

# The Reality of Resistance: The Experiences of Rural Parturient Women

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The closure of many local maternity services has given rise to contemporary realities of care for many rural parturient women in Canada, which, in turn, determines their experience of birth. To date, we do not have an understanding of the realities influencing the birthing experiences of rural parturient women. This qualitative investigation explored these issues with women from four rural British Columbian communities through semistructured interviews and focus groups. Women in this study articulated four realities that influenced the nature of their experience of birth, including geographic realities, the availability of local health service resources, and the influence of parity and financial implications of leaving the community to give birth. When these realities were incongruent with participants' needs in birth, participants developed strategies of resistance to mitigate the dissonance. Strategies included trying to time the birth at the referral hospital by undergoing an elective induction and seasonal timing of pregnancies to minimize the risk of winter travel. Some women showed up at the local hospital in an advanced stage of labor to avoid transfer to a referral center, or in some instances, had an unassisted homebirth. *J Midwifery Womens Health* 2006; 51:260–265 © 2006 by the American College of Nurse-Midwives.

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## INTRODUCTION

There has been a significant decline in the number of rural communities in Canada offering local maternity care since 2000.<sup>1–3</sup> This has resulted from a confluence of factors, including the regionalization of health services delivery in many jurisdictions,<sup>4,5</sup> physician recruitment and retention challenges,<sup>6</sup> and diminishing access to midwives and nurses trained in obstetrics.<sup>7–9</sup> In Ontario, for example, 11 small hospitals ceased providing obstetric care between the years 1988 and 1995.<sup>2</sup> A similar trend has been documented in Nova Scotia, where 32 of 42 hospitals closed their services between the years 1970 and 2002.<sup>10</sup> This situation is not unique to Canada; it mirrors the reduction in services found in Australia, the United States,<sup>11–13</sup> New Zealand,<sup>14</sup> and northern Europe.<sup>15</sup>

Although there is no consensus on the safety of small rural maternity services, the majority of studies record similar rates of perinatal mortality across all service levels, thus indicating that within a regionalized system, small rural services can provide safe care.<sup>13,14,16–18</sup> In fact, with the dramatic decline of local maternity hospitals, the question of safety may be reframed to pose whether closing local services is safe. Literature from the United States offers some insight into this question. A study conducted in rural Florida found that infant mortality increased when local access to care providers was reduced.<sup>11</sup> Research undertaken in rural Washington State found that when women birthed away from their local community, they were more likely to experience premature birth and pregnancy complications, and their

newborns had longer and more expensive hospital stays than those born in local facilities.<sup>12</sup> These results suggest that newborn outcomes are better where there is access to even a limited local maternity service, rather than no local access. In addition, qualitative research about rural women's experiences have found that they, along with their families, incur significant psychosocial and financial costs due to travel to access obstetric care.<sup>19–23</sup>

British Columbia, Canada's westernmost province, serves as an interesting case study. Since 2000, the province has experienced the effects of health care regionalization firsthand, as 17 small hospitals have closed their maternity services.<sup>24</sup> However, British Columbia is unique because of its topography; specifically, mountainous terrain and coastal communities, which may further contribute to the negative consequences experienced by women who need to travel for care. This study investigates the impact of service closures and other current realities of the rural maternity health services delivery context on the experiences of parturient women.

## METHODS

This exploratory qualitative study is part of a program of research investigating women's experiences of obstetric care in rural and remote communities in British Columbia.<sup>22,23</sup> The focus of this investigation was the realities of maternity care faced by rural women.

Data collection was carried out in four rural communities chosen to represent diversity in size (geographic boundaries, catchment areas for health care services, and population); distance to hospital with caesarean delivery capability and distance to secondary hospital; usual conditions of road and air access in winter months; and diversity of cultural and ethnic subpopulations within the

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communities. All communities were designated “high outflow” (i.e., more than two-thirds of low-risk births occurred outside the community). Prior to the onset of data collection, one of the research communities ceased providing local maternity care services.

Participants were recruited through 1) third-party recruitment through local maternity care providers and 2) a “snowball technique,” where key informants and regular interviewees help identify other interviewees. In the former technique, letters describing the objectives of the study were sent to local physicians and other local care providers who interacted with women meeting our inclusion criteria, including public health nurses, doulas, La Leche League representatives, Head Start program leaders, prenatal educators, community health workers, and mother and infant group leaders. The letter included a poster advertising the dates we would be in town to interview. Interested potential participants were invited to contact the research coordinator for more information and to set up an interview time. As all four study sites were small, initial participants recruited through care providers or posters were often connected with other local women who had delivered a baby recently. Through the connections, we gained access to a broad range of study participants. Inclusion criteria included having given birth without significant complications in the past 18 to 24 months, and primary residence being one of the rural communities selected for this study. Achieving target numbers of participants to ensure saturation of data was easily accomplished in each community.

