

Dene, métis and Inuvialuit peoples' voices on the impact of Canada's perinatal transport and non-medical escort policy in their communities: an outcome assessment approach and narrative literature review

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ABSTRACT

Historically, there is a documented lack of support for women leaving their communities to give birth. Due to an over-emphasis on risk discourse (no distinction between low- or high-risk pregnancies with options to birth at home, the large geographical distances to regional centres within circumpolar regions, remoteness of communities, lack of qualified staff, and limited resources), women are forced to travel great distances to give birth. In Canada until 2017, women travelled alone or bore the burden of paying out of pocket for someone to travel with them for support with the births of their babies. A recent policy change has allowed for one paid escort to accompany a pregnant woman. The purpose of this paper is to provide an outcome assessment of the perinatal transport and non-medical escort policy implemented by the federal government in Canada. The paper utilises a narrative literature review along with preliminary Indigenous photovoice results to illuminate the perspectives of Indigenous families. There are numerous challenges women face when travelling for birth including feelings of loneliness and fear, stress and separation from their children, lack of community connection, financial concerns, and a loss of self-determination. Women are given an opportunity in decision-making about who will travel with them as an escort. This does little to address the disparity of delivering their babies away from their families and communities, the burden of figuring out who cares for the children at home, and the impact their absences have on health of their families. Although, additional support has been provided for birthing women in northern Canada, there continues to be little effort to return to community birthing creating safety for Indigenous families through traditional practices, Indigenous midwifery, and community ceremonies and changing the disproportionate burden of poor outcomes experienced by Indigenous women.

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Introduction

For many years, perinatal travel has been an oppressive and isolating process for Dene, Métis and Inuvialuit women in the Northwest Territories, Canada. For all these decades, pregnant women travelled alone and without support (away from their home and families and the joy of celebrating traditional birthing practices with family and friends) to wait in a boarding home until the onset of labour (often up to four weeks) and then give birth in an institutional setting with healthcare providers who are strangers. The term "women" is used throughout this article to refer to individuals receiving maternity care however it is important to recognise that individuals of all gender identities (cisgender, transgender, non-binary, etc.) receive maternal care and we wish to acknowledge an intent of inclusiveness throughout this paper [1].

The Canadian federal government created an escort policy to address the issue of no personal support and the territorial governments are implementing this policy. There is little known about the decision-making by Indigenous pregnant women, about how and whom they choose to escort them, how the escort policy works for them, and the nature of their birthing experience in the Northwest Territories (NWT). There is a gap in stakeholder voices within the policy and it is well-documented that women often feel lonely and fearful when forced to travel for birth among the many other impacts and concerns with maternal evacuation. Thus, we realised the necessity to perform an outcome assessment of the transport and escort policies for birth with a narrative literature review¹ providing background information on the impacts of travelling for birth in preparation for future evaluation of the escort policy.

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¹A narrative literature review is defined as a review of the literature that describes the state of the science around a particular topic. Some researchers have defined the narrative review using a systematic review process design and we have adapted this method [46]. We have combined the two methods of outcome assessment with narrative literature review to create a more robust attempt at evaluating perinatal transport and the non-medical escort policy.

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Background and history of the transport and escort policies

The Northwest Territories is one of Canada's three northern territories situated with Nunavut to the east and Yukon to the west. The current population is approximately 41, 070 residents scattered across a large geographical area in 33 communities [2]. Many of the residents (approximately 20, 340) live in Yellowknife, the capital of the territory [2]. Birth rates have been slowly declining in the NWT with the most recent account of births in 2020 being 555 [3].

Travelling a great distance to give birth is not a reality faced by the majority of women in Canada with only approximately 2.5% of women having to travel greater than 100 km to give birth [4]. However, this is a challenge that is faced by a significantly larger portion of the population in the Northwest Territories at nearly 40.3% of women needing to travel greater than 100 km to give birth with the total distance often much longer than this [4]. This is due to the large size of the territory and the lack of maternity care services in each community, in 2017 of the 33 communities in the NWT only 4 provided maternity care (Yellowknife, Inuvik, Hay River and Fort Smith) [4,5]. Beginning in the 1980's in the Northwest Territories (NWT), a policy shift occurred which moved birthing from rural and remote communities to regional centres through the establishment of a maternal evacuation policy where women were transported to a larger centre to give birth. This policy change has remained in place since then [6].

