it becomes difficult for women to choose other options, under pressure from HCPs, family or friends that birthing outside of a tertiary hospital is unsafe.

This is one example of how traveling for birth may have become normalized, in other words, the socially accepted way to birth.

What issues do women who temporarily relocate to Winnipeg for birth face and how do they currently cope with these issues?

Women who relocate for birth cope with numerous challenges including managing daily life in a large urban centre, having limited social supports, experiencing language and cultural barriers, health concerns and fragmented health care, and a lack of choice and power. These will be discussed below along with some of the perceived outcomes associated with traveling for birth and coping strategies women use.

2. Challenges managing daily life in Winnipeg

At the most basic level, women must make preparations to leave home and life continues while they are away. They must have somewhere to stay, food to eat, money to live and transportation to and from appointments and leisure activities.

Women's perspectives

a. *Preparations* – Women must make preparations before they leave home. Packing everything that mom and baby will need is one aspect of preparing to go.

> *So I packed for everybody and then myself and then to think of what I might need for the baby just in case cause I'm not at home where everything is. (Mother of 4, Northern Manitoba)*

Preparing to leave home is more complicated for families with other children at home who need to be cared for. In most cases, these children are not able to travel with their mother and arranging for their care can be stressful, especially since women do not really know how long they will be away.

> *That one [the first baby] probably was the easiest one, just cause she was still with me so we didn't have to worry about everybody else. (Mother of 3, Northern Manitoba)*

> *My mom works full time so I had to arrange for a sitter while my mom is at work. My aunt from [another community] came to stay with my mom to care for my kids while she works. (Mother of 4, Northern Manitoba)*

> *I was a little bit worried and stuff but after talking to their dad it was like well, I just need your help for a little while cause I don't know how long I'm gonna be here, I don't know how long it's gonna take. (Mother of 4, Northern Manitoba)*

b. *Nutrition* - Some women reported that food choices within the various boarding homes were adequate, but perhaps limited in variety. A familiar refrain was "*I get tired of eating the food here.*"

c. *Safety* – In general, women did not identify concerns about their safety while in Winnipeg, but women in the focus group indicated that personal safety can be an issue. They reported not feeling safe at night and being unsure of which areas of the city were safe and unsafe.

> *I already feel safe here. (Mother of 5, Northern Manitoba)*
>
> *It's not friendly Manitoba. People do crazy stuff. (Mother of 5, Nunavut)*

d. *Accommodations* - The women interviewed did not report any concerns about staying at the boarding homes, especially if other people from their community were in the boarding home at the same time. On the other hand, although accommodation and food are provided for the women, it is usually not provided for their partners. This may mean that fathers must stay at home or find alternate accommodations.

> *It's hard on him I guess cause he has to stay up all night and he doesn't have anywhere to sleep and then he has to find his own meals. (Mother of 1, Western Manitoba)*

In addition, accommodations are not covered for all women who travel for birth. Some stay with family or friends, and being in someone else's space or in tight quarters for an extended period of time, presents its own challenges.

> *Being irritated and grumpy and having to be in somebody else's space. That's my big problem, I like my way of doing things and my space and that kind of thing so to have extra input sometimes is aggravating. (Mother of 3, Northern Manitoba)*
>
> *It gets a little frustrating there between the 2 of us sometimes. Just being stuck in a hotel room for 3 weeks. (Mother of 1, Nunavut)*

e. *Transportation and way finding* - Women come to Winnipeg by plane, bus or car, travelling over great distances. Some of the women have never been on an airplane before, and may be fearful of flying.

> *So I just opted to travel with him cause I'm, I've never been on a plane so, I just decided to torture myself and travel the 6 ½ hours. (Mother of 4, Northern Manitoba)*

Some boarding homes provide transportation to medical appointments, but in many cases women have to find their own transportation to participate in leisure activities. Women's sense of competency taking public transportation ranged from being comfortable to being quite scared. Some women expressed being so uncomfortable with public transportation that they chose to stay at the boarding home rather than going out. For other women, taxi and bus fare were too expensive, thus limiting their participation in leisure.

> *[Kivalliq Inuit] center is very good, and very organized, and they take us to medical appointments. (Mother of 5, Nunavut)*
>
> *I got lost coming home from Polo-Park on the bus. (Mother of 2, Nunavut)*

Some women expressed frustration trying to find their way to and from medical appointments and one woman expressed great frustration trying to locate the proper buildings and rooms in the hospital.

> *My doctor gave me his card, and said to call if you have any problem. I get confused with all the different acronyms at the HSC. No more babies, I'm done with this! (Mother of 2, Nunavut)*

f. *Financial strain* - Financial concerns impacted women and their families in a number of ways. Many women described feeling nervous having to wait for the arrival of their social assistance cheques prior to leaving home as this was the only financial support they would receive while in Winnipeg. For women who work, the financial effects of having to leave their jobs early were felt as there was often a lag between leaving work and receiving employment insurance.

> *Right now I have my own money, but it's hard as I only received one check, my Employment Insurance hasn't kicked in yet. (Mother of 3, Northern Manitoba)*

Women must arrange childcare for their children for an indefinite period of time, but do not receive any money to cover the costs of this care.

> *My kids are home with my mom. She doesn't get any money for watching them. (Mother of 3, Northern Manitoba)*

If family members accompany the women it has further implications on their financial situation. The majority do not have money to pay for someone to accompany them.

> *If my mom came with me it would help, but the transportation cost is hard, and she would need a place to stay. (Mother of 5, Nunavut)*

> *The last time my whole family came and there's [n] of us in my family. So that was costly on them, and then [baby] didn't end up coming so it was pointless. (Mother of 1, Western Manitoba)*

And finding things to do while in Winnipeg is a challenge if you do not have money to pay for them.

> *It's really boring without money here. (Mother from Nunavut, Focus Group)*

Health care providers' perspectives

a. *Nutrition* - Women have told the HCPs that there is no space available for them to cook their own food, and in some accommodations they are not able to enter the kitchen and do not have access to microwaves.

