BEING "SENT DOWN": BIRTHING EXPERIENCES OF RURAL PREGNANT WOMEN

by

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A Thesis Submitted in Partial Fulfilment of the Requirements for the Degree of

MASTER OF NURSING

in the Faculty of Human and Social Development

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ABSTRACT

In many rural communities of BC, the practice is to have pregnant women leave their home community to deliver in another community. This study used a critical feminist ethnographic approach to examine the culture of rural birthing practices as it relates to having women relocate to give birth.

Interviews with health care providers and rural women, and documentary analysis illustrated how urbanization of childbirth was seen as providing "the best possible" birthing care. Findings show that the decision-making process about the location and timing of relocation for delivery illuminated the power relations that exist between pregnant women and their health care providers. Findings also show that there were very few opportunities for the rural women to question the practice of relocation for delivery. When the women attempted to question this practice, the discussion was shut down by limiting it to risk discourse. As a consequence of current rural birthing practices relating to the urbanization of birth, a heightened sense of risk is attached to rural pregnancy compared to an urban pregnancy.

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Acknowledgements

This thesis would not have been possible without help from various people. I would like to acknowledge Colleen Varcoe, my thesis supervisor, whose enthusiasm and words of encouragement were immeasurably helpful to the completion of this thesis. I would also like to thank my committee members – Mary Ellen Purkis, Elaine Carty, and Kathy Teghtsoonian for all their help, suggestions, and support during this challenging journey of completing my thesis.

Finally a special thanks to the women who participated in this study. Without their involvement this thesis would not have happened.

Dedication

This thesis is written in loving memory of
Anneliese "Lisa" Hlavac

Chapter 1

Introduction

Currently in BC, many small towns do not offer local maternity services, or such services are threatened with closure (Howard, 2002; Hutten-Czapski, 1998c; Iglesias, 1999; Rourke, 1998; Sawchuck, 1998). As a result, labour and delivery care is rarely offered in rural communities and in some places is non-existent. Rural health providers give prenatal care locally but refer women to city doctors for delivery services. Today, out-of-community births are the norm for women living in rural communities throughout BC, including the northern portion of Vancouver Island (Grzybowski, Cadesky and Hogg, 1991; Hutten-Czapski, 1998; Iglesias, 1998; Iglesias, Grzybowski, Klein, Gagne & Lalonde, 1998; Lambrew & Ricketts, 1993; Rourke, 1998). Relocation for childbirth usually involves staying away from home for at least two weeks prior to the expected due date. This has significant social and personal implications, possibly leading to financial, social, and emotional stresses for women and their families. These trends can be understood within the twin frames of biomedical dominance and the evolving role of the state in health care, with particular emphasis on recent trends in health care reform.

A tension exists between actual and perceived risks associated with rural community birthing. Several factors, including limited financial resources, rural practitioners' availability and competence (actual or perceived), access to technically complex equipment and specialized staff, and the universal quest for a healthy baby, have contributed to the reduction of obstetric services in rural

areas. And yet, available evidence suggests that the provision of local maternity care, with or without local Caesarean section capability, offers better birthing outcomes for rural pregnant women. There is an increase in complications for newborns and the number of premature infants with out-of-community childbirth (Klein, Johnston, Christilaw & Carty, 2002). Evidence suggests that rural women experience shorter labours and better pain control when delivering locally (Nesbett, Connell, Hart & Rosenblatt, 1990). In contrast, rural women experience poorer birthing outcomes when out of their communities.

Background to the Problem

A discussion of the centralization of maternity care in urban communities requires an examination of what is meant by the term "rural" and how this impacts health care, particularly reproductive health. About eight percent of the population of British Columbia lives in rural or remote areas of the province (The British Columbia Royal Commission on Health Care and Costs, 1991). Defining what is rural has been difficult due to a lack of agreement about what constitutes “ruralness” (Hornberger & Kockleman Cobb, 1998). It is too simplistic to define rural as “non-urban”. Defining rural on the basis of total population and population density that is less than a specified threshold, is also seen as not capturing the true meaning of "rural" (Hornberger & Kockleman Cobb, 1998; Ramp, 1999; The British Columbia Royal Commission on Health Care and Costs, 1991; Troughton, 1999). Rather it is argued that multiple definitions should exist, as the rural contexts for individual communities are so very diverse (Hornberger & Kockleman Cobb, 1998; The British Columbia Royal Commission on Health

Care and Costs, 1991; Troughton, 1999). Ramp (1999) defines rural "...not just as a geographical area or an administrative demarcation, but as a living fabric of history, culture, social relations, economies and politics in which people strive to build and preserve communities, civic responsibility, and family well-being" (p. 1).

Rural communities dominated throughout BC until about half a century ago. During this period, many of these communities had doctors, dentists, nurses, and could sustain a small hospital (Troughton, 1999). Today this is not the case for most rural communities in BC. Rural communities' abilities to deliver quality health care are questioned. There has been a loss of resources due to a decrease in government spending in health care resulting in widespread concern for the sustainability of rural health care to respond to the demands placed upon it, particularly in the area of reproductive care. As a result of the evolving role of the state in health care, fiscal restraint has become a valued strategy for governments to demonstrate that small hospitals are not sustainable (Hornberger & Kockleman Cobb, 1998; The British Columbia Royal Commission on Health Care and Costs, 1991; Troughton, 1999). The discourse of "unsustainability" is enacted to justify the decline in or lack of rural heath care spending by the state. This sets the stage for centralizing maternity care to urban areas contributing to the gradual and continuous loss of rural maternity care.

Since the 1950s "...the federal government has become involved in health care by sharing the cost of programs and thus steering the health care system" (Shah, 1998, p. 311). Given that the Canadian health care system is governmentally funded a link can be established between the state and the

health care system. As a result of this link, the state influences the delivery of health care. So when the state reduces funding to health care, the health system's response is to reduce or cut health services and programs. In the case of rural health care delivery this means that reproductive care is often the first to be reduced or eliminated. In the context of reducing health care costs, the state imposes control over the types of health programs and services offered. The state is increasingly responsible for health care.