Funding for Travel

Maternal evacuation is the term applied when women are transported to a regional or southern hospital to receive obstetrical care [7]. The eligibility for maternal evacuation is regulated by the Medical Travel Policy for a particular region; however, the eligibility for escorts to travel alongside a pregnant woman is regulated by a separate non-medical escort policy. Both policies are regulated at a provincial/territorial level.

Most of the women who must travel to give birth in the NWT originate from small, isolated, Indigenous communities. Many of these individuals have health-care costs covered by the Federal Non-Insured Health Benefits (NIHB) Programme which provides eligible First Nations and Inuit individuals with coverage for a range of health benefits including health travel [8]. Prior to 2017, the NIHB programme did not provide funding for travel, lodging and food for a non-medical escort to travel with a pregnant individual who was travelling to give birth. This forced women to travel to a distant

often unfamiliar location alone with no support system or face the financial burden of paying out of pocket to bring an escort with them. This policy does not address the plight of children within the family. In April of 2017, the NIHB altered eligibility to allow all pregnant women who must travel to give birth the option to bring one fully funded non-medical escort with them [9].

It is important to distinguish between a medical and non-medical escort since both roles are accessed within medical evacuation policies. A medical escort is a health-care professional who must travel with a patient because monitoring or stabilisation of the patient during travel may be necessary. A non-medical escort is a person of the patients' choosing who accompanies them through travel to provide support and assistance. In this paper, we will focus strictly on non-medical escorts.

Because a large portion of women travelling to give birth in the NWT are covered by the NIHB programme, following the 2017 changes to this programme's framework the Government of the Northwest Territories (GNWT) altered its non-medical escort policy to provide funding for an escort for all women who must travel to give birth [10,11]. This change in policy eligibility also occurred in Nunavut at the same time, however, individuals not covered by the NIHB programme were not provided with a covered non-medical escort until 2019 [12]. The Yukon government will also currently cover expenses for up to 15 days for one escort for all women travelling to give birth however, it is unclear if this practice was in place before or after the NIHB altered their programme guidelines [13]. Personal communication has revealed a similar policy present in Alaska which regulates perinatal transport in the state will only fund an escort depending on the pregnant women's age or the severity of her condition if not, the burden of paying for an escort is entirely out of pocket.

"Inclusive voice assessment" approach

Despite the escort policy change in Canada, the effects of this policy have not been explored with pregnant women and their escorts. This represents a lack of primary stakeholder voices when it comes to the policies that regulate their experiences. One pertinent quote related to this comes from a blog series aimed at improving Alaska Native women's health, "Without prioritizing women's health, well-being and safety, the resources and interventions intended to serve Alaskan communities will miss the mark" [14]. Without understanding the impact of escort policy on the individuals regulated by it, we are worried about the well-being of

women who travel for birth, and it is unclear whether the escort policy has achieved the desired effect of reducing the burden associated with lack of support when women travel for birth. Including the voices of Indigenous people will ensure that we understand their birthing experiences from the point of view of the woman giving birth and from the perspective of her escort. In that way, the challenges faced by women and their families travelling for birth are authentically heard and acted upon to enhance safety and health within their birthing experiences. Although this paper focuses on the impacts of evacuation for birth in Canada, it is important to note that cultural dynamics and a historical oppressive background are consistent with the experience in many other locations across the globe including Alaska, Australia and beyond. With the brunt of the burden of being evacuated for birth placed on Indigenous individuals in these locations.

Methods

Research design

An outcome assessment design was utilised to evaluate the escort policy both from what is known in the literature and preliminary results from a photovoice with Indigenous women who travel for birth and their escorts who accompany them. Through these processes, we begin to capture the missing voice in the development and implementation of policies aimed at providing safe perinatal care for Indigenous communities of Northern Canada.

Photovoice

Photovoice is a community-based participatory approach whereby participants share their lived experiences through both photographs and narratives and then take action to reach policymakers [15–18]. Catalini and Minkler (2009) note that photovoice is a community engagement tool that creates action and advocacy to affect policy; while at the same time, the process of photovoice contributes to community empowerment by mobilising an understanding of community assets and needs [15]. In essence, the participants in the photovoice process become the researcher themselves, through a guided and facilitated process. They are actively involved in analysis through a group meeting where they share their photographs, name them, and add a meaningful narrative to explain both the visual and verbal data they contributed. As well as taking an active part in the knowledge productions, they decide on strategies for knowledge mobilisation.

Research questions

What is the meaning of the escort policy to pregnant women and their escorts? And what is the impact of the escort policy on their overall birthing experience?