> *[They] complain about the food, its greasy, it's too much the same. (HCP Winnipeg)*

b. *Safety* - HCPs interviewed also spoke about the issues of fear and safety, having heard from women that the city is too big, and that they experience discomfort being in a strange place.

She didn't feel safe there [at the hotel], there were people coming to her door, selling drugs. (HCP Winnipeg)

c. *Accommodations* - HCPs familiar with Kivalliq Inuit Centre (KIC) say that it is an invaluable resource. HCPs that work with both women from Nunavut and women from Northern Manitoba see distinct differences between the accommodations and services available to women from Nunavut and those from Northern Manitoba. In some instances, women arrive in Winnipeg from Northern Manitoba and have no place to stay. They may have no money for food, transportation and personal items. HCPs interviewed reported that some women prefer to stay in a hotel because then family members can join them.

Patient shows up here and has no place to stay, and finding a place to stay is a big challenge. (HCP Winnipeg)

[A] problem, and I think it is for the Aboriginal women, not Inuit, some of them don't like the boarding homes, they want letters … so that they can go to hotels. (HCP Winnipeg)

d. Transportation and way finding- In most instances HCPs report that transportation from the home community to Winnipeg is well arranged. According to HCPs, the bulk of the transportation problems for women, at least for those from Northern Manitoba, occur once the women arrive in Winnipeg. Upon arrival they are required to contact First Nations Inuit Health Branch insured services and then are only provided enough money for transportation to medical appointments. Some boarding homes provide transportation, but in other cases women must rely on taxis or buses.

It's challenging to navigate the bus system or take a taxi in a strange place (HCP Winnipeg)

Although driven to appointments, they are dropped off at the front door and must make their own way. We have had people "lost" in a hospital … strange as that may sound. (HCP Northern Manitoba)

e. Financial strain - HCPs spoke about the difficulty many families have trying to make ends meet when mom comes down to Winnipeg for weeks at a time.

You can imagine what it's like for them down there. A lot of the women borrow money for while they are down there, a lot of money switches hands, let's put it that way. (HCP Nunavut)

Several HCPs spoke about the challenges women face related to accessing Employment and Income Assistance (EIA) money while they are away from home.

Yes they are staying at the [Kivalliq Inuit] *Centre but when they are [in Winnipeg] they need some money. If they are on income support, as soon as they are out of the territory they can't access it. (HCP Nunavut)*

Finance is a big issue as most live on welfare and need to wait for their welfare cheque before going out for confinement. (HCP Northern Manitoba)

Lack of finances may also result in further separation and/or isolation from home. HCPs have been told by family members at home that they have not had any contact with the pregnant woman since her departure as the cost of telephoning is prohibitive. The Kivalliq Inuit Centre has attempted to ease the financial burden for Inuit families, offering a toll free number for families to call.

3. Limited Social Support

Similar to the findings in the literature, loneliness was an issue for the women in this study. Most women leave their home community without their partner and children, to travel hundreds of miles alone to birth in urban centres. In the literature and in almost every interview conducted, women and HCPs felt that the practice of women travelling alone for birth was emotionally harmful to both women and their families.

> *A new baby is supposed to be a happy time, but the time leading up to the delivery can be difficult. (HCP Nunavut)*

Women's perspectives

a. *Homesickness* - Many women described feelings of homesickness while staying in the city.

> *Ya, I even got homesick and couldn't get up in the morning … I just stayed in the bed for more than 10 hours. (Mother of 3, Northern Manitoba)*
>
> *I feel lonely here, because it's not home. (Mother of 6, Northern Manitoba)*
>
> *I wanna go home. (Mother of 4, Northwestern Ontario)*

b. *Waiting* - Typically women are required to go to an urban centre by 36 weeks gestation, meaning that some women are away from home for over a month. Waiting was a common theme described by the women. When one woman was asked what she would tell a friend or another woman who had to travel to Winnipeg for birth, she responded as follows:

> *Well, I'd probably tell her to expect a lot of waiting … and they tried, to start trying to induce me, it was a lot of waiting, and being in the city and waiting, waiting for the call and so that's probably what I'd tell her, expect a lot of waiting. (Mother of 1, Western Manitoba)*

Other women also described waiting:

> *Wait for appointment, wait for doctor, wait for bus, wait for taxi. (Mother of 4, Nunavut)*
>
> *It was ok but kind of hard to wait. (Mother of 5, Nunavut)*
>
> *It is a long wait to have baby, they send the mothers to Winnipeg too early. I have been here for two weeks, and my baby is only due [two weeks from now]. (Mother of 2, Nunavut)*
>
> *But it was just the wait, you know, sitting around and waiting till the time comes, that was the difficult part. (Mother of 1, Nunavut)*

c. *Being alone* - Women are required to leave their homes and the support of family and friends and many women said there was no funding for their partner or someone else to go with them. In general, only if a woman is underage or has significant medical complications will an escort be sponsored.

> *I am alone because medical services doesn't provide escort. (Mother of 4, Northern Manitoba)*

The absence of family support was identified as an issue for both the women and their families.

> *Um, it was hard on my parents because they wanted to come too for his birth, this is their first grandchild. (Mother of 1, Western Manitoba)*

> *I think it's probably just a little bit lonely cause all my family is up north, like my aunts and my cousins and my partner's back home. It's just a little bit lonely not having my partner here with me. (Mother of 4, Northern Manitoba)*

Some women were fortunate enough to have their kids or other family along with them. This was identified as critical to their ability to cope with being away from home for birth.

> *Just probably if I was here by myself, I wouldn't be able to be here by myself. (Mother of 1, Western Manitoba)*

Health care provider perspectives

a. *Homesickness* - HCPs in Winnipeg observed that women often get homesick and want to go home. Few are content with being away for an extended period of time and once the baby is born the women are eager to return home.

> *Sometimes we discharge people from the hospital earlier but it doesn't mean they are ready to leave the city. When you tell them this they start crying. (HCP Winnipeg)*

b. *Being alone* - HCPs noted that the majority of first time moms expressed fear and concern over having to birth alone in Winnipeg and other women experienced a deep sadness when they had to leave young children at home.

