

IN PRAISE AND SEARCH OF MIDWIFERY WELL-SUITED TO RURAL WOMEN

À LA LOUANGE ET À LA RECHERCHE D'UNE PRATIQUE SAGE-FEMME QUI CONVIENT AUX FEMMES EN MILIEUX RURAUX

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ABSTRACT

In order to investigate rural maternity care from the perspective of women, narrative interviews were conducted with 36 mothers and 36 health care workers in three small community case study sites in south central Ontario in 2000. Based on the resulting data, this article suggests numerous ways that living rurally affects maternal health. It goes on to explore ways in which midwifery is particularly well-suited to addressing the needs of women living in rural places and identifies sites of resistance to rural midwifery. The research findings indicate that a commitment to the sustained provision of rural midwifery services is well worth the effort and investment required, and this article discusses implications of such a commitment for both practitioners and policy makers.

KEY WORDS

perinatal care, rural health, rural health services, rural communities, midwifery, health planning

RÉSUMÉ

Afin de pouvoir étudier les soins obstétriques en milieux ruraux, du point de vue des femmes, nous avons mené des entrevues narratives en 2000, avec 36 mères et 36 membres du personnel soignant. Nous avons choisi trois petites communautés situées dans le centre-sud de l'Ontario, qui nous ont servi de site pour notre étude de cas. En se basant sur les données obtenues, cet article démontre de nombreuses façons, comment le fait de vivre en milieu rural affecte la santé des mères. Ensuite, il explore comment la pratique sage-femme arrive très bien à répondre aux besoins des femmes vivant en milieux ruraux, et puis identifie les lieux de résistance à la pratique sage-femme dans ces milieux. Les conclusions de cette recherche montrent qu'un engagement visant à assurer l'avenir des services de la pratique sage-femme en milieux ruraux en vaut l'effort et l'investissement nécessaire. Cet article présente également les enjeux d'un tel engagement pour les praticiens ainsi que pour ceux qui sont responsables des politiques décisionnelles.

MOTS-CLÉS

soins périnatals, santé en milieu rural, services de santé en milieu rural, communautés rurales, planification de services de santé en pratique sage-femme

THIS ARTICLE HAS BEEN PEER-REVIEWED

INTRODUCTION

The trends are all too familiar in rural health: hospital closures, physician scarcity, and poor access to essential services. Deficiencies and declines provide the backdrop for and shape popular consciousness about rural obstetric services in the province of Ontario, Canada. There is, however, much more to the story. There are mothers who are successfully living, working and having their babies in rural places.

What follows emerged from a research process designed to add mothers' experiences to the more dominant voices of physicians and health planners in describing formal and informal maternity care in rural contexts.¹ The objectives of this study were to document and compare women's maternity care expectations and experiences in three rural areas of Ontario, 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.

The women's stories both confirmed and called into question the prevailing depiction of rural health as vulnerable and failing. Their accounts illuminated a constellation of factors, extending well beyond physician and hospital services, which influence women's experiences of having children rurally. For many, one shining light within that constellation was midwifery. Women in all three sites, even some who were not midwifery clients themselves, reported extremely high levels of satisfaction with midwifery care. The reasons behind their satisfaction yield important insights into the ways in which the midwifery model of care matches, and could be even better suited to, the realities of rural living.

BACKGROUND

This study resulted from three motivating factors. One was the importance of the subject area. Few events in a person's life can compare with the significance of having a child. More than 80% of adult women in industrialized countries give birth at some point in their lives, and birth experiences have been shown to have a lasting impact on the psychological health of mothers and on their future relationship with their children.¹³ Not only are birth experiences important to women; the quality and accessibility of health services are important to communities. In order for communities to thrive, they must provide basic services to their residents. Low risk maternity care is one such service, and its sustainability therefore warrants research.

The second motivating factor was the rapidly changing context of maternity health care provision in Ontario. Family physicians are already scarce, and many are abandoning obstetric service

provision, leading to what some have described as a maternity care crisis in the province.^{4,8} This crisis is felt differently, and often more acutely, in rural places. At the same time, midwives are growing in numbers and popularity, and their role in rural Ontario had yet to be thoroughly explored.