Ethical approval

Ethical approval has been received from Aurora College and a research licence from Aurora Research Institute to complete this project entitled “Understanding A Woman’s Journey to give Birth: A Community Engagement Photovoice Project” licence number 16839 and protocol number 20210302.

Data collection

This assessment of the literature was performed using the UBC summon search tool, which catalogues several databases (including OVID and MEDLINE) as well as UBC’s collections. The following search terms were used including “travel for birth” “medical travel for birth” “maternal evacuation” “labor support” “birth support” “informal birth support” “mothering in labor and delivery” “Indigenous birthing practices” etc. The term “Canada” was added to find additional articles relevant to the Canadian birthing experience. To fill gaps in the literature, searches were also performed in the Journal of Obstetrics and Gynaecology Canada and the Canadian Medical Association Journal for “labor support”, “birth support” and “escorts for birth”. An attempt to find articles relevant to the birth escorts experiences with maternal evacuation were unsuccessful search terms including “non-medical escorts for birth” “medical travel for birth escorts” and “maternal evacuation escorts” did not yield any pertinent results. Articles from the 1990’s and later were considered, with a focus on articles written after 2010. Articles from international journals were included in this literature including those from Australia, Greenland, and Alaska as the realities of birthing in these locations are similar to those in the NWT.

The evolving photovoice started during the pandemic so data was collected at this time over the telephone using semi-structured interviews. The interview data was recorded and stored on a word-protected laptop along with photographs submitted by the women and their escorts. In 2022, interviews have been face-to-face often in the home of the participants but sometimes over the telephone by mutual agreement between the research assistant and the participants. The group meeting has not yet occurred.

Theoretical literature review

The need to travel to give birth comes with its own set of unique challenges that are not experienced by the general population. These include feelings of loneliness, disconnection with the community, lack of support, financial strain and many more. One struggle that is frequently explored in the literature is the lack of support women experience when forced to travel and birth alone without the presence of a partner or family member.

Challenges for women travelling for birth

As previously mentioned, 40.3% of women who give birth in the NWT travel more than 100 km to do so, the total distance travelled is often much longer considering the territory spans approximately 1,171,918 sqkm [4,19]. Transfer to another location prior to birth happens anywhere from 36–38 weeks of pregnancy. However, birth could happen anytime up to week 41–42 [9]. This often results in a woman being outside her home community for 3–6 weeks barring any complications with the pregnancy/birth which could warrant a longer stay in hospital [20] This is a significant amount of time to be away from family, friends, and their communities. Prior to 2017 in Canada, when the NIHB programme did not provide funding for an escort to travel with a pregnant woman who was travelling to give birth, the majority of women travelled and birthed alone without a support person to help them [9]. This lengthy time alone led to women feeling lonely and scared. Birthing in this manner, often caused women to want to return home as soon as possible including prior to the birth or immediately post-partum when it may not be comfortable to travel [21,22]. Women expressed longing for a partner to be allowed to support them while travelling for birth and even offered it as a suggestion for how to improve the Medical Travel Policy for pregnant women [23,24].

Loneliness and fear

This phenomenon of loneliness and fear with travel for birth is not unique to the Northwest Territories or even Canada with studies in Greenland and Australia demonstrating the same findings when mothers who travelled to give birth were surveyed about their birthing experiences [20,24,25]. One study conducted in Alaska found that when interviewed about maternal evacuation pregnant women highlighted that they did not have any opportunity to have discussions around the impacts of maternal evacuation [26]. Despite the desire

expressed by women to have an escort with them when travelling for birth, no research has been published since the 2017 policy change to allow it. Because of this, it is unclear what the effect of this policy change has been on the birthing experience of women and if the policy change helped reduce the emotional and physical hardships women experience while travelling for birth.

Stress and separation from children

Another one of the most highlighted concerns for women leaving their home communities to give birth was stress and fear around leaving their family members behind at home, especially young children [20,21,23,26–28]. One study, that looked at the experience of 12 women from remote British Columbia, found that those who were able to travel with their other children expressed less stress both in the mother and the children, than those who were separated [22]. Studies have also shown that being separated from other children while giving birth can be detrimental to the family connection and to the older child's well-being [7,29]. One study asked women what improvements could be made to the maternal evacuation policy and the women highlighted that better apartment style accommodations to allow family members to travel with them could be beneficial, this change could serve to reduce stress of the mothers and could promote greater family connection with other children [7,22,23]. Some suggested efforts to help mitigate the feelings of loneliness and fear at leaving behind family members included tele-visitation with them [27]. This option was met with mixed feelings from prospective mothers as some felt it was uncomfortable having family members on the TV and some felt their children would not want to participate fully in the visits due to shyness [27]. These hesitations may have diminished since the start of the Covid-19 pandemic due to increased usage of computer-based visitation, telehealth appointments, and online education.