Issues of access to and quality of health care are central to the shaping and delivery of rural health care. The inherent difficulties caused by remoteness and the widely dispersed population are compounded by the current shortage of medical professionals[1] working in rural health, lack of health services, and fewer, smaller hospital facilities (Troughton, 1999).

Limited access to health care services is due in large part to issues of geographical distance and terrain, sparse and small clusters of populations, and climate (Leipert, 1999). As a result, many services that are easily accessible to persons living in urban centres are not available to persons living in rural areas of BC. A person residing in a rural community must travel and incur costs associated with traveling in order to access health care services which are readily available to persons living in urban communities.

The perception that the quality of medical care in a rural BC community is less than the quality of care in an urban or metropolitan area negatively impacts

[1] The use of the term health professionals refers to physicians, nurses, and community health representatives (CHR). First Nations communities employ CHR's to assist with the delivery of health care in the First Nations communities. They work with public health nurses in the delivery of culturally sensitive health programs.

rural health care. Urban health care is seen to ensure access to the latest medical equipment and technology, medical specialists, and specialized treatments which are not available locally in rural communities. Scott (1999) describes rural health care delivery as "...the weakest link in the system" (p. 179). Factors such as decreases in medical and hospital funding and changing patient populations prevent small rural hospitals from providing basic medical care (The British Columbia Royal Commission on Health Care and Costs, 1991). Consequently, the potential to receive good quality medical care may be less for a person residing in a rural community than for a person in an urban one. This may be a contributing factor to rural areas having the highest infant mortality and teenager pregnancy rates in the province (Leipert, 1999; The British Columbia Royal Commission on Health Care and Costs, 1991).

Further contributing to the perception that small rural hospitals are not as good as larger urban hospitals is the visibility of a small hospital's mistakes or inability to handle complicated cases, resulting in having to transfer these cases out. About one fifth of rural patients are referred out to larger urban centers (The British Columbia Royal Commission on Health Care and Costs, 1991). Since these transfers from small rural hospitals to large urban ones are often based on not being able to provide a particular type of care needed, deficiencies in quality are implied. By contrast, transfers from one large urban hospital to another are not seen in the same way as transfers from a small hospital to a large one. Transfers between two large centers are seen as providing access to specialized services or care which the referring hospital does not have. There are no

implications of lack of service quality at the referring hospital. The same holds true for maternity services and care. Rural maternity care is seen to be not as good as urban care. Childbirth care in urban communities is preferred and considered best for the health and well-being of the unborn child and rural mother.

Health care in Canada.

This next section will briefly provide an overview of the organization of delivery of the Canadian health care system and discuss its implications on the accessibility of maternity care in Canada. The Canadian health care system is "...unique among all industrialized nations because it combines a system of private service delivery (where health providers are self-employed rather than employees of the state) with publicly financed care through a single-source provincial government payer" (Shah, 1999, p. 283).

In the mid 1980s, the federal government enactment of the *Canadian Health Act* in response to concerns about accessibility of services due to extra billing. Funding is transferred from the federal government to the provincial governments with federal guidelines attached. As a result of enacting this act the federal government has an increase role in Canadian health care particularly in the area monitoring and enforcing program conditions (Shah, 1999).

Though this act promotes universal access to health care, this is not always the case in practice. In the 1990s there has been a marked reduction in funding for health and social welfare from the federal to provincial governments (Benoit, Carroll & Millar, 2002; Shah, 1999). In response to the fiscal

considerations and concerns about increases in health care costs the health care system has had to restructure. In an attempt to balance the needs of governments, health care system, providers, and clients compromises have been made. As a result health ministries have reduced spending and deemed some health services as 'non-essential' or attempted to centralize or regionalize health services. "Many health activists and researcher are concerned about whether these and other developments will threaten the principle of accessibility, arguing that they inevitably weaken health services to women and other vulnerable members of our society" (Benoit, Carroll & Millar, 2002, p.374).

Maternity care in Canada.

Obstetricians, family physicians, community health nurses provide maternity care, at no cost to the women in Canada. Costs for maternity health services are provided by the Medicare system. Prior to the 1990s,

> "labour coaches/doulas and midwives worked unregulated in private health sector, offering alternative services to birthing women who were dissatisfied with the mainstream system. Initially these substitute services were offered for free or for exchange of services in kind. Eventually, out-of-pocket monetary payments were applied, in some cases on a sliding scale depending on the birthing woman's ability to pay" (Benoit, Carroll & Millar, 2002, p. 374).

In the 1990s, midwifery services were legalized in six provinces, including the province of BC (Benoit, Carroll & Millar, 2002; Kornelsen, 2000). Midwifery services are now integrated into the health care system affording them the same rights and responsibilities as family physicians. The province of BC is one of the four provinces that provide public funds to cover midwifery services.

Despite significant changes to the health care system particularly with maternity care, systemic barriers still impede access to maternity services. The province of BC has experienced a significant decrease of family physicians attending births. There is a similar trend with midwives resulting in not having enough to meet the demands (Howard, 2002). For women residing in rural communities, the issues are compounded as they tend to have limited or no access to health care providers providing obstetrical services. Within this context, rural women tend to be under serviced as it relates to maternity services. Though there have been efforts to improve accessibility to health care through various health acts and the legalization of midwives, this is not always the case for rural pregnant women. In fact health services both nationally and in the province of BC as it relates to maternity care have increasingly been centralized. For rural communities this also includes the act of urbanizing of some health services.

Birthing practices on northern Vancouver Island.

It is widely recognized that there is a crisis in maternity care in rural Canada. This applies to rural British Columbia, as well, where there are about 30 hospitals that do not offer maternity services or have Caesarean section capability (British Columbia Reproductive Care Program, 2000). In many rural other areas of the province, local maternity units are threatened with closure. More than a third of rural facilities in British Columbia participating in the Rural Obstetrics Survey (Sawchuck, 1998) indicated being at risk for losing obstetric services in the near future. The trend to reduce rural obstetrical services in BC

continues in the current political conditions of fiscal restraint and restructuring of the health care system. For rural pregnant women this means, at best, an inconvenience as a result of relocating to another community for birth. More likely, it will mean significant social, emotional, and financial hardships and even a reduction in good perinatal outcomes.