The third impetus was a gap in the current academic literature. Without up-to-date research we are “rapidly approaching a situation where policies to support rural health care and to ensure that rural populations receive fair access to health services of acceptable quality and cost will be made in ignorance.”⁹ Canadian research on rural women's health is scarce.¹⁰ What little has been written on rural maternity care comes primarily from the perspective of physicians, often excludes the voices of women, and frequently ignores the importance of both formal and informal care within a maternity care system.

TABLE 1: SUMMARY OF THE RESEARCH SAMPLE

	<i>Site A</i>	<i>Site B</i>	<i>Site C</i>
MOTHERS	16	8	12
Midwifery Clients	1	4	5
Age	30 (range 26-36)	30 (range 21-41)	30 (range 20-37)
Number of Children	1.75 per mother	2.8 per mother	1.91 per mother
Length of Residence	21 years	14 years	11 years
Household Income			
<\$30,000	0	4	0
\$30,000-\$45,000	7	3	2
\$45,000-\$60,000	3	1	4
>\$60,000†	6	0	6
University Degree	7	0	7
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

These three motivating factors led to the question, “If births are primarily attended by doctors, and those doctors are disappearing, where does that leave rural women? Clearly women still live, and have their babies, in rural areas. How are they coping in the absence of accessible doctors? Are doctors really the issue at all? This led to the question, “What is important to rural women about their maternity care?” One answer was found in the midwifery model of care.

METHODS

A critical interpretive approach to research was adopted, in which personal stories were interpreted in light of their political contexts, in order to give voice to women's experiences and to shade in the middle ground between macro analyses and decontextualized individual reports.^{11,12} From April to November 2000, semi-structured narrative interviews lasting approximately 90 minutes were conducted with 36 mothers in three rural case study sites in southwestern and central Ontario. Interviews were conducted in the women's homes.ⁱⁱ Thirty-six additional interviews with health care workers helped to fill in the contexts for the women's accounts. (Table 1 provides a summary of those interviewed.)

The case study sites were selected primarily to reflect diversity in the availability of family physician-led obstetric care, in size and in economic resources, as well as some consistency in the availability of midwifery care. Populations ranged from 1,318 to 7,604

* Age, number of children and length of residence figures are averages of the mothers in each site.

† Not all participants provided income figures

‡ Also includes a former senior midwifery student

people. Economies of the three sites were mixed and varied, with some reliance on local industry, agriculture and tourism, and significant commuting ties to the closest urban centres. All three sites offered midwifery services, although awareness and use of those services varied. In the smallest site, local family physician services were not available at all; in the second, family physicians no longer delivered babies, and in the largest site, local family physicians continue to be responsible for the majority of deliveries.

Participant recruitment strategies differed slightly in each location. 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 with at least one child less than 18 months old, who lived in the case study sites regardless of where they actually gave birth. The number of mothers interviewed in each site was determined based on theoretical saturation, reasonable coverage relative to population and birth rates, and overall manageability of data.

Although the sample of mothers is diverse in terms of birth experiences, income, education levels, number of children, length of rural residence and age, it is strikingly homogeneous in other important ways. For example, considerations of race are absent because the sample was all white, with virtually no ethnic or linguistic variability. Although this reflects the demographic composition of much of rural Ontario, it eliminates an important level of social analysis that might otherwise have been included.ⁱⁱⁱ

Interviews were taped and detailed notes were also taken. Tapes and notes were transcribed verbatim, and then returned to each participant. This provided an opportunity for participants to fill in any gaps in the data. Transcripts were then manually coded and the coded portions were entered into Citation bibliographic software, organized by site, by person and by key word. Follow up focus groups were held in each site to act 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.

DEFINITIONS OF RURALITY

In order to examine rurality's influence on women's experiences of maternity care, it is important first to clarify how rurality is being employed and understood. Rather than a fixed definition based on a particular reference point, which tends to downplay rural diversity, I am working from a contextualized understanding of rurality in which it "is [selectively] constructed and deployed in a variety of contexts."¹³⁻¹⁵ I argue that rurality is socially negotiated, in reference to an external reality that is spatial. That spatial reality is, in most cases, a place with low population, peripheral to a core centre. My interest lay in exploring the diverse health implications of living in small places.