Lack of community connection

Another challenge faced by women leaving their community for birth included a lack of connection to their community. The study previously mentioned above that surveyed remote British Columbian women about their maternal evacuation experience found that there was a loss of celebration in the birth experience when giving birth away from home compared to birthing in the community [22]. This can prevent a bonding experience and an opportunity to share knowledge between

the mother, her child and the community and can also remove a typically happy and joyful experience from the community [30]. A recent article out of Alaska found that Indigenous maternal evacuation results in a loss of ceremonies, cultural practices and a loss of knowledge translation which are imperative in a culturally safe birth [31]. Alternatively, one paper that interviewed Indigenous women in British Columbia about their birth experience found that women see support by friends and family members as one of the main benefits when allowed to birth in the community [32]. By extension, through having community involvement in their birth it returned a celebration to the community and allowed specific ceremonies to take place including potlaches (ceremonial feasts) [32]. Some women have also expressed difficulty in reintegration into their community upon their return [29]. However, this result was not replicated in another study which found no difficulty in reintegration into the community upon return from birthing away [27]. After speaking with researchers, we found one study out of Alaska that showed that a women's choice in birthing practices was tied to the open expression of traditional or western values in her community. With open expression of Inupiat values in a community alternative birthing practices were more strongly pursued which included giving birth within the community, this is in comparison to communities with open expression of western values in which women accepted the maternal evacuation policy and travelled to a larger centre to give birth. This paper explored how it is not simply women's ideas and perceptions that lead to a decision about her birth, but it is the expression of values in her community that contribute to this decision.

Financial burden of birthing away from home

One of the most apparent challenges faced by women who are evacuated for birth is the financial burden it brings. There are numerous financial concerns that occur when a woman must leave her community. These include paying for childcare for any children who remain at home, lost time hunting and providing food for the family, and lost wages due to the mother and possibly her escort being out of the community for an extended period [26,28–30]. Prior to the 2017 policy change, if a woman wanted an escort to support her, the financial burden of the escorts transportation, housing and food was entirely the responsibility of the family [9,29,30]. This occasionally caused women to choose more affordable means of travel such as busing, using ferries and staying in cheaper accommodations to offset the added costs of paying for an escort

[22]. This could increase travel time and create a more uncomfortable experience for the women and their escorts [22]. The additional cost of supporting an escort can add financial difficulty to an already emotionally and physically demanding situation, despite these challenges women still feel it is important to have a support person at the birth and it has been shown to be beneficial for the partner and the child, this topic will be explored in more detail later [30].

Loss of self-determination and choice

One of the most concerning challenges faced by women who leave their communities to give birth, is threats to their self-determination and a lack of choice in their care. One study that interviewed women and community members in Manitoba regarding the maternal evacuation policy found that women felt they did not have a choice when it came to their birthing experience, including the location they give birth in, at what time they were evacuated from their community and even choices in their maternity care (e.g. to breastfeed or not) [30]. Women felt they were not included or consulted by healthcare staff or given adequate information to make these important decision [30]. These results were replicated in a study conducted in Alaska which interviewed pregnant women about their experiences with maternal evacuation and found that women felt powerless over their birth experience [26]. Women felt as if the only option available to them was evacuation as they were repeatedly told community births were too risky, which created a sense of fear around the birthing process [26]. Alternatively, some Indigenous women asked questions about their situation to empower themselves and to allow them to be involved in making informed choices about their care [30]. Another study that interviewed Inuit individuals found that pregnant women felt there was a lack of choice in the location of delivery, the method of delivery, and the support they received during their labour and delivery [29]. Specifically, when comparing evacuated women to those who were able to birth in their home communities the evacuees felt they had less choice in their care [29]. It is extremely concerning that women who are evacuated for birth in Canada, the majority of whom are Indigenous, are suffering from a lack of choice in their care. This experience is consistent with the numerous experiences of Indigenous people facing systemic racism and discrimination when accessing healthcare services in Canada [33,34]. Some women developed strategies in order to exert control over their labours and births such as undergoing elective interventions (e.g. inductions,

elective c-sections), seasonal timing of conception, delaying presentation at the hospital to avoid transfer and finally having an unassisted homebirth [6,26,28]. All of these can be seen as methods used by women to exert control and resistance in a situation in which they may not feel like an active and informed participant in their care [6,28].

