

Adding women's voices to the call for sustainable rural maternity care

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The shortage of maternity care providers in Canada has been documented largely from the perspective of physicians. Women in rural communities, however, have much to contribute to this discussion. Exploratory research in 3 rural communities in south central Ontario eliciting the perspectives of 36 birthing women has affirmed the need for integrated models of maternity care. Rural women seek care that is local and "relational," characterized by time spent with care providers, continuity and personalized care. They also seek care that is based on fully informed choice. Collaborative models of care, including rural physicians, nurses and midwives, have the potential to create the sustainability and collegiality required to achieve these qualities.

On a abordé la pénurie de prestateurs de soins en maternité au Canada principalement de la perspective des médecins. Les femmes des communautés rurales ont cependant beaucoup à contribuer à cette discussion. Une recherche exploratoire dans trois communautés rurales du centre-sud de l'Ontario, de la perspective de 36 femmes ayant donné naissance, a affirmé le besoin de modèles intégrés de soins en maternité. Les femmes des milieux ruraux veulent des soins accessibles localement et «relationnels», caractérisés par le temps passé en présence des prestateurs, la continuité des soins et leur personnalisation. Elles veulent aussi des soins fondés sur un choix entièrement éclairé. Des modèles de soins en collaboration, réunissant médecins, infirmières et sages-femmes des milieux ruraux, offrent la possibilité de créer la viabilité et la collégialité nécessaires pour obtenir ces qualités.

Introduction

The shortage of maternity care providers in Canada, particularly in rural and remote areas, has been well documented, mainly from the perspective of physicians.[1–6] Yet childbearing women themselves bear many of the costs associated with the lack of health care service, and their voices have gone largely unheard within the relevant Canadian literature and in policy-making circles. Their experiences may be instructive to physicians and other health care workers committed to improving the delivery of rural maternity care.

In this paper, I discuss preliminary research designed to fill that gap. This research documented and compared women's maternity care expectations and experiences in 3 rural Ontario communities to explore the relative importance of various components of maternity care from women's perspectives, and to examine mediating factors influencing how rural women experience maternity care.[7]

Methods

From April to November 2000, 36 new mothers in 3 rural study sites in southwestern and central Ontario (Havelock Southampton and Goderich) underwent semi-structured narrative interviews. The case study sites were selected primarily to reflect diversity in size, economic resources and the availability of family physician-led obstetric care, as well as some consistency in the availability of midwifery care. In Havelock, the smallest site (population 1318), local family physician services were not available at all; in Southampton (pop.

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3075), family physicians no longer delivered babies, and in the largest site, Goderich (pop. 7604), local family physicians were responsible for the majority of deliveries.

Women were initially contacted through local physicians, midwives, nurses, hospitals and community development workers, and subsequently by word of mouth. In all cases, participants were women who had at least one child younger than 18 months, and who lived in the case study sites regardless of where they actually gave birth. Additional interviews with 36 health care workers helped to supply the contexts for the women's accounts. Priority was given to the birthing women's perspectives on rural maternity care.

Interviews were taped and transcribed verbatim, then manually coded for common themes in the women's experiences. Coded portions were entered into Citation (a bibliographic software package), organized by site, person and key word. Transcripts were returned to participants for verification, and follow-up focus groups were held in each site as an additional validity check for preliminary findings. External sources, including academic literature and health statistics, were then introduced to provide further context to participants' reports.

Results

Of the 36 new mothers interviewed 16 were from Goderich, 8 from Havelock and 12 from Southampton. Table 1 summarizes the participants' characteristics with respect to age, number of children, duration of residence in the study site, household income and education and indicates the numbers of health care-related workers in the study sites. Table 2 summarizes the provision of maternity care in the 3 study sites, by location and care provider.

Rural women and many of the health care workers identified 3 features of maternity care that were of particular importance to them. Women wanted care that was local, relational, and characterized by informed choice.