The maternity practices on northern Vancouver Island are consistent with the current provincial trend to centralize maternity care into urban areas. Pregnant women residing there are offered limited maternity care. Prenatal care is available to women residing in the area. Until recently, local labour and delivery care was offered only to women with pregnancies deemed low risk. Only women pregnant for the first time or those whose pregnancies were assigned a medium-to-high risk status were relocated to another community for childbirth. However in the last few months, the Vancouver Island Health Authority (VIHA) temporary suspended all labour and delivery services on northern Vancouver Island. In a recent news release the following reason was provided for the suspension of childbirth services, "[p]atient safety is our first priority, Rick Roger, VIHA chief executive officer, said ...we will work closely with our nurses, doctors and our stakeholders to plan the safest care we can for moms and their babies" (Allan, 2003, p. 1). Notwithstanding this withdrawal of childbirth services, there will always be a small proportion of deliveries on the North Island - women presenting to hospital with emergent maternity problems, or in full labour, having refused to relocate for delivery.

The process of relocation involves both the woman and her rural practitioner. Though no formal process exists in the form of policies or procedures, the woman identifies a community for childbirth and the physician refers the woman to a general practitioner in that area. The rural practitioner refers the woman during her third trimester to meet with the new physician. If the pregnant woman experiences any prenatal complications she is referred to an obstetrician at that time and often remains under the obstetrician's care for the remainder of her pregnancy. If there are no complications or problems with the woman's pregnancy, then she usually relocates for childbirth about two weeks before her due date. During this time, she meets once more with the practitioner who will be attending to her birth.

Should a woman delivering locally require relocation during childbirth due to a complication arising during her labour, the attending practitioner arranges emergency medical transfer to a larger facility with Caesarean section capability. This process involves the rural practitioner consulting with an obstetrician and organizing emergency medical transportation for the labouring woman. Depending on the level of urgency assigned to the situation, the woman will travel by ambulance or helicopter to the larger facility. Her partner is not always able to travel along with her and must arrange his/her own transportation to the receiving facility. Organization of the transfer and transport of the labouring woman can take several hours or even longer, depending on the availability of the obstetrician, operating room and its staff, and a vacant bed at the receiving facility, and may be further complicated by poor weather conditions.

Birthing practices of the Kwakwaka'wakw people.

Although First Nations birthing practices were not my main focus of interest, the Kwakwaka'wakw people account for a large portion of the population of the study area. Therefore, a brief review of their traditional birthing practices and how they have changed will help to further understanding of rural birthing practices on northern Vancouver Island.

Traditionally, the Kwakwaka'wakw people sought out healing and cures for illnesses from healers or shamans (Codere, 1966; Culhane Speck, 1987). "Shamans were believed to have obtained, from supernatural sources, power over life and death which allowed them to either cause illness or to cure it" (Culhane Speck, 1987, p. 69). Treatments for illness involved the specialized use of natural medicines from plants, prayers, and rituals. Shamans did not have a role in childbirth. Childbirth was attended by community midwives. Community midwives were Kwakwaka'wakw women who were taught the necessary skills and understanding from listening and watching other skilled midwives. The labouring woman with the assistance of one or two midwives or "ma'mayutse'aenox" would deliver the child into a cedar-lined pit (Codere, 1966).

With the building of a hospital facility in Alert Bay in 1909, the Kwakwaka'wakw women started to deliver their babies in the local hospital attended by physicians (Culhane Speck, 1987). In his autobiography, James Sewid, a Kwakiutl First Nations member, makes reference to his pregnant wife temporarily relocating to Alert Bay in the early 1940s from her home in Village Island to await the delivery of her babies (Spradley, 1969). This suggests that in

a relatively short period of time, First Nations women in the northern part of Vancouver Island went from having a First Nations midwife attend to their births to physician-attended births in a hospital. After this, First Nations babies were predominantly delivered in hospital settings attended by medical professionals, and community midwives were attending to fewer births. Consequently, community midwives became obsolete and today there are no practicing Kwakwaka'wakw community midwives in the north part of Vancouver Island.

Researcher's Interest in Understanding Rural Birthing Practices

My interest in understanding rural birthing practices stems from my nursing practice in several small rural communities in British Columbia. I first encountered resistance to local birthing while working in a small rural hospital in a coastal First Nations community. The nurses and physicians expressed strong resistance against women delivering within the community. For example, when a pregnant woman presented in active labour to the small hospital's emergency room, the health care providers met the woman with scorn. It was common practice when a woman presented in active labour to immediately arrange for air ambulance to fly her out if she was not too far along. In this particular community, the primary focus of childbirth care was on arranging the medical evacuation rather than on the labouring woman and her delivery experience. Often the women ended up delivering without any complications before medical evacuation could be organized.

An instance of a woman actively ignoring her physician's advice to leave the community further demonstrated the lack of support on the part of the

medical team for local rural births. A pregnant woman believed to have left the community to await the delivery of her baby, arrived at the hospital in active labour. Choosing to deliver locally, she had avoided the medical staff and had not sought care from the local medical community from the date she was scheduled to leave, which was about two weeks prior to her due date, until immediately prior to her due date. Upon presenting at the hospital, the woman was met with comments that implied her decision was irresponsible and selfish and that she did not exercise good judgment. The need for the extreme measure of "going underground" in order to experience a local birth further sparked my interest in understanding what rural birthing practices were really about.

Further, while I was working as a community health nurse in a small rural community on northern Vancouver Island, pregnant women often expressed ambiguity around birthing location. The women often made contradictory statements about wanting to deliver locally and then not wanting to. Their statements indicated a perception that local deliveries placed babies at a greater risk of harm than if the delivery occurred in an urban setting. In connection to this, First Nations Elders—many of whom delivered their own children locally—indicated that rural deliveries were riskier than urban ones. The perceptions of risk and risk reduction strongly influenced attitudes to rural maternity care.