Birthing supports

Given the research previously described, it is clear that women who are prevented from having a partner/support person at their birth expressed increased loneliness and fear during their time away from home. However, little formal research has shown how this may affect the mother and her missing partner during the birth itself. It is also not clear how the choice of an escort/birth support person is made and what factors are considered when choosing a support person. In the following section, support people in the birthing experience are examined from two angles, first the effects of the support person on the labouring mother and second, the effects of the birth on the support person.

One study conducted in China that compared the birthing experience of women who received continuous support from a family member (mother, sister, partner) or midwife to that of women who received only regular maternity care found that those with continuous labour support had a significantly shorter labour/delivery and had a significantly reduced likelihood of requiring an emergency caesarean [35]. This paper demonstrated that there are medical benefits for the mother when they are allowed access to a support person of their choice for the entirety of their labour and delivery. This presence of support persons is in accordance with the 2017 NIH policy change to provide funding for one support person for all pregnant women who are evacuated for birth. Studies have also shown that in Canada the presence of the father at the labour and birth was preferred by women, however, elsewhere in the world women may prefer a female support person due to their insight and increased understanding of the situation [36,37]. This study also examined the type of support women prefer during childbirth and found that women prefer a continuous physical presence and emotional support from their support person, they also found certain physical supports such as massaging and holding hands were helpful [37]. A study that interviewed Indigenous pregnant women from a remote community on the Ngaanyatjarra Lands of Western Australia found that women needing to travel for birth prefer when an escort can accompany them, not for support during labour but for support during the antenatal and postnatal period and to pass on traditional knowledge [38]. This paper also noted

that the preferred support person in this situation was a female family member; however, this contrasts with urban Indigenous women in Central Australia who often preferred their male partners support [38]. Another study determined that it is imperative that pregnant women should discuss their expectations of their partners involvement in the birth so the partners are aware of what they should be doing [39]. This same paper found that the age, duration of marriage and number of births had no impact on the preferences for the type of participation of the partner in the labour and delivery [39].

Studies on the impact of the birth experience on the partner found that many partners desire to be at the birth not only because of their partners expectations but also because they feel engaged, involved and supportive both physically and emotionally [40,41]. Studies have shown that having partners at the birth can improve their attachment to their child, this was also highlighted by Chief Merrick of the Pimicikamak Cree Nation who said that it is important for the father to be at the birth to have “one-on-one time” with their newborn [30,40]. It has also been shown that a father’s presence at childbirth may be beneficial for the newborn who can hear both parental voices and can begin to bond with both parents [40]. One additional paper found that access to antenatal and birthing services in the community they live in caused increased involvement of fathers with their babies from the beginning of the pregnancy [29]. There have also been negative consequences that have been elucidated when fathers are present in the birthing room including feelings of vulnerability, a lack of attention and feelings of helplessness at observing their partners in pain, numerous papers also suggested possible negative impacts on the women’s birthing experience as well due to differing expectations at what a partner’s involvement in the birth should be [40–42]. One paper highlighted the importance of support for the father for them to feel involved in the experience, this could be achieved by communicating with their partner, being allowed to ask questions and being able to interact with healthcare staff [42]. Given these possible negative and positive experiences this paper suggested that the choice for the father to be in the birthing room or not should be made by the two partners together after considering their beliefs and expectations [40].

Current efforts by indigenous groups to maintain autonomy

There have been numerous groups created in the past few years across Canada/Alaska and in other circumpolar regions that aim to train Indigenous individuals in

midwifery and doula care in the hopes of returning birthing to the community. This paper interviewed doulas from five Indigenous Doula collectives across Canada (British Columbia, Manitoba, Ontario, Quebec, and Nova Scotia) to understand the challenges and innovations they faced when providing Indigenous centred doula care [43]. As previously mentioned above, continuous support during labour has shown to lead to better outcomes overall, these results are also observed with doula presences at a birth as well. Doulas help women cope with the pain of labour and reduce their anxiety which can both shorten labour length and reduce interventions [43]. The main conflicts doulas faced in trying to provide Indigenous centred labour support included conflict with the western biomedical approach, challenges with infant and child apprehension, difficulty in accessing Indigenous specific doula training and spaces to problem solve with other Indigenous doulas as well as access to adequate compensation [43]. Not only are women faced by challenges when travelling for birth but Indigenous individuals attempting to provide doula care are also facing barriers.