Local care

There is clear support among maternity care professionals for the provision of maternity care for

Table 1. Summary and profile of the research sample

	Study site		
Mothers / Staff	Goderich	Havelock	South-hampton
Mothers			
No. interviewed at each site	16	8	12
Age, mean (and range), yr	30 (26–36)	30 (21–41)	30 (20–37)
Children, no./mother	1.75	2.8	1.9
Residence at site, yr	21	14	11
Household income, $*			
< 30 000	0	4	0
30 000–44 999	7	3	2
45 000–59 999	3	1	4
> 60 000	6	0	0
University degree	7	0	7
Health care–related staff			
Family physicians			
Local	3	1	4
Out of town	0	1	0
Midwives	1	3	3
Doulas†	2	0	0
Specialists	0	0	1
Planners and administrators	2	1	2
Nurses and lactation consultants	1	0	3
Municipal politicians	0	1	0
Community workers	2	3	2

*Not all participants provided income figures.
†Includes a former senior midwifery student.

healthy women in their home communities.[1,5,8–11] The importance of local care was strongly echoed by the rural women in this study. Health care workers were also supportive of local care in principle but were more likely to emphasize its difficulties rather than the need for it. Women spoke at length of the emotional, social and financial costs of having to travel elsewhere for care. The most common concerns had to do with increased stress, employment disruptions and difficulties arranging child care.

Perhaps surprisingly, anxiety was particularly acute for those who did not know if they would have to leave their home communities or not. In Goderich, where family physicians were still delivering babies locally, surgeons and anesthetists were inconsistently available at the time of the study. As a result, women were unsure of the location of their delivery right up until the final stages of labour. Three women reported intentionally scheduling an induction or cesarean section in advance, during business hours when local specialist availability was guaranteed. As one said, "I didn't want to take the chance of not having a surgeon available and getting shipped out." This uncertainty was more problematic for women than knowing they would need to give birth elsewhere and planning accordingly.

Relational care

The second aspect of maternity care of importance to rural women is what I refer to as "relational care," — care characterized by time spent with the patient, continuity and personalization. Assessing quality of care is complex; Haddad and associates[12] suggest distinguishing between the quality of interpersonal processes, technical processes and outcomes. The birth outcomes were positive in all cases in this study, and the level of technical intervention, despite varying widely, did not figure prominently in these women's stories. Instead, par-

Table 2. Provision of maternity care for the study participants by study site, care provider and location

	Study site					
	Goderich, *n* = 16		Havelock,† *n* = 8		Southampton,‡ *n* = 12	
Type of care	Provider* and distance in min	No.	Provider† and distance in min	No.	Provider‡ and distance in min	No.
Regular primary care	Local FP	16	Local FP	0	Local FP	11
			FP < 40	3	FP 40–60	1
			FP 40–60	3		
			FP > 60	1		
			None	1		
Prenatal care	Own local FP	7	Own local FP	0	Own local FP	0
	Different local FP	8	Different local FP	0	Different local FP	0
	Midwife	1	Midwife	4	FP < 40	3
	Obstetrician	0	Obstetrician 40–60	3	FP 40–60	3
			Obstetrician > 60	1	Midwife	5
					Obstetrician 40–60	1
Intrapartum care	Own local FP	3	Own local FP	0	Own local FP	0
	Local FP on call	5	Different local FP	0	Different local FP	0
	Local FP but unclear who	2	Midwife at home	1	FP < 40	3
	Own FP < 40	1	Midwife 40–60	3	FP 40–60	2
	Midwife < 40	1	Obstetrician 40–60	3	Midwife at home	1
	Unknown physician 40–60	2	Obstetrician > 60	3	Midwife 40–60	1
	Unknown physician > 60	2			Midwife > 60	1
					Obstetrician 40–60	1
					Emergency,§ local	1

*Physicians < 40 min were located in Clinton, Ont. Those 40–50 min away were in Stratford, Ont., and those > 60 min away were in London, Ont.
†Physicians < 40 min were located in Norwood and Hastings, Ont., those between 40–50 min away were in Peterborough, Ont., and those > 60 min away were in Trenton and Belleville, Ont.
‡Physicians in both Southampton and Port Elgin, Ont., were considered local; physicians < 40 min were in Walkerton or Chesley, Ont., those 40–60 min away were in Owen Sound, Ont., and those > 60 min away were in Markdale, Ont.
§The emergency delivery occurred in Southampton.

ticipants strongly emphasized interpersonal processes in their assessments of care quality, far more than did the health care workers. Overall satisfaction was expressed in terms of the relationships established with their care providers. They emphasized the importance of "feeling comfortable," receiving "personal care," "not being rushed," being "listened to" and feeling "totally supported." A midwifery client said, "You become like family . . . it was just so personal, and that was the best part."