The contradictory feelings and opinions about delivering locally or leaving for childbirth, the attitudes of the health care providers, birthing women, and their families, as well as my own experiences in both hospital and community nursing have led to my interest in developing an understanding of the broader context

that frames current rural birthing practices. From such an understanding a platform to encourage and create quality rural maternity care practices may be developed.

Research Questions

Studies indicate that small rural hospitals in British Columbia can provide safe and appropriate childbirth care (Grzybowski, 1998; Grzybowski et al., 1991; Hutten-Czapski, 1998a; Hutten-Czapski, 1998b; Hutten-Czapski, 1998c; Iglesias, 1998; Iglesias, 1999; Iglesias et al., 1998; Lambrew & Ricketts, 1993; Rourke, 1998; Sawchuck, 1998). In fact this literature indicates that decreasing the availability of rural obstetrical services results in poorer birthing outcomes and increased health care costs.

The practice of temporarily relocating for delivery has a significant impact on the lives of rural women, their families, and community. "...[R]emoving access and forcing women to travel longer and longer distances to give birth, [is resulting in] B.C. becoming a Third World country with first-aid stations instead of rural hospitals" (Howard, 2002, p. 19). Thus there is a need to examine the impact of these birthing practices.

Much of the available research focuses on the clinical aspects of pregnancy and childbirth. With the exception of studies on issues of safety of rural obstetrics, none focus on the impact of out-of-community birthing on pregnant women. It is my opinion that childbirth is much more than a technological event that is always better managed in technology-equipped medical facilities. Because childbirth is about emotional, social, family, and

community issues, birthing practices ought to incorporate more then just a fetus-centred approach to care. My interest was to develop a fuller understanding as to why and how the current birthing practice in rural communities evolved. This included identifying the rules surrounding this practice of centralizing maternity care in urban centers, identifying where the decision-making power rested, and investigating how these practices affect a woman's beliefs, values, and experience of her pregnancy. I was interested in developing an understanding of the rural pregnant woman's world as she experiences it. In particular, I wished to understand how the women affected see and make meaning of the practice of relocation for childbirth. I wanted to create a more knowledgeable base for nursing practices related to rural reproductive care, particularly as it relates to relocation for childbirth. The central research question was: *What are the impacts of rural birthing practice as it relates to having pregnant women temporarily uprooted from their home community to deliver in another community?* Other questions that were examined include*: How have the current rural birthing practices evolved; how are decisions about location and timing of delivery accomplished; and what happens if a woman resists?*

A rich understanding of the impact of urban birthing on rural women can be best captured by a qualitative approach and therefore that was the methodology chosen for this study. This approach allows for an examination and analysis of a complex system of values, beliefs, and knowledge, and the impact of these on socially organized actions such as health care delivery.

In the next chapter, literature and background information relevant to the understanding of rural birthing practices in BC will be reviewed. The third chapter provides the study's methodological approach to inquiry, while the fourth chapter examines the study's findings. The last chapter discusses the study's findings as they relate to the literature and their implications for nursing practice and policy.

Chapter 2

Literature Review

In this chapter, literature arising from the areas of women's health, nursing, midwifery, rural health, and childbirth is reviewed to provide an overview of what is known about rural birthing practices. The focus of this literature review is to develop a conceptual understanding of childbirth practices, as they relate to rural birthing practices in BC. The current rural reproductive practice of urban birthing can not be considered without considering the changing meaning given to childbirth in society, the location in which it takes place, and the surrounding cultural and political climate within the study area – Northern Vancouver Island.

This chapter attempts to frame the picture of this study of rural reproductive care by examining social, historical, structural and cultural factors. These factors describe the medicalization of childbirth which resulted in the shift from midwife to physician providers; the urbanization of hospital care and its effects on rural health care; medical and technological specialization and concentration; the linkage of reproduction with pathology; real and perceived risk and risk management; woman-centred health care; and the possible impacts of class, race, and gender on rural birthing practices. This examination will create a framework that is fundamental for an understanding of the current urbanization of childbirth.

This review of empirical and theoretical literature will provide a background for further understanding of the effects on women and their families of the rural birthing practice of relocating to another community for childbirth.

This review will also assist in using this study to develop nursing policy in the practice area specific to rural maternity care.

Providers of Reproductive Care—From Midwife to Physician

In order to develop an understanding of the urbanization of reproductive care, the changes that have occurred in providers of reproductive care must be taken into account. This will illustrate the complexities that frame the current practice of having rural women relocate to an urban community for childbirth.

Significant changes in the management of childbirth have occurred over the past century. Up to about a century ago throughout North America, reproduction was defined as a natural occurring process rather than a state of potential disease (Arney, 1982; Nelson & Robinson, 1999; Oakley, 1984; Oberman & Josselson, 1996). At the turn of the twentieth century, midwife-attended births dominated in Canada, and throughout the world (Cahill, 2001; Kornelsen, 2000). Midwives were women who developed their knowledge and skill informally through observation and apprenticeship with other midwives (Cahill, 2001). Midwives attended to births which occurred in a home setting—the private sphere. Hospital births were rare, if not non-existent. Women birthing within their own homes was the predominant birthing practice.

A shift in the management of reproduction from midwife to physician began to occur with the formalization of medical practice. Significant changes in the delivery of childbirth care resulted when the medical professional began to intervene in the birthing process (Walzer Levitt, 1983). The organizational developments of medicine in the last half of the nineteenth century led to

establishing childbirth as part of the domain of medicine. By the early 1900s, midwives were delivering about 50 percent of all babies, mostly in rural areas in the US, as was the case in Canada as well (Arney, 1982). The creation of obstetrics as a specialty within the profession of medicine reinforced to the public the notions of childbirth as dangerous and of the physician as expert.