Unstructured interviews and focus groups were undertaken with women who had given birth up to 24 months prior to the onset of the study and whose primary residence during this time was in the research community. The interviews were guided by the following key probes: 1) “Tell us about your experience of birth.” 2) “What maternity care services did you have access to in your community?” 3) “How satisfied were you with the services available in your community?” 4) “If you could change things to promote better maternity care in your community, what would they be?” 5) “What is a good birth?” and 6) “What is a safe birth?” Ethical approval for the study was sought and received from the University of British Columbia Behavioural Ethics Board, and consent was obtained from all women who participated in the interviews and focus groups before the onset of their involvement.

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The study was undertaken by using a transdisciplinary approach<sup>25</sup> by a family physician who practiced obstetrics in a rural setting for 12 years and a sociologist whose research focus includes the study of conditions of child-birth for vulnerable populations.

All interviews and focus groups were undertaken by two members of the research team within a dyadic approach in which questions and probes were initiated by either researcher. The principal investigators’ respective disciplines of medical sociology and clinical medicine led to a richness of data due to the complementary approach to the subject area. The combination of clinical and sociological perspectives gave rise to a more thorough interpretation of women’s experiences than could be achieved by one perspective.

Analysis was carried out in two phases using a modified approach to grounded theory, which included the use of traditional procedures, such as coding emerging data, making connections between themes and sub-themes, and self-reflective memo writing.<sup>26</sup> Initially, five transcripts were individually coded by three members of the research team to ensure consistency and relevance of codes. Codes attributed to the text by the individual researchers exhibited a high level of congruence between them. A code book was developed on the basis of initial coding. A qualitative data analysis software program was used to apply codes to the transcripts, organize the data by themes, and link data to field notes and analytic memos. This allowed for multiple sorting of data as the analytic framework emerged.

The first phase of the analysis gave rise to a schema that revealed that women’s experiences were determined by the congruence between their needs in childbirth and the realities of their geographic, health services, and social context. When there was dissonance between participants’ needs and realities, many developed strategies to mitigate it. Because of space limitation, the focus of this discussion is limited to the realities rural parturient women face and the concomitant strategies they develop. Although the research sites for this study were chosen to represent diversity in key characteristics, direct transferability to other rural locations cannot be assumed because of the heterogeneity of rural communities. Further studies in diverse communities capturing varied geographic and sociodemographic variables (e.g., communities in the far north and religious communities) are warranted.

## RESULTS

A total of 44 women were interviewed. Of these, 6 birthed within their local community and 38 birthed in a referral community. All data were included in the analysis. Seven women in three communities were videotaped.

## Overview

Participants in this study recognized a set of circumstances, or “realities,” that affected their experience of labor and delivery. These realities included their geographic location (i.e., degree of isolation, proximity to the nearest referral community, and usual travel conditions), the health system resources available to them in both their local and referral community (i.e., access to care providers, tests, and diagnostics), and their parity. If these realities challenged participants’ ability to give birth in their home community, they developed strategies to overcome them. Strategies included elective induction of labor, seasonal timing of pregnancy, presenting at their local hospital at 10-cm dilation to avoid transport to a referral community, and having an unassisted home-birth. Each of the realities and strategies are described thematically in the following paragraphs.

## Geography, Travel, and the Stress of “What If”

All of the women we interviewed conveyed an awareness of the logistic challenges involved in giving birth away from their community in relation to specific geographic circumstances. Common areas of concern were en route deliveries, the inconvenience brought by travel, and seasonal considerations, regardless of both the distance between the participant’s community and the referral center or anticipated mode of transportation. These concerns gave rise to anxiety for many participants:

*“That was the only time I was a little concerned about being out here and being pregnant. The roads [are] bad. After the last ultrasound, I did come off the road in the snow, so that was a concern” (participant 9, community 2).*

Concerns about driving in winter conditions led many women to compromise their course of prenatal care, often with reprisal. As one participant noted:

*“So then you have to go to [the referral community] once a week. I chose not to go because it was winter. . . . So it was kind of tough because I got sort of flak for not going” (participant 1, community 1).*

Anxiety over travel was not limited to getting to the referral hospital. Several participants noted concern about traveling back home with an infant, especially when the experience of motherhood was new.