Three characteristics of relational care emerged from the data: time, continuity and personalization. Women appreciated a care provider who took time to talk to them and to answer their questions without feeling rushed. As one mother said of her doctor, "She was really good because she took time . . . she really wanted to know how things were going with me." Participants were particularly affirming of midwives' willingness to ensure that appointments were not rushed. Women also reported wanting timely care, meaning the ability to get appointments when needed, as well as someone who showed respect for their time by keeping the office running roughly on schedule.

The women acknowledged that it takes time to develop a relationship, and they therefore considered continuity of care over time to be another important dimension of relational care. This desire for continuity did not apply only to their current pregnancy; many rural women spoke highly of being in the care of the same physician who had delivered their previous babies, or in some cases had cared for them all of their lives. This was particularly true in Goderich, where local obstetric care has been consistently available for many years. Although it was often more difficult to receive personalized, continuous care from a practitioner who was not local, those qualities had more to do with the practitioner's approach to care than with the location. With the exception of a few individual physicians, midwives were reported to be best suited to providing personal, non-rushed care.

Women felt more comfortable within an established relationship because they felt that care could be individualized. One woman explained that in a rural area, "When you call the hospital or doctor, you know the people who are answering the phone, so you get a more personal touch." According to another, "[Doctors] don't care for you . . . as they would Joe Blow down the hall. They know you as a person; they know your family. Nine times out of ten they know one of your parents, if not both, so there's that personal connection."

Some of the women also acknowledged a darker side to being well known by one's physician. They expressed concern about doctors making assumptions and being less thorough because of their history with that patient. As one woman suggested to physicians, "Maybe it is better seeing someone that you are not as familiar with; you are more thorough because you have to check them from top to bottom instead of taking for granted that you know what is wrong."

Personalized care is often more likely in rural areas because of overlapping social networks in small communities. As one mother explained, "[Doctors] are not going to treat you awful in the hospital, because nine times out of ten they're going to see you on the street." When physicians practise in a small town, they are likely to be embedded in the community in ways that extend beyond their professional boundaries. As another mother explained, "When you live in a small community, your physicians take on a different role because they have to live here too. So their kids are involved in the same things your kids are involved in, and you see them in other settings other than the office."

Seeing someone in multiple contexts can accelerate the building of trust. It appears from this exploratory data that having a positive relationship with a care provider leads to a more positive perception of care quality, independent of the technical quality of that care. Women in Goderich, where their own family doctors attended their deliveries, were far more likely to report being satisfied because of the relationship, even when the details of their stories revealed a less than satisfactory experience even by their own standards. To cite 2 examples: one woman reported being "furious" with her doctor, yet chose to stay in his care because "it was important to go with someone I was familiar with." Another mother spoke of her care as "extremely negative" because her doctor failed to provide her with timely information, yet she chose to have him deliver her next baby because he was "a nice man in town." A similar pattern did not appear in the accounts of the women in Southampton and Havelock where local physicians did not provide maternity care, suggesting that relationships may be compensating for care that might, in other contexts, be deemed problematic.

Everybody knowing everybody can also mean that there is more at stake in rural communities in "rocking the boat," since doing so can endanger one's entire social network.[13,14] As one woman who was unhappy with her doctor explained, "I have to live in this community, so I don't want to be known

as that kind of trouble-making, witchy person. . . . Here, there's almost an unspoken word that you can't doctor hop. It's not even considered. You don't. I wouldn't want to get that name." Rural women whose deliveries were attended by local physicians may therefore have been less likely to express dissatisfaction than women who had to travel elsewhere for care.

Informed choice

The third aspect of maternity care that rural women deemed important was informed choice. Informed choice requires at least 3 elements: a range of options, knowing what they are, and being able to act on them. The narrow range of maternity care options for rural women in Canada has been well documented.[1,6,9,15–24] Clearly, informed choice is not possible when no choices exist.