> The transition to [physician] attendants occurred so easily among advantaged urban women that it can only be explained by understanding the women's impression that physicians knew more than midwives about the birth process and about what to do if things went wrong. (Walzer Levitt, 1983, p. 283)

The involvement of the medical profession in childbirth occurred very rapidly; within less than forty years childbirth care shifted almost exclusively to care by medical practitioners (Arney, 1982; Oakley, 1984). Increased frequency of births in hospital settings occurred with the increased involvement of the physician. As a result of increased physician involvement, pregnancy care moved into the public sphere. With the shift of childbirth care from the private to the public sphere, the social experience of childbirth was altered, setting the stage for acceptance of medical intervention (Hunt & Symonds, 1995). Women's childbirth experiences underwent a cultural and structural change.

Maternity Care in Canada – Fall and Rise of Midwifery

This next section will briefly discuss maternity care in Canada with a specific focus on the integration of midwifery services into the health care system. The rebirth of midwifery into the Canadian health care system is a fairly recent occurrence that has resulted from both consumer and government

support. Though the integration of midwives into the health care system has occurred over a short period of time, it has not been easy.

Before the turn of the 20th century, midwives were the predominant attendants at childbirth in Canada as in other parts of the world (Bourgeault, 2000; Kornelsen, 2000). The entrance of physicians into the practice of birthing resulted in the fall of midwifery in Canada. Though today reproductive care throughout Canada is primarily provided by physicians in hospital settings there is a relatively new resurgence of midwifery once again. The lack of legally recognizing midwives gave "...Canada... the dubious distinction of being the only Western industrialized nation not to have any formal provisions for midwives to provide care to pregnant women" (Bourgeault, 2000, p. 172). Since the turn of the 20th Century to the early 1990s birthing options for Canadian women were limited to physician- attended births in hospital settings. Prior to the 1980s there were a small number of midwives in Canada and the practice of midwifery was neither legal or officially recognized (Bourgeault, 2000; Kornelsen, 2000).

The struggle to recognize and legitimize midwifery in Canada started in the 1980s when women wanted more that just the birthing option of a physician-attended hospital birth. The "...consumer backlash to medicalised childbirth, promoted most emphatically by the counterculture Home Birth Movement" contributed significantly to giving midwifery its legal recognition in Canada (Bourgeault, 2000, p. 173). The move to legitimize midwifery was further accelerated in 1991 when the Royal Commission on Health Care and Costs recommended that midwifery be legalized as this would cut costs in health care

spending. Offering midwifery services was seen as a key strategy by the state to decrease health care cost. As a result of the backlash by Canadian women to medicalized births and the government strategy to cut health care spending, midwifery was legalized and in some provinces – BC, Ontario, Quebec and Manitoba - publicly funded (Benoit et al., 2002; Kornelsen, 2000). Today, midwifery is once again reestablished in the health care system. However, in some provinces midwifery services are threatened with extinction once again, this time for a different reason.

In the provinces that do not provide public funded midwifery care, midwifery services are in a critical state. Many women are not able to afford to pay for midwifery services themselves and thus not accessing the services. This in turn makes it difficult for midwives to economically sustain their practice and overtime midwifery services are withdrawn as midwives close their practice (Bourgeault, 2002; Michaels, 2003). Just this past year "...one quarter of Alberta's midwives did not renew their registration...not because they wanted to stop practicing midwifery, but due to the lack of public funding" (Michaels, 2003, p.17). Though the federal government acknowledges that midwives are a valuable service, some provincial governments will not commit to public funding and thus are contributing to the crisis in maternity care.

Over a relatively short period of time, state support for midwifery practice occurred. Though on the one hand, state support has been an effective strategy in the rise of midwifery practice by legalizing the profession, it has in some areas contributes to the fall of midwifery through the lack of public funding. Midwifery

continues to seek a legitimate place in the Canadian medically dominated health care system.

Urbanization and Rural Maternity Care

The current practice in most rural communities in BC is to have first time and medium to high-risk pregnant women leave the community to deliver in hospitals in urban centres with physicians overseeing their care. The reasons for the urbanization of maternity services are complex. The end result of centralizing maternity care in urban areas has resulted in a shift in service delivery that exposes women and their babies to complications and threatens the sustainability of rural communities.

There have been several steps in the 'urbanization' of reproductive care. The first consists of the gradual redefinition of childbirth as pathological – requiring medical intervention; the second consists of the incorporation of risk discourse in perinatal care. In other words, risk is associated with virtually every pregnancy and risk can be predicted and reduced. This movement in reproductive care resulted in reconstructing pregnancy and childbirth so medical expertise is required and that this expertise has come to be represented as technical-medical knowledge. The dominant belief is that this "technological system of childbirth management" will result in "safely achiev[ing] motherhood" (Oakley, 1984, p. 237). For rural women this means an urban birth.

The urbanization of maternity care has resulted from a shift in ideology that urban medical care, particularly childbirth care, is more desirable than rural care. Urbanization of health care has occurred as technological techniques and

specialized equipment have been constructed as providing the safest level of care to ensure the well-being of the fetus[1] and the labouring woman. These expensive aspects of health care are concentrated in urban areas with large populations and correspondingly large hospitals. Those living in smaller, less populous centres with less elaborate facilities are likely to believe that in order to receive the best "treatment" they need access to highly technological and specialized medical care. However, while the specialists and equipment of urbanized healthcare concentrate on the safe production of a healthy fetus, other important aspects of childbirth are typically seen as less important: these aspects include the relationships and support systems within the family and community.

Despite evidence to the contrary, it is believed by rural women and health care providers that small rural hospitals are not able to provide as safe and appropriate care during the delivery and postnatal period as large urban hospitals. [2] Though the evidence from the professional literature suggests that rural hospitals can provide safe and appropriate childbirth care (British Columbia Reproductive Care Program, 2000; Fallis, Dunn & Hilditch, 1988; Grzybowski et al., 1998; Grzybowski, et al., 1991; Iglesias, et al., 1998; Iglesias, 1999; Klein, Johnston, et al., 2002; Rosenblatt, Reinken & Shoemak, 1985), the practice in

[1] The use of the term fetus is understood in this thesis as not supporting the separating of the mother-baby dyad. I feel the use of the term baby or unborn baby implies the separation of the mother-baby dyad and thus not used.