Analysis and discussion

As has been outlined above, there are numerous challenges faced by women who are evacuated for birth. Many of these challenges were exacerbated by the previous non-medical escort policies which did not provide funding for an escort to accompany pregnant women who must travel to give birth. These challenges include a lack of support in their birthing experience, loneliness and fear, stress and separation from children and a lack of community connection. There are additional challenges that arise with maternal evacuation including the financial burden of birthing away from home and the loss of self-determination and choice which is especially concerning and may reflect ongoing systemic racism towards Indigenous people in the healthcare system [33,34].

In addition, Rich et al. conducted a scoping review to identify quality indicators for circumpolar maternal care systems and explicated these indicators under domains of determinants of health, effectiveness, responsiveness, expenditure, health outcomes, safety, and accessibility [44]. As noted by these authors, there is an obvious gap in priorities and indicators of Indigenous values, priorities and conceptualisation of wellbeing and good health within the maternal health care system. On top of that and through exclusion of Indigenous participants in health outcomes and

changes within the system, an ongoing colonial lens is applied to what constitutes good health.

We agree and see that a community-based method with northern women and their escorts is one way to capture their experiences and recommendations. Although interviews for our photovoice project are ongoing, preliminary data show that the escort policy does not address the core issue of birthing away from home and family. This oppressive and essentialist policy continues to be applied to all women outside of the four communities that offer birthing services. The escort policy offers a means of providing support to alleviate the loneliness and isolation that women face. Indigenous women, basically making the most of a bad situation, are formulating their decisions for choices of escorts on their unique situations, socio-economic circumstances, and social supports. During the life of this study and following a closure of the maternal child unit at the regional hospital in Yellowknife, approximately 86 women were evacuated from communities that normally access the regional hospital in Yellowknife [45]. This pitted women against women as is often the case in oppressive situations. Some of the pregnant women who were scheduled to deliver in Yellowknife but had to go south when the service was disrupted, were labelled in the social media as “privileged” by community women who have had to bear the burden of travelling for birth for decades with little to no action to change the policy and now women experiencing the policy for the first time were outraged. Although this is preliminary, participants in the photovoice are from both cohorts; those who have been mandated for decades to travel for birth and those who travelled for birth during the recent four-month disruption of service. In a later paper, we will provide a more fulsome description of the results, but a preliminary analysis suggests that during the disruption non-Indigenous women participating in this study chose their partners as escorts to southern Canada to give birth, while Indigenous women participating chose a diverse group of escorts, such as friends, fathers, mothers and sometimes partners. Although we know this anecdotally from maternal service providers, we first heard about this when recruiting participants into the study from the boarding home, an Indigenous mother of a pregnant woman at the boarding home shared that she was accompanying her daughter as an escort. We also know of a case where an Indigenous father of a pregnant woman accompanied his daughter and stayed with her and her child while she awaited birth and then stayed with the child during birth.

Although both Non-Indigenous and Indigenous women who travel for birth experience many of the

same hardships, the decision of escort does appear to differ. Childcare weighs in heavily as an influencing factor on pregnant women's travel while making arrangements for care, support and safety of their children. There is no process within the escort policy that supports travel for the children. If women bring their children with them, they must finance this and find the supports they need when they go into labour in a community away from home. This can be very difficult if there is no family support in the community where birthing will occur or if you are not familiar with the availability of local resources in your place for birth. There is a constant push/pull on decision-making which meant that in one case the partner still could not be present for birth because he had to be with his toddler when his partner went into labour. The birthing process for women who must travel is fraught with separation from their loved ones.

Research has shown that continuous support during labour not only improves the labour experience but can also promote bonding and involvement in a child's life from early on. This highlights the need for an escort policy that allows for a support person to be present during the labour and delivery to provide continuous support for the birthing mother. Research has also shown that attending the birthing experience can be an important experience for a partner and can be beneficial for the newborn child as well. Although negative outcomes are possible when a support person attends the birth, if both parties discuss their expectations ahead of time the experience is likely to be a positive one for everyone.