Yet for the women in this study, even when maternity services were available, informed choice was compromised owing to a lack of awareness of the few options actually available. Most women reported relying on their family doctor to make them aware of the maternity care choices available to them. As one woman said, "My doctor told me what to do. It didn't occur to me to ask any differently." According to another, "Midwives were never even talked about at all. I wish they had been." For those women with no family doctor, or a physician who did not inform them of the full range of maternity care options, informed choice could not be fully exercised.

Discussion

Collaborative models of maternity care have the potential to offer rural women the qualities of care they are seeking. In order to make local care a certainty, such models should incorporate not only family physicians, nurses and midwives, but also the specialists and emergency personnel who provide the back-up needed for the other practitioners to attend local births with greater confidence.

The emphasis on relationships in care quality reflects the assertion of Berg and associates[25] that "a necessary condition for practicing good care is to establish a good relationship," and the 3 aspects of relational care reflect qualities of desirable care highlighted throughout the maternity care literature.[26–31] Tinkler and Quinney,[32] for example, have argued that the nature of the provider–client relationship is "integral and crucial," since a lack of continuity, information and support are central to maternal dissatisfaction. These findings also parallel those of Green and colleagues,[33] wherein emotional wellbeing after birth was not significantly correlated with the level of obstetrical intervention but rather with the extent to which women felt they had a say in what interventions were used.

It could be argued that this apparent valuing of relationship over quality of technical care reflects the tendency for women to express satisfaction regardless of the care actually provided, particularly in the context of a positive birth outcome.[31,34] It also supports the notion that women "bolster" their childbirth choices, playing up the advantages and minimizing the negatives of a selected course of action.[35] Yet the tension between relationship and care quality did not emerge in the sites where women had to look elsewhere for care, suggesting that the interpersonal dynamics in small communities played a role in shaping women's assessments and choices. Relationships are especially important in small rural communities, which rely on face-to-face interactions and are often characterized by social stability and long-term residence. McKie[36] has suggested that the community-based values of rural life revolve around personal identities, as "custodians of the emotional heart of small communities."

Because of the increasing scarcity of rural maternity care providers in Canada, the likelihood of establishing a stable relationship with a care provider over time is diminishing. When caregivers are not part of the local fabric, relationships cannot develop as easily. Continuity of care is undermined when professional turnover is high. To the extent that collaborative models of maternity care would allow for more consistent, sustainable service, they could go a long way toward facilitating the kinds of relationships that rural women consider important, not only between clients and caregivers but also among maternity care professionals. Moreover, collaborative models of care could be intentionally structured in ways that allow health professionals to spend more time with women, much as the current midwifery model allows.

Improved interprofessional collegiality could also lead to improved information-sharing and reduce barriers to referrals. Having access to timely and complete information is especially important in the changing contexts of rural health care, where women frequently have to take the initiative to piece together their own maternity care plan. Improved collegiality is not the only solution — rural women need more and better access points to information, and they need the social and economic freedom to

act on the information they receive — but it would be a helpful start.

It is obviously important to recognize the limitations of a study based on the stories of a small nonrandom number of mothers in just 3 rural sites. As people with access to midwifery services, living in communities relatively close to major urban centres, their experiences may not mirror those in more remote parts of the country. Yet the validity and resonance of these exploratory findings are starting to be confirmed in larger scale research among rural women in Canada,[37] affirming the need for rural health care providers and planners to find creative ways to offer services that are local, relational and based on informed choice. Doing so is clearly difficult, but hearing the voices of rural women can help health professionals stay focused in their commitment to sustaining rural care.

Conclusions

These rural women's experiences confirm the well-documented need for consistent, sustainable, local rural maternity care. They affirm the importance of care providers intentionally investing in relationship building, with their patients as well as with other health care professionals. As physicians, midwives, nurses and other health care professionals grapple with the pressures and complexities of providing high quality maternity care in rural contexts, perhaps hearing from the intended beneficiaries of their efforts will affirm that those efforts are not in vain.

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