> *I don't think it's fair that a woman has to go down alone, it is such an emotional thing for them to have to go such a long way alone. (HCP Nunavut)*

> *The biggest thing is that spouses/dads don't get [to go] along with Mum – I don't know the history of this decision, just that it causes lots of worry. (HCP Northern Manitoba)*

> *Many primips have never been to a Winnipeg hospital and are very scared and lonely. (HCP Northern Manitoba)*

> *They are often looking for female relatives for support and they derive a lot of their courage from them in the moment and not having them there in Winnipeg I think this might affect their experience. (HCP Nunavut)*

4. Misunderstandings about culture and language

During the interviews, the topics of culture and language were raised mostly by health care providers. Women discussed food and a little bit about understanding cultural norms, and HCPs spoke about language, food and cultural norms.

Women's perspectives

a. *Food* - From a cultural perspective, food was mentioned most often by women. There were mixed opinions on the food at the boarding homes, but many women talked about missing country foods (traditional foods) or being able to cook for themselves.

> *The food is very different. I miss caribou and fish, country food. When caribou or fish come in, it goes quickly. (Mother of 2, Nunavut)*

b. *Understanding cultural norms* - A few women described the challenge of being in a new, unfamiliar environment. When asked what was different about being in Winnipeg, one woman in the focus group replied "the people". Many of the women interviewed were either planning to adopt out their baby or had adopted a previous baby out. Although the women did not talk about a lack of understanding around custom adoption directly, one woman talked about not being provided with the support she needed in this regard.

Health care providers' perspectives

a. *Language* – Health care providers felt that although women had access to interpreters, they were not always available. Several HCPs felt the degree to which language was a barrier was not always easy to determine. They described how sometimes women would nod and smile when they were being given information, but that they may not always completely understand what was being said.

> *Most of the women are unilingual- Inuktitut and that adds to the fear and anxiety because obviously there is not a lot of Inuktitut, some have interpreters but not always. (HCP Nunavut)*

> *The language is also a barrier and the girls who are 15, often English is not their first language. Sometimes they will just nod and act like they understand but really they didn't understand a word you said. (HCP Nunavut)*

b. *Food* - Depending on where the women stay when they arrive in Winnipeg, eating habits and food choices may be altered drastically. HCPs from all areas indicated that finding traditional foods can be difficult in Winnipeg, and availability in the boarding homes and hospitals is inconsistent. Although some women will bring caribou meat with them, they are unable to bring enough to last for the duration of their stay.

> *Probably their cultural food and their country food if they don't have access to that, some hospitals will provide it but it is kind of hit and miss, depending on the time of year, if they got a delivery in or not and sometimes the younger ones or the older ones don't understand that they can request this food, that it is available for them. (HCP Nunavut)*

c. *Understanding cultural norms* - One care provider shared her understanding that in Aboriginal culture the community plays a significant role in raising children and others described how at home it was not uncommon for women to receive help from family members or neighbours.

> *We (Aboriginal people) do not view children as "ours" or belonging to anyone but the Creator, and so we believe that it is all our responsibility, to raise children with that lens. (HCP Winnipeg)*

Other HCPs in Winnipeg noted that this worldview of collective childrearing may cause confusion and misunderstanding between women and providers.

> *Staff see it as negative that they leave the baby* [with staff], *but in their mind someone is looking after the baby. (HCP Winnipeg)*

Similarly, another HCP felt that the women are sometimes judged by HCPs when they arrive at the hospital without any supplies for baby, not realizing that their family is out shopping for things that the mother and new baby need.

Many HCPs observed that the women typically present as shy and quiet, and some appear to be afraid to ask questions or challenge decisions. Some Winnipeg HCPs reported that they have rarely heard the women complain. However, Nunavut HCPs reported that once back home the women will discuss the negative experiences.

> *A lot of the women won't complain and they just accept what was given to them until they get back to their community and tell everyone how bad of an experience it was. (HCP Nunavut)*

HCPs in Nunavut expressed concern that there is a misunderstanding on the part of the health care providers around custom adoptions. Custom adoptions are based on Inuit traditions and do not require the involvement of social services. However, HCPs stated that there were occasions in Winnipeg when social services *were* called, raising fear in the women, as well as other situations when conflict developed between a woman who was trying not to bond with a baby she was adopting out and HCPs who took this to mean that the woman was not taking care of her baby.

5. Health and health care challenges

Some women traveling for birth experience medical and other personal issues. Women and HCPs also identified both strengths and challenges related to communication and coordination of care for women traveling for birth.

Women's perspectives

a. *Physical and emotional health concerns* – Many of the women interviewed described serious health concerns such as high blood pressure, diabetes and acute illnesses.

> *It's hard being away from home and I have become blind with this pregnancy. I don't know what's going to happen with this blindness … I feel frustrated and worried. (Mother of 5, Northern Manitoba)*

> *I had to have my appendix removed last week. I had an attack, and didn't know what it was, the home thought that I was in labor, but I knew it was a different kind of pain than labor. They rushed me to the St. Boniface hospital by ambulance where I had to have my appendix removed and I was scared as they said there was a chance that I might go into labor from doing this surgery and have baby early. (Mother of 6, Northern Manitoba)*

Other women were worried about their baby or had personal issues that they were worrying about.