RURALITY IS A DETERMINANT OF PREGNANT WOMEN'S HEALTH

The women's stories revealed several specific ways in which living rurally affects their health. This is not surprising since

rurality affects people's physical and social environments, which are widely accepted determinants of health.^{iv} In this section I explore how several distinguishing features of rural life influence the health of pregnant women, before turning to a discussion of how midwifery is well-suited to addressing those features.

Participants reported that living rurally influences their health in important, and often contradictory ways. First, low population density and wide dispersion of services lead to geographic and social isolation, particularly for women without transportation. Isolation is exacerbated by the seasonal nature of farm and tourism work, as well as harsh winter weather, which often serve to keep rural people at home during particular times of the year. The implications of such isolation are far-reaching and can include increased stress, depression, lack of access to information, and lower health service utilization rates.¹⁶⁻²⁴ According to one woman, "I was losing it, because I'd been stuck in the apartment all winter long. My vehicle was broken down, I had a newborn baby and I was stuck there. It was a nightmare."

Living rurally also affects the amount and quality of social support women experience. The value of positive social support to pregnant women and new mothers has been well documented.^{3,17,21,25,26} Many women spoke positively of the social support they enjoy. One explained, "I think a lot of people who live in rural communities have a lot more support. You've probably got family and friends close to you, whereas in the city you could be quite isolated." Yet although "everybody knowing everybody" in small communities makes some women feel "safer" and "more at home," it can also be a source of frustration. It can breach confidentiality and thereby limit women's access to health care. For instance, in one site, several women reported avoiding a particular parenting group because of who else they suspected would be there. Elsewhere, one adolescent mother described, "You know people are talking about you and saying these awful things about you, and it's really hard." Health care workers reported difficulties finding central but private locations at which to offer services. According to one, "People are going to see you at the rendezvous place. There's just no way around that one. And then there's the confidentiality in groups, because in really small communities, often times you'll have people from the same family in the same group."

Despite some women feeling too well-known, others reported having difficulty building relationships in small places, calling their communities "cliquey" or "closed". As one person explained, "If you didn't grow up here, people don't know you and they don't really want to know you." These examples illustrate how a single feature of rural life can function simultaneously to support and undermine good health.

Living rurally also means that women's health care choices are limited because services are scarce. The dearth of health professionals is overlaid with a reluctance to switch caregivers in small towns. As one mother said, "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." Yet perhaps unexpectedly, this same lack of access to care did at

times increase women's choice and agency, by forcing them to make active decisions about their care. Where local doctors did not attend births, women reported considering options they otherwise might have overlooked, and piecing together a birth plan that best suited their needs. One woman admitted, "If I didn't have to make a choice, I never would have thought of a midwife." It thus appears that limited access to health care services can have both negative and positive effects.

Living rurally influences not only the quantity of available health care, but often its perceived quality as well. For some women, living rurally meant making sacrifices in health care quality; they mentioned concerns about local doctors being unaware of the latest research, or not being sufficiently thorough. Several mothers described trading convenience for quality in smaller communities. As one explained, "If you want quality care, you're going to have to seek it out by going to the bigger cities. But that's a hassle, and sometimes it's not worth it." Yet for others, knowing one's physician and living in a small community translated into more personalized, appropriate care.²⁷ One mother described it this way,

...in a small community they know who you are and you know who they are, so they know how you run....[In a city] they just care for you as they would Joe Blow down the hall, whereas here they know you as a person. They know your family. Nine times out of 10 they know one of your parents, if not both, so it's that personal connection....We have a personal connection; you know the care you're getting. They're not going to treat you awful in the hospital, because nine times out of 10, they're going to see you on the street.

It is evident from these examples that rurality, as both a geographic and social concept, influences women's health in identifiable, although often contradictory ways. The specific effects of rurality must therefore be taken into account in maternity care delivery and planning. In its ability to respond and adapt to the realities of rural living, the midwifery model of care was described as being well-suited to meeting rural women's particular needs.

MIDWIVES RESPOND TO RURAL REALITIES

a) By being there

One way midwives respond to the effects of living rurally on women's lives is simply by being there to offer services in rural places. In a recent survey, four out of 47 midwifery practices self-identified as being rural, and 34 reported serving both urban and rural clients.²⁸ There are still rural parts of the province not served by midwives; however, the supply and distribution is improving.²⁸ Their presence fills a growing gap left by physicians no longer available to attend births.