[2] Safe and appropriate care is defined by rural practitioners as having the capability to provide Caesarean sections in case of an emergency; access to technology such as fetal monitors, ultra sound equipment, and so forth; and access to skilled physicians comfortable in providing obstetrical care including Caesarean section and the use of high tech equipment (British Columbia Reproductive Care Program, 2000).

rural communities continues to require many pregnant women, including those who are considered low risk, to deliver their babies elsewhere.

The current fiscal restraint in health care results in restructuring and re-organizing of health care services, often resulting in rural obstetrical care being the "first to go" (Klein, Johnston, et al., 2002). At first glance, the centralizing of maternity care into larger centres is seen as advantageous within the contexts of budgetary cuts and minimizing risk in childbirth. However Klein, Johnston, et al. (2002) argue that the urbanization of maternity care creates a false sense of cost savings as the reduction in rural health services carries with it significant health and economic risks. The loss of rural health services "releases a cascade of adverse consequences for mothers and their babies" (Klein, Johnston, et al., 2002, p. 2). With the withdrawal of rural obstetrical services, the number of premature babies increases, as does the number of maternal and newborn complications, even though the women are delivering in hospitals that have access to state of the art equipment and specialized medical staff (Klein, Johnston, et al., 2002). These complications result in a significant increase in costs to the health care system as well as to families.

The urbanization of maternity directly impacts the sustainability of rural communities. With the withdrawal of rural health services, it becomes more difficult to retain and recruit health care providers interested in working in rural communities. With the withdrawal of rural maternity care, rural health care providers feel that their own competency in the delivery of childbirth care declines because they no longer provide these services. This is furthered by the lack of

available back up and support from other health care providers. Within this context, rural health care providers may feel dissatisfied with their work, ultimately making it difficult for rural communities to recruit health care providers skilled in rural health care, particularly in reproductive care. Many residents are moving out of rural communities with limited health services, resulting in rural communities becoming unstable.

The quality of medical care, patient satisfaction, accessibility to care, and the type of care are just some areas that may be impacted by the urbanization of childbirth care. The practice also affects the birthing woman's family and social support system. The shift in ideology regarding what constitutes optimal management of pregnancy and childbirth combined with the economics of health care reform result in the urbanization of childbirth care.

Effectiveness of rural perinatal health care.

There is some compelling evidence that birth outcomes for larger urban facilities and for communities with high rates of out-of-community birthing are not necessarily better than for births that take place in smaller rural facilities. A study conducted by Rosenblatt et al. (1985) in New Zealand examined the perinatal outcomes for all hospitals over a four year period. It was found that the lowest perinatal mortality rates were in facilities with fewer services.

A study conducted by Nesbitt et al. (1990) compared the birthing outcomes for women who were from rural communities with high rates of transferring out, to those from comparable rural communities with medium to low transfer rates. This study found that women from rural communities with high

rates of transferring out experienced higher rates of complications and rates of premature deliveries than women from the otherwise comparable communities with medium or low rates of transfer. Higher rates of complications were found to be due to lack of support from family and friends and lengthy delays in transportation.

A five-year prospective study conducted by Grzybowski et al. (1991) examined whether or not a small rural BC hospital registering fewer than 50 births per year could provide a safe and acceptable level of obstetrical care. A total of 286 births occurred during the five-year period. The study concluded that the small hospital in this study provided a reasonable standard of practice, as defined by complication rates.

Fallis et al. (1988) examined the relative safety of small hospital obstetrics in Canada over a fifteen year period. This study used birth weight-specific perinatal mortality figures as an indicator of quality of hospital care. They concluded that hospitals with fewer than 400 deliveries per year had no significant difference in the perinatal mortality than hospitals with more than 400 deliveries per year. The result was the same for those hospitals doing fewer than 100 deliveries per year compared to those doing more than 100 births. They concluded there was no difference in the perinatal mortality rates for the smaller facilities and that smaller hospitals could provide safe maternity care.

The Society of Rural Physicians of Canada (SRPC), the College of Family Physicians of Canada (CFPC) and the Society of Obstetricians and Gynaecologists of Canada (SOGC) created a joint position paper on rural

maternity care. The joint position of the three organizations is that maternity care should be provided as close as possible to the rural woman's home, within the limits of safe practice, regardless of on-site Caesarean section support (Iglesias, et al., 1998). The joint position goes on to conclude that women in rural communities achieve better delivery outcomes when cared for by local intrapartum programs. Further to this, the SOGC has taken the position that physicians do not need a specific number of deliveries per year to be competent in obstetrics (SOGC, 1996). The SOGC instead emphasizes the maintenance of competency by attending courses rather than by designating a specific number of deliveries per year.

The British Columbia Reproductive Care Program (BCRCP) Consensus Conference Report (2000) supports the idea that rural hospitals, even with their limited scope of maternity services, contribute to better birthing outcomes than transferring women out to deliver elsewhere. This report defines safe and appropriate care as maintaining adequately trained physicians, nurses and midwives, appropriate equipment for labour and birth, and an emergency transport system for women and infants. Urban birthing is justified when pregnancy and childbirth are viewed as potentially unpredictable and requiring expert medical intervention.

Defining Reproduction[3]: Pathology, Life Experience, or Medical Event?

In Western society, reproduction is predominantly defined as a biological

[3] The term *reproduction* is often interchanged with such terms as childbirth, motherhood, and pregnancy and delivery, and for the purposes of this study they will be used interchangeably.

process, but it is also defined as the social and emotional experience of passage to motherhood. Through examination of the biological and social meanings attached to reproduction, an argument will be made as to why a solely biological approach to childbirth is inadequate.

The scientific literature (particularly journals designated to support medical and nursing practice) discusses pregnancy and childbirth in terms of physiology and pathology: for example, the interaction of one biological process with another, or the development of the fetus. Primarily this approach focuses on the physiological development of pregnancy, ignoring or minimizing the social and emotional aspects of childbearing (Oakley, 1984). "In over-emphasizing the physiological (i.e. safety) aspects of pregnancy, [this physiological and pathological approach] both underestimates and undervalues vital psychosocial changes occurring within the woman as she undergoes this important transition in her social status, i.e. from woman to mother" (Cahill, 2001, p. 339). Little attention is given to the pregnant woman's subjective experience. Greater value is placed on the healthy development of the fetus than on the pregnant woman's experience. Within this framework that defines pregnancy solely in terms of physical development, all other aspects of pregnancy are excluded or their importance diminished.