Conclusion

Despite the many challenges women face when being forced to travel for birth it is still the most widely used policy when it comes to birthing in remote, isolated communities. Although a recent policy change has been made to provide funding for an escort for all women in the NWT who need to travel for birth, it is unclear what this policy change has achieved. As previously outlined, there is value of having a support person at the birth, however no research has been completed to assess the exact impact of the recent policy change on a women's birthing experience. Our photovoice study is contributing to closing the knowledge gaps about families travelling for birth in the Northwest Territories. By using an inclusive voice assessment our project will ensure the individuals most impacted by these policies have their perspectives prioritised, amplified, and acted upon.

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References

- [1] Dahlen S. Do we need the word 'woman' in healthcare? *Postgrad Med J.* 2021;97(1150):483–484.
- [2] Statistics Canada. Census profile. 2021 census of population. Ottawa, ON: Statistics Canada; 2022.
- [3] Government of the Northwest Territories- NWT Bureau of Statistics. NWT vital statistics crude birth rate. Government of the Northwest territories - NWT bureau of statistics (Inuvik, NT: Government of the Northwest Territories). 2021.
- [4] Public Health Agency of Canada. What mothers say: the Canadian maternity experiences survey. Ottawa, ON: Public Health Agency of Canada; 2009.
- [5] DRPA. NWT midwifery stakeholder engagement report. Yellowknife (NWT): Government of the Northwest Territories Health and Social Services; 2017.
- [6] Moffitt PM, Vollman AR. At what cost to health? Tliche women's medical travel for childbirth. *Contemp Nurse.* 2006;22(2):228–239.
- [7] Silver H, Sarmiento I, Pimentel JP, et al. Childbirth evacuation among rural and remote indigenous communities in Canada: a scoping review. *Women Birth.* 2021;35(1):11–22.
- [8] Government of Canada. Non-Insured Health Benefits (NIHB) medical transportation policy framework (interim). Ottawa, ON: Government of Canada. 2019.
- [9] Lawford KM, Bourgeault IL, Giles AR. "This policy sucks and it's stupid:" mapping maternity care for first nations women on reserves in Manitoba, Canada. *Health Care Women Int.* 2019;40(12):1302–1335.
- [10] Digness C. Changes to non-insured health benefits. *GNWT Newsroom;* 2017.
- [11] Territories N. Government of the northwest territories-department of health and social services. *Med Travel Escort Criteria.* 2019.
- [12] Rogers S. Nunavut expands its medical travel benefits for parents. *Nunatsiaq News;* 2019.
- [13] Government of the Yukon. Insured health & hearing services medical travel escorts policy. Whitehorse, YT: Government of the Yukon. 2020.
- [14] 'Ramanarayanan D, Stith M, Maddox M, et al. Interdisciplinary solutions will improve alaska native