There is an acute shortage of maternity care professionals in Canada, which is the result of a number of trends.⁴ First, it reflects an overall lack of doctors, particularly family physicians. According to a provincial report, "the current supply of physicians and particularly physician services (i.e. effective supply) is not sufficient to fully meet the health care needs of Ontarians."²⁹

That shortage is particularly acute in rural areas. As one moves

farther away from urban centres, the number of physicians decreases much more rapidly than the general population. Rural Ontario has one family physician for every 1751 people, compared with the provincial rate of one for every 1105 people. There can be as much as a fourfold difference between urban and rural physician-to-population ratios in Canada.³⁰⁻³³

Where family physicians are available, the number offering obstetric services within their practice is low and declining. In 1983, 68 percent of family physicians in Canada attended births. By 1995 that figure had dropped to 32 percent.³⁴ According to a 1997/98 survey, in Ontario just 22 percent of family physicians provide intrapartum care.³⁴ Obstetrician numbers in Ontario have declined more slowly, but they too are diminishing as existing specialists age and as medical school graduates look to more lucrative, less disruptive specialties.³⁵

There is, then, a clear need for maternity care professionals, particularly in rural areas. Midwives provide a service increasingly unavailable to rural women through other means. As one rural midwifery said, "If we didn't [drive long distances to care for women], the question would be who would care for those women? Because we are filling a gap. There are fewer and fewer family physicians, obstetricians are closing their practices -- somebody's got to take it up and we're committed to doing it." Currently the approximately 260 registered midwives in Ontario attend just over six percent of the births in the province. Supply is growing by approximately 30 to 40 midwives per year, but is currently inadequate to meet the demand. In 2003/2003, 3400 prospective midwifery clients, representing an additional 45% over the number of women who received midwifery services that year, were unable to be accommodated by existing midwifery practice groups.³⁶

As midwives step into the gap left by obstetricians and family physicians in rural areas, there are implications both for them and their clients. The rural midwives in this study reported an increase in client numbers, as well as a change in the mix of clients they see as a result of the scarcity of other maternity care professionals. They spoke of serving "a less self-selecting population." They also recognize that their different scope of practice means that midwives will not completely fill the roles occupied by specialist physicians. For pregnant women, the scarcity of doctors has offered greater exposure to midwifery than they might otherwise have had.

In this context of scarce health care services, midwives provide more than clinical care for birthing women. They also serve as important sources of health information and support. For instance, lactation services, where available, are offered in cities, at preset, limited times. In rural places, these barriers are exacerbated by distance, causing several of the rural mothers in this study to abandon breast-feeding altogether. Midwives' 24 hour accessibility, often in women's homes, means that they are well positioned to encourage more sustained breast-feeding. According to one midwife, "The kind of care that we can offer makes it easier for women to be able to continue [breast-feeding]. They wouldn't get that support if they had to drive 45 minutes to see the doctor. They can't get an appointment right away. We come to them instead."

As female care providers, midwives also respond to women's desire to be in the care of a woman. Research evidence is clear that women prefer to be cared for by women when possible.³⁷⁻³⁹ In this study, gender was frequently cited as one of the motivating factors behind women's selection of maternity care practitioner. Yet in 1998 in Canada, the rural generalist physician was 2.8 times more likely to be male than female.³³ Johnston suggests, "Rural women are a practical lot and are grateful if they can get any medical care. For them, there is little use in preferring a female doctor if it means money and time they can ill afford on a trip to the city."³⁸ Yet she goes on to argue that it is especially helpful to rural women to have a care provider with whom they are comfortable, because they are more likely in a small community to have frequent and sustained contact with their physician, not only in clinical settings but also socially or unexpectedly on the street.

b) By how they care

Midwives offer care well-suited to rural women not just by being present in rural communities, but also by how they provide care in those contexts. There is considerable literature documenting what women want in terms of their perinatal care.^{21,40-52} Independent of their chosen maternity care provider, women consistently identify choice, control, personal treatment, sufficient time, respectful support, involvement in decision-making, clear communication with full disclosure, and continuity of care as being important to their pregnancy, birth and postpartum experiences. These preferences were clearly reflected in this study, and the midwifery model of care was reported to be the approach best suited to providing that kind of care.