By contrast, in the feminist literature, reproduction is defined in terms of a life experience. Pregnancy is "...not only about making babies. Birth also is about making mothers—strong, competent, capable mothers, who trust themselves and know their inner strength" (Rothman, 1996, p. 254). In contrast

to the scientific literature, the biological aspects of pregnancy are not the sole focus in feminist literature. Women's subjective emotional experiences of childbirth are also recognized and valued (Rothman, 1996; Oberman & Josselson, 1996).

Further, feminist theorizing of reproductive practices are critically descriptive of how women's positions in society are marginal to dominant authoritative positions such as that of "the scientist", "the physician" and "the husband". For example,

> feminist theories...direct attention to the social structural arrangements of motherhood within the nuclear family as one of the principle mechanisms for excluding women from full participation within the public sphere. Similarly, it has been argued that motherhood as institutionalized within the social role of the housewife, is oppressive to women....[T]he target...was patriarchy, not mothers. (Nelson & Robinson, 1999, p. 393)

Viewed through a feminist lens, reproduction and motherhood are seen as relational events that significantly impact and change women's lives (Nelson & Robinson, 1999; Oberman & Josselson, 1996).

Medicalization of reproductive care.

Though there is not one single definition of reproduction, a medicalized view is dominant and most pervasive throughout North America. Medicalization is defined by Morgan (1998) as the "...unintentional or intentional expansion of the domain of medical jurisdiction" (p. 85). The medicalization of pregnancy and childbirth as 'unnatrual' placed it in the domain of medicine and science. When childbirth took on the meaning as an 'unnatural' event, the focus of technical intervention and medical application was central. Defining pregnancy and

childbirth in these terms results in seeing reproduction through a lens of pathology and suggests management by an expert.

When reproduction is viewed as medically problematic and reproductive care is regarded as preventing and treating disease processes, antenatal care is shifted towards ensuring the physical well-being of women and their fetuses. This focus produces related needs for medical intervention, technological surveillance, and scientifically based intervention (Arney, 1982; Barker, 1998; Oakely, 1981; Oakley, 1984; Walzer Leavitt, 1983). Pregnancy as a state of potential pathology favours physician-attended births in hospital settings. Consequently, medicalization of reproduction is justified to ensure that risks and harm to the fetus are minimized. The delivery of a baby in an acute care hospital setting is rationalized in terms of having all the necessary knowledge and technology available to handle the potential of a medical emergency arising during childbirth.

Much of the literature on alternative birthing is in direct opposition to the contemporary scientific approach. Rather than being viewed as pathological, pregnancy is viewed as a natural process, as it was viewed in the nineteenth century (Arney, 1982; Nelson & Robinson, 1999; Oakley, 1984; Oberman & Josselson, 1996). When pregnancy and childbirth are viewed in terms of natural occurring processes, the social and emotional aspects of motherhood are seen as significant and fundamental (Arney, 1982; Cunningham, 1993; Hunt & Symonds, 1995; Oakley, 1981; Oakley, 1984; Symonds & Hunt, 1996). Pregnancy as a natural state places the decision making power with the woman. Her previous childbirth experiences and her wants and desires for her current

pregnancy influence her reproductive care. This is consistent with midwife-attended births. When pregnancy and childbirth are seen as a natural occurring event sophisticated technology or surveillance are not supported or felt to be necessary.

The scientific paradigm[4] informs and guides the current approach in Canadian society to reproductive care. In BC today, obstetrical care is provided primarily by family doctors and obstetricians, with family doctors attending the largest number of births. The majority of births in both rural and urban communities take place in hospitals. The Canadian Institute for Health Information reports that pregnancy and childbirth care account for one of the largest shares of acute-care hospitalizations (Picard, 2000). Birthing in an urban setting is seen as the best means of reducing the risk of potential harm to the fetus for a rural woman. In my experience within this paradigm, often pregnant women's wishes are set aside in favour of a "scientific approach" by health care providers. For example, a labouring woman requested that she birth her baby in her hospital room rather than the designated delivery room, as the hospital room was brighter and larger. Even though the delivery room was located only about ten metres from her room, her request was denied because the medical staff required immediate access to the emergency equipment located in the delivery room.

[4] A paradigm is defined as "a basic set of beliefs that guide action" (Denzin & Lincoln, 1998, p. 185).

The Role of Risk in Childbirth

The medicalization of childbirth has resulted in the treatment of pregnant women as though childbirth were inherently pathological and dangerous. Individuals and organizations operating within this scientific framework have an interest in reducing physical risks to the mother and fetus, risk reduction which is seen as integral to reproductive care due to the uncertainty associated with pregnancy outcomes. In an attempt to control this uncertainty, medical professionals, nurses, and midwives have turned to a technique of risk calculation. This has led to the conceptualization of pregnancy in terms of risk levels. The framing of pregnancy as unsafe and risky results in the blurring of the differences between normal and abnormal states of pregnancy. Elimination of these boundaries opens the path for the monitoring of all pregnancies and births (Arney, 1982).

Risk management has become integral to medical practice. A risk management approach implies that medical logic has shifted from diagnosing to predicting - calculating the probability of an untoward outcome in a pregnancy. In the current context, increased monitoring and surveillance of the pregnant woman is further justified. “Every aspect of every woman’s life is subject to the obstetrical gaze because every aspect of every individual is potentially important, obstetrically speaking” (Arney, 1982, p. 153). A risk management approach to childbirth implies that medical care is based on predictions and assumes that the pregnant woman has some understanding of "expert" knowledge (Rose, 1996).