## Health System Resources

An awareness of lack of access to caregivers, whether in a participant’s home or referral community, was expressed by many participants in this study and often met with a sense of incredulity:

*“I went in there and said, ‘I think I’m pregnant . . .’ Somebody said they weren’t seeing new patients and I said, ‘How can you not see new patients? Do you have to go out of town to see a doctor for a minor cold?’ He said ‘Yup’ . . .” (participant 9, community 3).*

Most women in this study expressed a desire to access midwifery care or to have the choice to access such care. Although no registered midwives were practicing in any of the study communities, several participants arranged midwifery care by traveling outside their communities for prenatal visits and moving to their midwife’s community prior to labor and delivery—sometimes at significant personal costs.

Beyond securing a care provider, most participants from communities with no local services struggled with understanding why they were not able to deliver in their home community, especially when there was a history of local care. As one said:

*“And it surprised me because . . . the nurses know how to do it because they’ve done it before. The doctors know how to deliver and like, to me, it’s like, why? You know they do deliveries here—they have no choice if somebody comes in and they’re having a baby . . . they’re going to have to deliver it” (participant 2, community 1).*

## The Reality of Parity

There were significant differences between the narratives of primiparous and multiparous participants in this study who had to leave their home communities to give birth. Differences stemmed from the stress incurred by both the logistic challenges of arranging care for other children, either in their own or referral communities, and the stress of separation for those who had to leave their children behind. As one participant noted:

*“You know, the first time around, I think you’re prepared [to leave the community] because you don’t have any other responsibilities, but when it’s your second or third and you’ve got other children, that’s the hardest thing. . . . My family’s not here so I don’t have. . . . I can’t phone my mom and say, ‘Okay, can you come and watch the kids?’” (participant 2, community 1).*

For some, the stress and anxiety of being away manifested in the form of depression (“I’ve had postpartum depression. . . and I knew it was just because of the situation of being away from [my son] and everything . . .” [participant 5, community 3]), whereas for others, it precipitated the desire to return home as quickly as possible.

## Financial Realities

Almost all participants in this study expressed anxiety about the financial costs of leaving their community to give birth. Although status Aboriginal women had travel and accommodation costs reimbursed by their band councils, remuneration was often barely enough to cover the basic necessities and fell short if other children came to the referral community as well. The stress was highest for those with limited resources who, beyond food and lodging, had to contend with other miscellaneous costs such as parking and phone calls home.

Beyond explicit costs, many participants also acknowledged the cost of missed work their partners incurred to come with them to the referral community, even if only at the time of birth. One participant noted that her partner was off work for 12 days and went on to say, “That amount of time was hard because his was the only income coming in” (focus group participant, community 2).

Several participants noted that even a short trip to the referral community was difficult if the material means to do so were lacking. “I don’t drive and we don’t have our license, so it’s hard to get from there back, and that’s the one thing that frustrated me” (participant 7, community 2).

## Strategies

As noted earlier, when the participants’ psychosocial and physiologic needs were challenged by the realities of care in rural and remote communities, they developed strategies to mitigate the dissonance. These strategies included elective interventions to exert control over the timing of the birth, seasonal timing for birth, showing up in advanced stages of labor to preclude transport to a referral center (the “10-cm strategy”), and even unassisted homebirths.

### Elective Interventions

To accommodate their need to plan time away from their home communities, several women in this study arranged elective inductions. As one said:

*“So in the end, I phoned the doctor in [the referral community] and I said, ‘I don’t know what to do.’ And we decided to get induced. So that is how we got to that stage, and I just felt like I did not have an option anymore. My options were all taken away from me” (participant 7, community 3).*

### Seasonal Timing of Conception

Several participants spoke of their awareness of seasons and the desire to avoid possible inclement weather at the time of birth, which might hamper their ability to leave

the community either before labor or if an intrapartum transfer was necessary. As one noted, “If you are planning a baby, don’t plan it from like October to March, ‘cause you never know [about the weather]. That was the scary part” (participant 1, community 1).

### The 10-cm Strategy

In every research community, a small number of participants revealed either having delayed presenting at the local hospital for assessment or delayed leaving for the referral community until they were in advanced stages of labor to secure care in their local community. As one noted:

*“I stayed here until noon and put up with the pain by myself and I walked around in here and kept quiet as long as possible because the contractions were really bad—they were really hard. . . . I said, ‘There is no way I want to go to the referral community. It is a really long drive and I don’t want to do that.’ And that’s why I stalled” (participant 4, community 1).*

Although most participants did not alert their care providers that this was their plan, some did. “I kept telling [my doctor] I was going to deliver here, I just wasn’t going to tell anyone when I was in labor” (participant 6, community 1).