Although such preferences apply to women living in rural and non-rural locations, participants cited specific reasons why midwifery is of particular benefit to rural populations. First, midwives are especially helpful to rural women because of their willingness to travel to where their clients live. Not only were midwives' home visits appreciated for their convenience, but at times they facilitated women getting access to care at all. In the absence of rural public transit, many women in this study lacked daytime transportation. Asking for rides is burdensome, as are the costs of gas and parking to go to the city, particularly for economically vulnerable rural clients. For some, this meant going to pre- and postnatal appointments less frequently. As one mother said, "Having the midwife able come out here made such a big difference, because I couldn't always make it in to her." Interestingly, physicians reported no difference in their practice style as a result of their patients living rurally, since their patients come to them. For midwives, serving a rural clientele has far-reaching implications on their time and approach to practice.

Midwives' home visits also lower the stress of new mothers. Mothers appreciated not having to drive with a new baby, particularly on slippery winter roads, or to worry about child care for older children, which several described as "a really big issue." Midwives' willingness to attend home births was reported to be especially helpful for rural women with precipitous labours, who would not have made it to the hospital on time.

Providing in-home care also facilitates midwives' becoming aware of women's needs that might otherwise go unnoticed. Midwives reported cases of depression, neglect and abuse being detected earlier as a result of being physically present in a woman's home. As one midwife said, "We have access to the home situation that doctors don't see." These problems are less likely to be reported or addressed if the woman herself must take the initiative to do so. While this is potentially true for all women, it is particularly salient in rural situations characterized by increased social and geographic isolation, where violence may be more frequent.^{53,54}

Even when midwives cannot be physically present, they offer care more readily over the telephone. This was one difference between physician and midwifery care most frequently cited as helpful by women and midwives alike. As one midwife said,

The use of the telephone becomes very important when distances are great... We have to work really hard to develop our skills to be able to communicate with people and get information and give information over the phone; also to set our limits to know at what point do we have to then get in our cars and go out to that woman, or ask that women to come into the hospital or a clinic.

Another aspect of the midwifery model of care that suits rural women's realities well is the emphasis on building a relationship between practitioner and client. "She took time to listen and answer my questions" was a common refrain of midwifery clients. Offering longer appointments is of particular benefit to rural women, who might otherwise lack ready access to health information. Prenatal education classes, for instance, were only occasionally available locally. Adolescent mothers were especially appreciative, since midwifery appointments provided them with a supportive environment and helpful information during a time otherwise characterized by stigma and isolation.

Longer appointments also serve to build trust between midwives and clients. Such trust is of particular importance in small communities because of the difficulties women often experience achieving confidentiality in their health care.⁵⁵ Moreover, the shortage of local health care providers has undermined the stability of relationships between practitioners and patients, since people have had to travel for care, or to rely on a rotation of locum physicians. Women in this study spoke clearly of the importance of trust and relationship to quality of care, regardless of their chosen care provider. For midwifery clients, that trust developed more quickly because of the extended time spent together.

SITES OF RESISTANCE TO RURAL MIDWIFERY

Although these examples demonstrate that midwifery care is well-suited to rural women's needs and preferences, participants also shared examples of midwifery being resisted in rural contexts. At times the resistance was not openly discussed, but it was evident to varying degrees among doctors, clients, and midwives themselves. A thorough analysis of the extent to which these barriers are specific to rural populations was beyond the scope of this study, but they warrant mention here because of their implications for practitioners and policy makers.

There was considerable variation in the extent to which physicians were comfortable referring their low risk patients to midwives. According to physicians and their patients, reasons for not making such referrals included not being aware of the availability or scope of midwifery services, not being confident in the ability of midwives to provide adequate care, and preferring to refer patients to another physician colleague. In a few cases, physicians were referring their patients to midwives only because there was no one else locally available to provide maternity care services.

Several women reported not realizing that midwifery was covered by Ministry of Health funding, confusing midwives with private doulas, or thinking that midwifery care could only be accessed for home births. Some women were not aware that midwifery services were even available. According to one, "It was something that was never mentioned. I really wish it had been." In one case, the local midwifery practice was too full to accommodate one woman, even though she was only eight weeks pregnant when she called.