> *It has been up and down. There are two reasons why, I am pregnant and alone in Winnipeg, and second, my dad died [this year], here in Winnipeg, so it has been hard. (Mother of 5, Nunavut)*

b. *Communication and coordinating care* - Although this issue was raised primarily by HCPs, a few women also raised concerns about communication between providers and patients:

> *Because, well my mom was **really** mad, cause like nobody was telling her anything 'cause they couldn't tell her anything … We thought maybe it was just that the doctors wanted me to deliver over here and there was no reason for it so it was kind of upsetting. But once we found out all the information we were alright with it and if it was best for him. (Mother of 1, Western Manitoba)*

> *Be really prepared, talk to your doctor about what his plan is for you and the baby because when it's sprung on you, oh your baby is being flown out, or you're being flown out, it kind of puts you in a panic mode. (Mother of 4, Northern Manitoba)*

As well as communication and coordination between sites:

> *When they sent me home from here, they said it was ok, but when I got home they said they weren't equipped to deal with me over there and they had to send me back. So, like there's no communication between the hospitals … They admitted me and everything and then they told me after that I wasn't, that they weren't able to care for me. And then they sent me home again and then I came here the next day. (Mother of 1, Western Manitoba)*

Health care providers' perspectives

a. Physical and emotional health concerns – HCPs identified many physical and emotional stressors that affect women traveling for birth, such as diabetes, anemia and substance use.

They are already dealing with a high risk pregnancy, they are here alone, they're upset, stressed. (HCP Winnipeg)

b. *Knowledge of available resources* - Nunavut HCPs indicated that prenatal care is done well in their communities, while conversely some HCPs in Winnipeg mentioned that prenatal education classes and postpartum visits occur haphazardly in the North. HCPs from Northern Manitoba and Nunavut expressed concern that the HCPs in Winnipeg are unaware of the resources available (or not) in the North, such as which medications are kept in stock at northern health centres, the limited formula options and its high price, and access to running water. HCPs in the northern communities thought that if there was more awareness of these details, information provided to the women could be tailored to better suit the environment.

The nurses down south will tell the girls that your nursing station will have this for you when you get back, but we don't have the same access to meds like they do down south. (HCP Northern Manitoba)

From the perspective of HCPs, women do not always know what resources are available to them or what services and equipment (e.g. meals, breast pumps) are covered.

They don't know where to eat, or that they are entitled to have meals covered or a room. (Winnipeg HCP)

c. *Communication* – Communication about the care of women traveling for birth has to be shared between the physician(s), the nursing station, the boarding home, public health and of course, the woman. HCPs perception of communication was generally mixed. Some HCPs indicated that communication between the hospital and the nursing stations is good.

We are kept appraised of everything that is going on. We are told as soon as the baby is born, that kind of thing. We have regular contact with Winnipeg while the woman is away. We are told if there is anything wrong with the baby [and], excellent communication [occurs] pre and post-delivery. (HCP Nunavut)

However, some Nunavut HCPs said they receive no communication while women are in Winnipeg. One major concern with communication to the north is that connectivity for internet, telephone and fax is inconsistent. Nunavut HCPs have started sending a copy of the prenatal history with the women to give to the hospital because it was noted by multiple HCPs in Nunavut that this information is not always being sent to the hospitals who need it to care for the mom and baby.

There have been countless times when the hospital calls at 2am because the docs never sent the prenatal records to the hospital. (HCP Nunavut)

d. *Continuity of care* – According to HCPs, the nurses and obstetricians who travel to Northern communities follow the women closely before and after birth, and try to continue providing care once the women arrive in Winnipeg. Kivalliq Inuit Centre helps with service coordination, and many commented on how helpful the nurses at KIC are. However, Nunavut HCP's also reported that it can

be challenging finding someone to assist them with linking the care received in the home community with the care provided in hospital.

> *I can't say enough about [KIS nurses], they are our biggest resource, what they do for these women. (HCP Winnipeg)*

> *I find it is time consuming trying to locate someone to talk to. This is when we are trying to get someone out before the 36 weeks or if we need to tell someone that this test hasn't been done or this or that hasn't been done, you know, the continuity of care. (HCP Nunavut)*

> *We try to liaise with the Inuit Centre and they have been good but they also don't always get the info from the docs either, it is like there is a missing hub in the wheel. And if something happens over the weekend you are screwed because all you get are answering machines. (HCP Nunavut)*

In addition, although Public Health sees individuals from Nunavut prenatally in Winnipeg, there is a lack of consistency in terms of whether they will be made aware of a woman's arrival in Winnipeg. Public health also attempts to provide postnatal care to the women but this is challenging due to the speed with which women return home.

6. Choice and Power

The literature reported that women who are forced to travel for birth feel that they have lost the power to decide what is right for their birth process. Similar findings came from HCPs and women in this study. The challenges experienced recruiting women to participate in interviews may reflect this historical difference in power between the women, HCPs and the health care system. Similarly, HCPs appeared to be comfortable expressing their opinions, whereas the women appeared more hesitant.

Women's perspectives

There was a sense from some women that what was going on was outside of their control. This was reflected in both what they said and the words they chose to describe their situation.

> *I didn't expect anything. I just stay here. (Mother of 2, Nunavut)*

> *I became confined here and not allowed to go home. (Mother of 5, Northern Manitoba)*

> *They normally ship the mother here to Winnipeg one month in advance. (Mother of 2, Nunavut)*

> *Just do what the nurses say, the doctor. Just make an agreement and everything's gonna be fine. (Mother of 4, Nunavut)*

Some women described how the threat of police involvement is used if they refuse to leave home.

> *If a pregnant mother refuses to come, they get the RCMP to knock on their door, and say that you have to go to Winnipeg. (Mother of 2, Nunavut)*

> *I wanted to stay home but the doctor said the hospital isn't equipped to deliver babies. I was threatened that if I didn't come to Winnipeg they would bring in the police to make me. (Mother of 4, Northern Manitoba)*

And another woman who felt that she was going to birth earlier than expected (and did), wanted to leave her community early but was not allowed to.

> *This one, I wanted to go earlier and they didn't, weren't gonna let me. (Mother of 3, Northern Manitoba)*

Often the power relationship described was between the woman and the health care system, but there was also one example of a struggle between a mother and her partner and other members of their family related to adopting out a child.