- maternal health (part 2 of 2). *NewSecurityBeat* 2020 [updated 2022 Oct 7]. Available from: <https://www.newsecuritybeat.org/2020/11/interdisciplinary-solutions-improve-alaska-native-maternal-health-part-2-2/>
- [15] Catalani C, Minkler M. Photovoice: a review of the literature in health and public health. *Health Educ Behav*. 2010;37(3):424–451.
- [16] Moffitt P, Vollman AR. Photovoice: picturing the health of aboriginal women in a remote northern community. *Can J Nurs Res*. 2004;36:189–201.
- [17] Moffitt P. Telling it like it is 'anyays': capturing Tlich pregnancy experiences through photovoice. *Pimisiwin*. 2012;10:207–216.
- [18] Wang C, Mary Ann Burris MA. Empowerment through photo novella: portraits of participation. *Health Educ Q*. 1994;21(2):171–186.
- [19] Government of the Northwest Territories Municipal and Community Affairs. HIRA section 2: overview of the northwest territories. Yellowknife, NT: Government of the Northwest Territories. 2014.
- [20] Montgomery-Andersen RA, Willen H, Borup I. "There was no other way things could have been". Greenlandic women's experiences of referral and transfer during pregnancy. *Anthropol Med*. 2010;17:301–313.
- [21] Grzybowski S, Kornelsen J. The costs of separation: the birth experiences of women in isolated and remote communities in British Columbia. *Can Womens Stud*. 2004;24:75–80.
- [22] Kornelsen J, Kotaska A, Waterfall P. Alienation and resilience: the dynamics of birth outside their community for rural first nations women. *J Aborig Health*. 2011;7(1):55–64.
- [23] Webber GWR. Childbirth in the north. A qualitative study in the Moose factory zone. *Can Fam Physician*. 1993;39:781–788.
- [24] Seear KH, Spry EP, Carlin E, et al. Aboriginal women's experiences of strengths and challenges of antenatal care in the Kimberley: a qualitative study. *Women Birth*. 2021;34(6):570–577.
- [25] Watson J, Hodson K, Johnson R, et al. The maternity experiences of indigenous women admitted to an acute care setting. *Aust J Rural Health*. 2002;10(3):154–160.
- [26] Salmon V, Brocious H, Demientieff LX. When delivery means departure: describing the practice and impacts of mandated maternal transport in Alaska. *J Rural Mental Health*. 2022;46(4):260–270.
- [27] Kelly L, Payne L, St Pierre-Hansen N, et al. Delivering away from home: the perinatal experiences of First Nations women in northwestern Ontario. *Can J Rural Med*. 2011;16:126–130.
- [28] Kornelsen J, Grzybowski S. The reality of resistance: the experiences of rural parturient women. *J Midwifery Womens Health*. 2006;51(4):260–265.
- [29] Chamberlain M, Barclay K. Psychosocial costs of transferring indigenous women from their community for birth. *Midwifery*. 2000;16(2):116–122.
- [30] Lawford KM, Giles AR, Bourgeault IL. Canada's evacuation policy for pregnant first nations women: resignation, resilience, and resistance. *Women Birth*. 2018;31(6):479–488.
- [31] Pember MA. The midwives' resistance: how native women are reclaiming birth on their terms. *Rewire News Groups*. 2018.
- [32] Kornelsen J, Kotaska A, Waterfall P, et al. The geography of belonging: the experience of birthing at home for first nations women. *Health Place*. 2010;16:638–645.
- [33] Goodman A, Fleming K, Markwick N, et al. "They treated me like crap and I know it was because I was native": the healthcare experiences of aboriginal peoples living in Vancouver's inner city. *Soc Sci Med*. 2017;178:87–94.
- [34] Hole RD, Evans M, Berg LD, et al. Visibility and voice: aboriginal people experience culturally safe and unsafe health care. *Qual Health Res*. 2015;25(12):1662–1674.
- [35] Wang M, Song Q, Xu J, et al. Continuous support during labour in childbirth: a cross-sectional study in a university teaching hospital in Shanghai, China. *BMC Pregnancy Childbirth*. 2018;18. DOI:10.1186/s12884-018-2119-0.
- [36] Price S, Noseworthy J, Thornton J. Women's experience with social presence during childbirth. *Am J Maternal/Child Nurs*. 2007;32:184–191.
- [37] Lunda P, Minnie CS, Benadé P. Women's experiences of continuous support during childbirth: a meta-synthesis. *BMC Pregnancy Childbirth*. 2018;18. DOI:10.1186/s12884-018-1755-8
- [38] Simmonds DM, West L, Porter J, et al. The role of support person for Ngaanyatjarra women during pregnancy and birth. *Women Birth*. 2012;25:79–85.
- [39] Sioma-Markowska U, Poręba R, Krawczyk P, et al. The preferences of parturient women and the participation of the child's father during birth. *Neuro Endocrinol Lett*. 2015;36:447–451.
- [40] Khajehei M, Hajizadeh N, Behroozpour E. Fathers in the birthing room: theoretical expectations and real-life experiences. *J Midwifery Womens Health*. 2020;65:737–740.
- [41] Johansson M, Fenwick J, Premberg. A meta-synthesis of fathers' experiences of their partner's labour and the birth of their baby. *Midwifery*. 2015;31:9–18.
- [42] Bäckström C, Hertfelt Wahn E. Support during labour: first-time fathers' descriptions of requested and received support during the birth of their child. *Midwifery*. 2011;27:67–73.
- [43] Doenmez CFT, Cidro J, Sinclair S, et al. Heart work: indigenous doulas responding to challenges of western systems and revitalizing indigenous birthing care in Canada. *BMC Pregnancy Childbirth*. 2022;22. DOI:10.1186/s12884-021-04333-z
- [44] Rich R, D'Hont T, Linton J, et al. Performance indicators for maternity care in a circumpolar context: a scoping review. *Int J Circumpolar Health*. 2016;75(1):31470.
- [45] Zingel A. As birthing unit slowly reopens, many parents still expected to give birth in Edmonton until April. *CBC North*; 2022.
- [46] Jahan N, Naveed S, Zeshan M, et al. How to conduct a systematic review: a narrative literature review. *Cureus*. 2016;8. DOI:10.7759/cureus.864.