All three of the midwifery practice groups involved in this study were accustomed and committed to providing care to rural clients. As one midwife said, "We have this model of care and we're accountable to provide that. We can't just give rural women part of it, even though it's inconvenient for us." Some midwives commented on the difficulties of offering rural care, particularly in terms of driving time, compensation, and caseload maintenance. One described it this way,

When you have a rural community, you don't have the same level of caseload that you do in an urban community, so in order to put a group of midwives together, which you need in order to be able to work effectively and not burn out and be available all the time, how do you get a group of midwives into a community that will maybe support one? The way that we've done it is that we have been committed to serving a very large area... the challenges are mostly for us. We try not to allow the clients to feel the challenge but for us it means we have to be prepared to drive great distances.

Midwives also reported lacking the backup required for them to provide safe care around the clock in rural areas, specifically in terms of timely ambulance service and access to obstetricians, anesthetists and surgeons. As one midwife reported, "We need fairly close access to a level two hospital with surgical, obstetric and pediatric backup. The bottom line is that we need the specialist backup to be able to support our clients to have babies in that community. Without it, it's very hard to expect us to be there."

IMPLICATIONS FOR PRACTITIONERS AND POLICY MAKERS

Rural women in this study were unequivocal in their support for midwifery in their communities. In response, maintaining and expanding midwifery's presence in rural areas will require an extra level of commitment from practitioners and policy makers. Midwives' willingness to offer care over the telephone, to drive, and to be present with women is what sets them apart from other rural maternity care providers. As one midwifery client said,

"[Doctors] don't seem to calm you down the same. You can't get them at any hour of the day. So [my midwife] made me feel better, knowing she was there." Midwives must therefore remain committed to maintaining such accessibility, since it provides an extremely valuable service to rural women.

Another dimension of accessibility is accurate information; without awareness that midwifery services are available, women will not access them. Rurality can affect women's awareness of choices, and ability to act on them, in contradictory ways. Awareness of health options may be constrained by such factors as thin social networks, limited Internet access, lower than average education levels and a rapidly changing mixture of service options. Physicians may resist informing their patients about midwifery services. There may also be more at stake for women in small, close-knit communities in choosing "alternative" care. Yet when clients have a positive experience, they can enhance the reputation of midwives very quickly by word-of-mouth in small places. All of the midwifery clients in this study heard about midwives from friends or family members. It is incumbent upon midwives' to make every effort to dispel the myths about their services and to make their benefits widely known.

It is also important for midwives to forge strong linkages with other local community services and care providers. First, because midwives' direct access to women's homes positions them well to detect those struggling with depression or abuse, midwives must be well equipped to perceive when women are in trouble and to make timely and appropriate referrals to help them. Second, despite their scarcity, physicians remain among rural women's primary sources of health information. Midwives are more likely to maintain a manageable rural caseload if they are obtaining referrals from local physicians. This requires intentionally strengthening interprofessional collegiality, especially in small communities heavily reliant on face-to-face relationships and word-of-mouth. Third, midwives need strong backup from other health professionals. Availability of emergency personnel, nurses and specialists is often the limiting factor for midwives seeking to provide consistent rural service.

The extra time and driving required to provide rural midwifery care can be exhausting. Living with the unpredictable, around-the-clock intrusions of a pager is difficult to sustain anywhere, and in rural areas, the potential for burnout is even more pronounced due to professional, social and cultural isolation. Professional burnout is being addressed within many health professions. For instance, the literature on rural physician retention is extensive, and it highlights challenges related to educational preparation, lifestyle concerns and disincentives inherent in rural living that are equally applicable to midwives and other rural health care professionals.^{7,30,33,56,57} Rural midwifery can only realistically be sustained to the extent that midwives, and their professional associations, continue to find ways to make the lifestyle and workload of rural midwives tenable over the long-term. Integrated, interdisciplinary care models involving physicians, nurses and midwives should be explored further.^{62,63}

Midwives also need the support of those who develop midwifery policy in order to make rural practice sustainable. This means,

first and foremost, acknowledging that rural practice is different. As one rural midwife expressed, "To deliver rural health care takes more time; somebody powerful needs to say that." Practices and policies developed with urban midwifery in mind often do not fit with the realities of rural life and practice. Rural-specific requirements include remunerating rural midwives sufficiently to cover the overt and hidden costs (e.g. travel time, telephone) of providing high quality rural care. Caseload expectations and catchment area sizes should be adjusted to reflect the longer distances and travelling times in rural places. Expectations regarding second attendants and appropriate backup should also be flexible enough to reflect the scarcity of health care providers in rural locations.