> *When I got pregnant I didn't want to keep baby, I have 4 [children] at home. Then I decided to keep baby. I dreamed about my dad. My dad died … then I didn't want to give baby away. So I asked my husband, and he said I had to. I told my mother-in-law about my dream about my dad. With my belief, a dream is important. My dream means that my dad wants to be with me, and have the child named after him. My mother-in-law said that it was better to adopt out the child. So I kept my thoughts to myself. (Mother of 5, Nunavut)*

Despite the fact that some women may be feeling powerless or as if the situation is beyond their control, some find ways to assert their power and to make choices for themselves. These small challenges to the system were not mentioned by many, but as will be seen below, HCPs also support that these challenges occur.

> *Ya, even if I wasn't allowed to I would. (Mother of 4, Nunavut)*

> *They tried to make me come to Winnipeg on the bus on Sunday, but I refused. (Mother of 4, Northern Manitoba)*

Health care providers' perspectives

> *Women who must travel for birth have lost all power. (HCP Winnipeg)*

Health care providers described several aspects of women's experiences traveling for birth that they felt were unnecessarily oppressive.

> *They are only given money for transportation to medical appointments, and they check to see if they attended. If not, they don't get a flight or money. (HCP Winnipeg)*

> *They are stuck here with no rights, being told they're less important than the next person and they see it as unfair. (HCP Winnipeg)*

> *Women are crying, it doesn't feel right, it reminds me of the residential schools and I imagine myself 15 years from now called before a tribunal to talk about this. (HCP Winnipeg)*

Women may also be caught between their family's demands and those of the system.

> *Some spouses don't want their wives to go out but there is no choice, they often have a problem when it comes to the pregnant women going out, not very often but it does happen. Sometimes we have to try two or three times before the wife actually boards the plane. (HCP Nunavut)*

HCPs also described situations in which women were struggling for some small or large amount of control over their lives, instances where women adamantly refused to go or tried to negotiate a later date. One HCP in Winnipeg knew of a woman who chose to return home because she was willing to sacrifice the current pregnancy for her other children.

> *Some of the women do hide in the community or out on the land so you can't find them to send them at 36 weeks. Also, there were times where some of the women convinced the doc in Winnipeg that there was a death in the family and that they needed to go back, so they did, and then you need to track them down before they deliver. (HCP Nunavut)*

> *They all tell the nurses they are doing both [breastfeeding and bottlefeeding]. What is the reason they are telling that they'll do both? To make the HCPs happy … get out of hospital quicker. (HCP Winnipeg)*

7. Perceived consequences of birthing away from home

Both women and HCPs felt that there were negative outcomes associated with birthing away from home and being away for an extended period of time. Women often described their sadness associated with leaving without their children. HCPs also described the strain this separation caused and speculated on the possible outcomes of this separation.

Women's perspectives

a. *Family separation and strain* - For most women, leaving their kids behind was the most difficult part of traveling for birth, and some women reiterated this at various points during the interview.

> *The most difficulty was having to leave my babies, they are 2 and 4 years old. (Mother of 4, Northern Manitoba)*

> *Sometimes I won't tell my children and sometimes I tell them when I'm leaving … Cause they're gonna miss me for a long time. (Mother from Nunavut, focus group)*

Health care provider perspectives

a. Family Separation and Strain – Significant family strain was noted in previous studies and was also a concern for HCPs interviewed in all regions during this needs assessment.

They worry about their kids at home, are they getting enough food, are they sick, are they going to school, all of their normal responsibilities as wives/mothers. (HCP Winnipeg)

My concern is not at the Winnipeg end, but in the community: home and child care supports are often neglected or unavailable which often has mom refusing to leave community because of her concern for child care in the home while she is in the city. (HCP Northern Manitoba)

Their babies are crying at home, it's hard for the women. (HCP Nunavut)

A few times they have had to call social services because of things going on back home. To take care of the children back home. (HCP Nunavut)

Several HCPs also felt that some women experience severe relationship strain while traveling for birth, including accusations of being unfaithful. And some worried that this separation may in fact have long-term consequences.

Worry that their man will find another woman. (HCP Northern Manitoba)

The bigger picture is family discord, suicide rates, but nobody cares because those things are somebody else's budget. (HCP Winnipeg)

b. Breastfeeding and attachment issues - Some HCPs from Winnipeg spoke about the contradictory messages that women from the North receive. While Health Regions are stressing to women that breastfeeding is critical for the health of their babies, they are required to leave breastfeeding children at home. A number of HCPs also felt that this separation impacts attachment, both with the children left at home and the infant.

This can affect their feelings about the infant, resentment, because they have to leave their family behind because of the infant. (HCP Winnipeg)

In addition, they worried that attachment between the father and the newborn may be impacted by this separation.

They get pregnant, they go down to Winnipeg and then come back and we hope, you know, that everyone bonds. It would be interesting to see what kind of studies come out of talking about bonding with parents and children where a parent was not there for the birth. There is some excitement when you are part of the birth and if you don't have that then I am sure there are some issues with attachment. (HCP Nunavut)

c. Medical outcomes - Some HCPs connected negative medical outcomes to the fact that the women were traveling for birth. For example, one HCP wondered if women were in fact motivated to birth before they reached term in order to return home more quickly, and another commented on "social inductions" – inducing women early so that they could return home.

8. Coping

So how do women cope with being away from home, separated from their families, alone, in an unfamiliar environment, sometimes dealing with complicated medical issues on top of being pregnant and trying to access care and supports in a fragmented system? As was seen above in the section addressing power and choice, some women cope by finding ways to regain some power or making choices for themselves. Women and HCPs also identified other strategies women use to cope.

Women's perspectives

Women spoke of many ways in which they cope. These included, staying strong for the baby:

> *But then my grandma would tell me it's better to try being happy even if you're being stressed out cause if you're stressed out too much, something can happen to your baby. The baby feels what you do. (Mother from Nunavut, Focus Group)*

They also spoke about the importance of family and community support, whether from near or far.

> *I talk to people in the boarding home and visiting with them makes it a little easier for me. (Mother of 4, Northern Manitoba)*

> *And he [partner] makes it easier being here. (Mother of 1, Western Manitoba)*

> *My roommates are all pregnant so we talk, and we support each other. I don't have my mom with me. (Mother of 5, Nunavut)*

> *Just to make sure you have supports and if not then I've, it would be really tough if you didn't have supports, just always try to have family around. (Mother of 4, Northern Manitoba)*

And a few talked about how their faith helped them to cope.