### Unassisted Homebirths

Although several participants talked about the possibility of having an unassisted homebirth for subsequent pregnancies as a way of avoiding the logistic stress and anxiety they faced when leaving their communities for previous births, only three women in this study had planned unassisted homebirths. The women who undertook these drastic measures did so out of a sense of lack of alternatives and may not have chosen to do this had there been adequate antenatal support within their community.

## DISCUSSION

Parturient women in many small rural communities across Canada, the United States, and other jurisdictions face the challenge of securing maternity care within a context of diminishing access to local resources. In light of these structural constraints, many participants in this study developed strategies to mitigate the feelings of anxiety and stress caused by the dissonance between their needs in childbirth and the realities of accessing maternity care services when they were no longer available. These strategies may be understood as acts of resistance or, what Fogerty calls “reactance,” which refers to the “motivational state aimed at recapturing the [perceived loss of] freedom.”<sup>27</sup> (p. 1277) This reactance

can be manifested as conflict with local caregivers over what is the most appropriate and “safest” plan of management for the pregnancy. Local care providers may pressure women to leave the community as the due date approaches, not to be caught by a precipitate local delivery. This situation worsens over time as local care providers have less opportunity to practice and maintain their obstetric skills, and hence, feel even less confidence in their capacity to provide a “safe” local birth.<sup>28</sup> Care providers may become more rigid and inflexible, and the inherent inequity in power that can occur in the doctor-patient relationship may lead to a strengthening of a woman’s resistance. As Fogerty states: “Those who have. . . greater amounts of social power than oneself can issue threats of relatively great magnitude to one’s own free behaviours [thus] add to the possibility of arousing reactance and, as a result, noncompliance.”<sup>27</sup> (p. 1282)

Ideally, the recourse to this is care providers’ formation of a “social unit”<sup>27</sup> with the patient to engage in collaborative decision making marked by equal participation. The desire for enacting collaborative decision making regarding their care was articulated both by women in this study and rural maternity care providers who recognized the challenging circumstances of providing maternity care services in a community without local access to cesarean birth. Collaborative decision making is much more difficult to achieve in a community that no longer provides even limited local birthing services. For participants in this study, reactance—or resistance—was a product of the absence of such collaborative processes.

Reactance may further be understood as the result of differential interpretations of risk between care providers and birthing women, leading to participants’ sense of distrust. This parallels Anthony Giddens’ theory of the close links between risk and trust and an awareness that risks are socially constructed; trust is strongest within social groups, and distrust often prevails between one social group and another.<sup>29</sup>

Support for acts of resistance was often garnered from other women in the community, reflecting what Cahill described as the supercedence of community values over medical directives: “Although medical science is powerful and doctors are respected members of society, patients are generally more influenced by their immediate communities.”<sup>30</sup> Once one woman had successfully enacted a 10-cm strategy, or perhaps even an unassisted homebirth, the example is set for other women to emulate.

When the needs of rural parturient women were not supported by the local health care system, resistance to the medical model that mandated birthing away from the home community occurred. This led to situations in which mothers were unattended in labor and sometimes during the birth itself, and local care providers were forced to provide birthing services on an emergency basis with minimal preparation. As increasing numbers

of rural communities cease providing local maternity care, the phenomenon of resistance will only increase. It is ironic that in seeking to centralize birthing services to larger and perceived safer facilities, rural birthing women adopt strategies of resistance that include unsupported labor at home, and on occasion, unassisted homebirth. Perhaps this partially explains why Larimore and Davis documented increasing infant mortality in rural counties in Florida without local access to birthing services.<sup>11</sup> A further irony of this loss of local access to services is that multiparous women who would normally expect the least perinatal complications are placed at the greatest stress and risk. Given the struggle to deal with their older children and the uncertainty of a potentially precipitous delivery en route to a referral hospital, it is not surprising that they on occasion choose a 10-cm strategy or to stay at home and have an unassisted homebirth. When birth does occur at a referral hospital, women frequently advocate for early discharge and then face exhaustion, breastfeeding difficulties, and even postpartum depression in their home community.

## CONCLUSION

Loss of local maternity services in small rural communities is associated with parturient women choosing to resist relocation to a referral community to birth; instead, they undergo unattended labor and in some cases delivery. To plan rural maternity health services effectively, we need a clear understanding of rural parturient women’s needs, the health care realities they face, and the strategies parturient women will use to meet their needs. This discussion must take place within a context that balances our focus on the potential risks of birthing without immediate access to cesarean birth, the potential risks of closing services, denying access to care, and the sequela this precipitates.

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