Increasing the supply of midwives is also necessary. Rural midwives, with vast catchment areas, are straining to provide service, to train new midwives, and to become integrated into the communities they serve. Moreover, midwives are not evenly distributed, resulting in some areas having virtually no access to licensed midwives at all. Distribution is a function of both supply and demand; midwives are in scarce supply, but they are also encouraged to locate their practices in areas where consumer demand has been highest. This can work against rural areas where population density is low. As a result, the onus is on government officials, health planners, educators, health providers and rural communities to ensure that all rural residents have access to the benefits of midwifery care.

Midwives could also consider working toward an expanded scope of practice. Rural women need and appreciate local care; having to travel elsewhere for care is costly in terms of money, time, social disruption and convenience. Midwives already present in rural communities could be trained to provide a wider range of much needed services, such as prenatal education classes, rural prenatal clinics, well-baby check-ups, well-woman check-ups and lactation consulting. In Britain, for example, a successful pilot project has community-based midwifery-led clinics providing local perinatal care to all women, not just those identified as low risk. Seventy percent of those with initial complications were able to have half of their prenatal checks in their home community, with fewer routine hospital checks. Women needing to seek care at regional hospitals were transferred back into community care once their problems were rectified.⁵⁸ This model of shared care requires strong cooperation and resource sharing, but demonstrates that experimentation can be effective in making maternity care services more accessible and appropriate to rural women. Compensating midwives for a wider range of services might also serve to address problems of low rural population density, making midwifery services more affordable in smaller places.

CONCLUSION

Providing maternity care to rural women is costly. It frequently requires midwives to drive longer distances, stretch their catchment boundaries, take more time providing services and make complicated backup arrangements. With midwifery services in such high demand, are these extra costs of rural midwifery care worth incurring? Based on the experiences of the women in this study, that question must be answered in the affirmative, for three reasons.

First, making midwifery services available to rural women is part of fulfilling midwives' commitment to providing accessible, appropriate maternity care characterized by informed choice. Expanded rural midwifery care adds to maternity care choices available to rural women, strengthens their capacity to be informed health care consumers, and offers an approach to care consistent with what many women are seeking. It supports the objective set out in the "Joint Position Paper on Rural Maternity Care", which states, "Every woman in Canada who resides in a rural community should be able to obtain quality maternity care as close to home as possible. Whenever feasible she should give birth in her own community within the supportive circle of her family and friends."⁵⁹

Second, midwives' role in enhancing the local availability of rural maternity care contributes to the sustainability of rural communities. There is both practical and symbolic importance to the provision of basic health services, wherein threats to local health care services can be seen as an assault to the community itself.⁶⁰⁻⁶² Conversely, the continued availability of health services can serve an important role in contributing to a strong sense of place and an ongoing commitment to building a thriving community.

Finally, the women's stories captured here categorically affirm women's strong support for rural midwifery services. Without exception, every midwifery client spoke highly of the care she received. Clients described being "very, very pleased," the midwives being "totally supportive," and experiencing "a sense of loss when [they] didn't see [the midwives] anymore." As one mother said, "I don't know what I would have done without them." Even specialist clients were positive about midwives. As one said, "It's something to consider for the next time, because I've heard nothing but good stuff about them. People that have had [midwifery] once say, 'I'd do that again any day!' So there's got to be something there." Although rural midwifery is at times difficult and costly, it is a service that is both strongly needed and deeply appreciated. It is therefore well worth the investment.

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FOOTNOTES

ⁱFor a detailed report on the complete findings of the study see Sutherns R (2001) "Women's experiences of maternity care in rural Ontario: do doctors matter?" PhD dissertation, University of Guelph.

ⁱⁱOne interview was conducted at a local restaurant. Participants also completed a brief demographic survey. The consent form, demographic survey and interview guide were subject to ethics review and approval at the University of Guelph.

ⁱⁱⁱAboriginal and Old Order Mennonite women are important members of many rural Ontario communities. They were explicitly excluded from this study because of the uniqueness of their birth cultures. Their inclusion would have introduced race and culture into the analysis in a more meaningful way.

^{iv}For a brief discussion of health determinants see Health Canada's web site at <http://www.hc-sc.gc.ca/hppb/phdd/determinants/index.html#determinants>

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