> *I prayed a lot. (Mother of 6, Northern Manitoba)*

> *My pastor is in the city and I see her approximately every week. (Mother of 5, Northern Manitoba)*

Most women talked about making the best of the situation, by keeping busy and enjoying some of the things that Winnipeg has to offer.

> *I shop, go to Bingo, or movies. (Mother of 3, Northern Manitoba)*

> *We just, like the first time we would just spend time ourselves like my husband and I, movies, whatever, cause we don't have that in [community], we don't have restaurant. (Mother of 3, Northern Manitoba)*

> *Go shopping, following some of my friends. I just follow them because there's nothing to do. Sometimes follow them to appointments too. Sometimes walking. (Mother of 2, Nunavut)*

Health care providers' perspectives

HCPs reiterated many of the coping strategies that the women identified, including relying on family and community support and making the best of the situation.

They connect with others from their community. (HCP Winnipeg)

They do a lot of shopping while they are here. (HCP Winnipeg)

From the perspective of women traveling to Winnipeg for birth, their families and other stakeholders, what services and supports would be helpful to address these issues?

9. What services and supports do women need?

All participants were asked what kinds of services and supports women would find most useful or helpful while in Winnipeg for birth.

Women's perspectives

a. *Women really want family support* – It is not surprising that the most common response when women were asked "what would make your stay in Winnipeg better?" was family support.

I wanted my boyfriend here with me. So [have someone] that know everything about me. (Mother of 9, Nunavut, focus group)

If my mom came with me it would help. (Mother of 5, Nunavut)

One woman felt that having someone with her would help her to care for her baby who she was adopting out.

It would be easier to have my husband or my mother here, so that I would feel better about asking someone to look after the baby. (Mother of 5, Nunavut)

Women also wanted to have their children here with them.

I would be so happy if my kids were with me. (Mother of 4, Northern Manitoba)

Nothing would make me happier than to have my kids. (Mother of 5, Nunavut)

b. *Recreational opportunities* – The second most common need that women identified was opportunities to engage in recreational activities. A room to do sewing and other crafting activities in was a common suggestion, as was a place to exercise or someone to lead exercises or to take them out walking. Some women also suggested outings like swimming, bowling, the zoo, or attending sporting events.

More activities, more walks, a sewing room, and arts and crafts room. More board games, something ladies can do together. (Mother of 2, Nunavut)

c. *Financial assistance* – Many of the women stated that it would be very helpful to receive some form of financial assistance while they were in Winnipeg.

A living allowance while you are here in the city would be nice. (Mother of 6, Northern Manitoba)

d. *Professional support and education* – In addition to having the support of their families while in Winnipeg, women also identified a need for support from formal resources such as HCPs. Women identified several topics that would be useful to learn about from a health provider including pregnancy, birth and nutrition.

Information about a food program, on how to eat properly. Like education on what to expect during pregnancy and during and after labor. (Mother of 2, Nunavut)

Some women also felt it would be helpful to have someone to help them find their way around Winnipeg in general, but also at the hospital sites, and to share some tips on traveling with baby. During the focus group, women agreed that they would benefit from having a care provider to talk to while they were in Winnipeg. One woman talked about needs that were specific to adopting a baby out including help caring for baby and emotional support.

Staff were kind and helping me, but if I am adopting out, I need nurses to look after baby, so that I don't bond with baby. (Mother of 5, Nunavut)

I need someone to help me emotionally, like a counselor or a nurse. (Mother of 5, Nunavut)

e. *Accommodations* – Finally, a few women made suggestions related to accommodations, such as having family-friendly housing, activity rooms and televisions in the rooms.

I know money's tight around, but if there was an actual place for expecting parents, not, not just, I'm not saying it would have to be Inuit based … a place specifically for that, where you can stay and have a little bit more home-like features. (Mother of 1, Nunavut)

Health care providers' perspectives

Care providers agreed that coming to Winnipeg alone to give birth was less than ideal, and most (but not all) felt that services and supports could be increased in Winnipeg for women who travel for birth.

a. *Women really want family support* – All HCPs recognized the stress of being sent away for birth without family support and many felt strongly that families should be able to travel together. HCPs also suggested that services be available to help women connect to their families back home, either through TeleHealth, or something quicker and easier like Skype.

Ideally, Dads could be sent out for deliveries, and care options for other children might be considered too. (HCP Northern Manitoba)

> *Its [providing services] not gonna solve the problem, they need to have what everybody here has, the right to have a support person, we know outcomes are better when people have support. They need to have the basic human rights that we have here. (HCP Winnipeg)*
>
> *For first time moms that are 18, 19, 20, 21 who are delivering for the first time, they are not allowed an escort but they should be allowed to have their mom go with them too for the extra support. (HCP Nunavut)*
>
> *The biggest things that would make it more accessible would be if there were family there and they could be living like a family unit until they went in to give birth. (HCP Nunavut)*

HCPs felt that if the women had a support person with them they would be more likely to access the different services available to them, and would experience less emotional and physical stress.

> *I really think that if they could take an escort this would reduce the resistance* [to travelling for birth]*. They are scared, they are bored when they get there, especially if it is the first time they are having a baby, they want to take their partner or their mother, it is completely understandable. (Nunavut HCP)*

b. *Recreational opportunities* – Some HCPs suggested that women be provided with opportunities to engage in recreational activities such as swimming, bingo, art and visiting museums or the zoo.

c. *Health education* – HCPs had many suggestions for topics to address through health education, and many suggested a group education format. Suggested topics included:
   - Breastfeeding (and feeding in general)
   - Infant care – cord care, bathing, SIDS, transporting milk, taking infant on airplane, dealing with health concerns like cold and flu, what's normal for newborns
   - What to expect at the hospital and options during labour and birth (e.g. positions, pain control)
   - Parenting education and bonding
   - Nutrition
   - Tobacco and substance use
   - Contraception

d. *Assessment and treatment of medical issues* – One HCP suggested that public health could be involved in ensuring that needed tests and assessments are done while the baby is in Winnipeg (e.g. Bilirubin screening, hearing screening)

e. *Social support from care providers* – Many HCPs felt that social supports could be increased for women while away from home for birth. One HCP felt that women may be willing to access services in Winnipeg that they do not feel comfortable accessing in their home community. HCPs made many suggestions related to supporting women while they are in Winnipeg:

   - Having a consistent Public Health Nurse (PHN) visit women from each community so that the PHNs name may become known in the community;
   - Connecting women to elders in the community or churches as appropriate;

- Connecting women to mental health supports, the Aboriginal Support Worker at HSC, social work[1], Healthy Baby/Healthy Start groups, dieticians, programs at Women's Health Clinic and other community resources;
- Nurturing the women;
- Advocacy and helping women to develop a birth plan and to feel comfortable asking questions and advocating for themselves; and
- Labour support, doulas, midwives.

f. Coordination of care - Several HCPs suggested the creation of a liaison or navigator position similar to positions that exist in other Canadian communities women travel to for birth. HCPs in Winnipeg and one HCP from the north mentioned that they receive after hours contact from women waiting to go into labour. This contact indicates that the women are in need of support while in Winnipeg and that they have come to trust the care provider enough to feel comfortable reaching out. However, women may need this support outside the regular Monday to Friday, 9-5 timeframe. Across all regions, HCPs reported that having a support person, who was of a similar background to the women and had an understanding of where the women were coming from, would be ideal for offering support and navigating services.

> *Birthing moms could access this person antenatally with any concerns, could get advocacy for accommodations etc from this person, or be guided to care when needed. (HCP Northern Manitoba)*

> *If they cannot allow women to have their own personal escort it would be helpful if they had Inuit women to act as sort of midwives or act as a proxy to help these women, around the clock. I really think that having an Inuit person's presence would really help a lot. (HCP Nunavut)*

> *Often women will call us from the city to advocate or ask questions … They are not sure who to contact if they have a problem. (HCP Northern Manitoba)*

One Nunavut HCP suggested that in addition to assisting the women in attending appointments the navigator/coordinator could also be responsible for ensuring that communication occurs between communities.

[1] Although several HCPs suggested that some women need to be connected to social work for issues such as housing, family violence and child welfare, it was also recognized that sometimes the idea of having a social worker involved in their care was upsetting to women. They felt that although social workers are seen as a viable support by HCPs, many of the women may have only had contact with them through Child and Family Services, in circumstances that may not have been positive. Therefore the women may be fearful of having social work involved. HCPs would appreciate if there was better communication with the women around social work becoming involved in their care.

10. What do HCPs need?

In addition to making suggestions about direct service needs for women traveling for birth, HCPs also had suggestions about what they needed, or ways in which the health care system should change to better provide care for women traveling for birth.

a. *Knowledge of available resources* –Some HCPs reflected that they were personally not aware of services for women traveling for birth outside of the community they worked in, and others felt that HCPs in Winnipeg were not aware of available resources in home communities. HCPs suggested information sessions or a pamphlet to describe available resources.

b. *Communication* – HCPs in all Regions indicated a need for a formalized and coordinated process to ensure information is communicated effectively and to ensure that all individuals involved in a woman's care receive the information they need in a timely manner.

c. *Support* - One HCP stressed that many nurses working in the north need guidance because they are not trained in maternity.

> *A lot of us are not midwives … so it would be nice to have someone to talk to in Winnipeg so someone can advise on what is needed, do I need to do extra tests for you. In other health systems they have an on call midwife who you can call if you have trouble. (Nunavut HCP)*

Discussion & Recommendations

The findings of this needs assessment highlight the complexity of the needs and challenges that women who travel for birth and their families must cope with during the final weeks of pregnancy, birth, and the first days of their infant's life. Addressing these needs is not something that can be done in a silo, by one profession, or even by one organization. These families have a cascade of needs, from the overarching need for family and community support to the more routine, everyday needs of getting to the store to buy diapers. It is important to understand all of these needs in order to provide the most appropriate services and supports to women traveling for birth.

In some ways, the process of traveling for birth from rural and remote communities has become normalized, it has become accepted and unquestioned by many. There is a sense that women have little choice about not only their place of birth but also other aspects of their life as it relates to the birth of their baby. Although it has been normalized, women and HCPs highlight instances of resistance to traveling for birth and ways in which women try to have their needs met within the existing system. The biggest need identified by women and HCPs is to have the support of their partner, mother, or someone else who *knows* them during labour and birth. Participants identified that family support is critical for both coping with the situation and for celebrating the birth. The existing literature and this needs assessment illustrate that women experience a wide range of emotions when traveling for birth. Although a number of women described feeling excitement, the most commonly used descriptions of their feelings were scared and alone.

In addition to being pregnant and away from home, many women were also coping with complex medical needs or personal situations such as family violence, substance use or loss. Women worry about their families that they have left behind. HCPs described family strain, and worry about attachment issues and breastfeeding. Women described being homesick while away, and HCPs described how some women and HCPs struggle with language and cultural misunderstandings, although this point was not raised by any of the women. This is a situation where communication between providers, and most importantly with the woman, is critical. Important information does not seem to always get to the right place at the right time. Both women and HCPs identified areas where communication and coordination of care could be improved.

Women described ways in which they cope with all of these challenges. Most importantly perhaps, by relying on their family's support, but also by keeping busy and in some ways reclaiming power and control over decisions about their care. However, most participants felt that supports needed to be augmented both in Winnipeg and the home communities. They made recommendations related to health education, recreational opportunities, and improving the continuity and quality of care. Many HCPs felt that it would be useful to have a 'navigator' of some sort, who could provide social support to women while here, provide labour support and assist with coordination of care, including linking women to needed services and supports and communication between providers. Ideally, this person would speak the woman's language and be familiar with the culture.

It is important to consider that women who travel for birth are by no means a homogeneous group. The women interviewed came from a range of cultures and traditions, socioeconomic levels and experiences. In addition, women were generally apprehensive about sharing their experiences and recruitment was a significant challenge. This needs assessment will perhaps inform the development of an ongoing relationship with women and communities that should be fostered to gain increased understanding of the factors at play when women are required to travel for birth. Although the message is often that we need to ask the client to gain this understanding, it is also important that we consider the broader context in which the individual and family lives, and seek to gain knowledge from the communities in which the women and families reside.

Recommendations:

In December 2013, the Prenatal Connections Steering Committee developed recommendations based on the needs assessment draft report. Recommendations fit into 5 categories: The referral process and communication between providers; Service provision; Expansion of services; Evaluation and research; and Advocacy. Using SurveyMonkey, the ***committee members*** assigned priority ratings ("Not a priority at all" (0), "Low priority" (1), "Medium priority" (2) or "High priority" (3)) to each of the 33 recommendations. Nine committee members participated in this activity. The findings from the survey are presented here. Recommendations with a mean score between 2.5 and 3.0 were rated "High priority", those between 2.0 and 2.49 were rated "Medium priority" and those below 1.99 were rated "Low priority". When considering this list of prioritized recommendations, it is important to keep in mind that it was members of the Prenatal Connections Steering Committee, and not women and families or other care providers, who participated in creating and rating the recommendations.

Referral process and communication between providers

High priority

1. Develop strategies to make the referral process a standard part of practice in communities where women travel to Winnipeg for birth in order to ensure that referrals are received for all women (Mean (M)=2.89).
2. Develop clear, streamlined communication processes between providers (M=2.89).
3. Provide opportunities for HCPs in Winnipeg and northern communities to get to know each other and become familiar with the resources available to women both in the home community and in Winnipeg (M=2.56).
4. Develop a system to share Prenatal Connections information with the hospitals (M=2.56).

Medium priority

5. Develop a process to allow Prenatal Connections public health nurses to view the Nunavut prenatal record prior to women arriving in Winnipeg in order to enable them to plan appropriately for the woman's arrival (M=2.44).
6. Strengthen ties between primary care clinics and the Prenatal Connections service (M=2.11).
7. Consideration should be given to the development of a primary care navigator position (M=2.00).

Service provision

High priority

8. All staff should have training to develop skills at empowering women to have a say in their health care and to make informed choices for themselves (e.g. inclusion/exclusion models of practice) (M=2.78).
9. To aid in establishing trust and rapport, Prenatal Connections public health nurses should connect with women traveling for birth prior to their arrival in Winnipeg via email, postcard, e-card (M=2.67).
10. Consideration should be given to providing increased support to the women through a midwife, doula, cultural or peer support in order to decrease isolation and bridge the gap between women and health care providers (M=2.67).

Medium priority

11. Monitor the women for adverse health conditions and provide education about pregnancy, birth, parenting and general health (M=2.33).
12. Develop partnerships and identify community resources to provide recreational opportunities for women and support their participation in these activities (e.g. transportation and volunteers to accompany them) (M=2.11).
13. Increase the use of interpreters, or make interpreters a standard part of practice (M=2.00).

Low priority

14. Explore Healthy Baby funding for a group including a dietician (M=1.78).
15. Provide Prenatal Connections support 7 days a week and extended hours (M=1.78).
16. Have smoking cessation counselors available (M=1.44).

Expansion of services

High priority

1. Expand the Prenatal Connections program so that services can be provided to all women who travel to Winnipeg for birth (M=2.78). However, it is recognized that expansion to all women traveling for birth would require increased funding and this should await the findings of the evaluation.
2. Develop a community consultation process to be used when adding new communities to the Prenatal Connections Program (M=2.56).

Evaluation and research

High priority

3. Identify strategies to engage women traveling for birth in the qualitative part of the evaluation (M=2.56).

Medium priority

4. Further research is needed to understand the short and long-term consequences of traveling for birth at an individual (parent, child, infant), family and community level (M=2.22).

Advocacy

The advocacy category captures many of the recommendations that are not necessarily within the scope of the Prenatal Connections Steering Committee, but for which the committee could perhaps play an advocacy role within the larger health and social services system.

High priority

5. Advocate for women to be able to bring a breastfeeding child with them (M=2.78).
6. Advocate for and collaborate with FNIHB to develop policy that promotes attachment and integration of the newborn into the family unit (M=2.67).
7. Advocate for more women to be able to bring a support person with them (M=2.56).

Medium priority

1. Advocate for the development of ways for women to stay connected with their families – social media, free phone calls and computer access, telehealth to participate in birth (M=2.44).
2. Advocate for family-friendly accommodations (M=2.44).
3. Develop a better understanding of FNIHB policy regarding medical escorts in order to understand why the policy seems inconsistent (M=2.33).
4. Improve the cultural safety and awareness of all health care providers who interact with women traveling for birth (e.g. understanding of custom adoption) (M=2.33)
5. Develop the role of the Prenatal Connections Steering Committee related to advocacy around the policies and guidelines that affect women traveling for birth (M=2.33).
6. Health care providers in rural and remote communities may benefit from someone to liaise with and to support them in caring for maternity clients (M=2.22).
7. Advocate for access to emergency funds for women dealing with financial strain (M=2.00)

Low priority

8. Provide a transportation allowance while in Winnipeg or support other transportation options (M=1.89).
9. Provide additional supports for childcare (M=1.56).

Conclusion

The findings of this study are similar in many ways to the literature about women traveling for birth in Canada and Australia. This action research study will be used to inform the continued development of the Prenatal Connections service for women traveling for birth, and an evaluation will follow to assist in understanding how well the program meets the needs of women and families who travel for birth. In addition to providing direction for the local service, this action research has also raised broader questions about the practice of women traveling for birth that should be investigated further. These include questions about the short and long-term impact of traveling for birth on outcomes such as attachment, breastfeeding, family strain and separation and women's empowerment.

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