Once a pregnant woman has been assessed for risk, the fulfillment of the risk reduction plan is turned over to her. The pregnant woman's role in risk management is to minimize the risk associated with her pregnancy. The pregnant woman is held responsible should there be any untoward outcomes with her pregnancy. A risk management approach assumes that the woman has an understanding of or access to medical knowledge and is able to implement changes in her behaviour to minimize risk. The use of risk discourse is subjective and designation of the risk score rests with the health care provider. Both Arney (1982) and Rose (1996) conclude that increased monitoring, either by technology or medical personnel, is a structure for controlling pregnant women's behaviours.

Calculation of risk.

Risk-scoring tools are aimed at predicting adverse outcomes and thereby gaining control over a situation (Harding, 1997). Today the use of these risk-scoring tools in reproductive care is widely accepted by health professions. Risk levels are attached to maternal markers, such as blood pressure, nutrition intake, history of smoking, and so forth, in an attempt to identify the level of risk of harm towards the fetus.

The degree of accuracy and effectiveness of these scoring tools as a means to screen for adverse outcomes in pregnancy and childbirth are questionable. The underlying assumptions of these scoring tools are false, as they assume there is a measurable degree of regularity in pregnancy outcomes and that all risk markers have the same impact on every pregnancy. This has

been shown to be not the case (Enkin, 1994; Enkin, Keise, Renfrew & Neilson, 1995; Hall, 1994). Given this, it would be illogical to attempt to predict the state of the fetus by using maternal risk factors. Even though the effectiveness of these scoring tools is questionable and lacks support by research, they continue to be popular as they create a sense of certainty in pregnancy and childbirth for the physician (Arney, 1982; Enkin, 1994; Oakley, 1984).

Risk-scoring tools are considered a basic, acceptable standard of prenatal care; for example, British Columbia's prenatal guidelines recommend the use of risk scoring tools in pregnancy care. The linking of these tools into organizational policies aims to generate "certainty" within the context of risk management. Consequently, if health-care providers are required to undertake risk assessment as part of their fulfillment of their professional obligations, this will influence their use of the risk-scoring tools even if they believe that the tools do nothing to offset either good or bad birthing outcomes.

My experience as a community health nurse working with rural pregnant women is that risk assessment scoring is performed by their doctors as well as by community health nurses. These tools focus on factors such as nutritional and vitamin intake, weight gain, and attendance at medical appointments, with the resulting data entered onto forms. My discussions with pregnant women were framed around the risk scores assigned to their pregnancies. As a community health nurse, should an assessment identify a particular score to be above low risk, I would provide health education in the form of risk management or risk reduction. For example, if a woman's nutritional intake is rated as poor, then I

would focus on improving her food intake only and not extend to the socio-economical circumstances that might be necessary for such improvement. The forms focus the health care provider on the physical aspects of the pregnancy. Without any suggestion on the forms regarding the importance of relocation, this critical aspect of rural birthing is even more likely to be overlooked. For rural pregnancy, there is no place on these forms suggesting discussion of relocation or any aspect connected with relocation.

The focus of risk during childbirth.

The focus of risk in reproduction has undergone major shifts over the years. The primary focus of risk of potential harm during childbirth has moved from the mother to the fetus (Arney, 1982; Enkin, 1994; Oakley, 1984). In the current health care system, the focus of risk has broadened to protect the physician from harm through legal action.

Up until about the 1960s, maternal mortality rates in North America were high, with one woman dying for every 160 women who gave birth. Therefore, the focus of preventing harm during childbirth was on the pregnant woman (Enkin et al., 1995). The emphasis in reproductive care was placed on protecting the overall health of a woman during pregnancy. The perceived risk of harm to the pregnant woman at that time was valid.

The collective childbirth culture became entrenched in fear that harm could strike the pregnant woman at any time. Based on this fear, increases in monitoring and medical interventions during childbirth were justified and accepted by the majority of women and society in general. With the

advancement of medical technology and knowledge, the potential of harm to the pregnant woman significantly decreased, however. “Fewer than one woman in 20, 000 giving birth today [in Canada] will die: most women, and many doctors and midwives, will never see a woman die of childbirth-related cause” (Enkin, 1994, p. 132). Risk reduction during pregnancy and childbirth has taken on another focus with this decrease.

The focus of interest regarding harm is today on the fetus. This shift of focus was supported by the introduction of visualizing technologies such as ultrasound, which render the fetus visible externally to the mother and her health care providers (Arney, 1982; Balsamo, 1999; Enkin, 1994; Oakley, 1984). “This leads some obstetricians to claim that the fetus is actually the *primary* obstetrics patient” (Balsamo, 1999, p. 90).

As with the maternal mortality rates, the infant mortality rate during the 1960s was high, with 20 infant deaths per 1000 live births (Kelm, 1998). The overall infant mortality rates have diminished considerably across BC, to 3.7 deaths per 1000 live births in 1999. The rate for First Nations populations in BC in 1999 is 4.2 infant deaths per 1000 live births (BC Vital Statistics, 2001). Though the rate for First Nations remains higher than the overall rates for BC, there has been a significant decrease in the Status Indian infant mortality rates in the past few years in BC, decreasing from 14.7 infant deaths per 1000 live births in 1995 to a rate of 4.2 in 1999.

Though the focus of risk has shifted and changed over the years, the primary focus of reducing harm to the well-being of the fetus remains the primary

concern in childbirth care today. The medicalization of childbirth and the requirement for risk management has resulted in seeing access to high technology equipment and medical specialists as the safest means to ensure a healthy delivery. For rural women this means an urban birth. The current rural birthing practice of relocating the pregnant woman to an urban community for childbirth is consistent with a medicalized approach towards childbirth with an emphasis on risk management.

Approaches to Women's Health Care: Patriarchal or Woman-Centred?

Through examination of patriarchal and woman-centred approaches to women's health care, an argument will be made as to why a patriarchal approach to reproductive care is inadequate. Medicine and health are embedded in a system of male dominance (Ballem et al., 1995; Muecke, 1996; Taylor & Dower, 1997; Zadoroznyj, 1999). A health care system that has a deep gender bias favouring men has a negative impact on women. Assumptions are made that men and women have similar health needs and similar health concerns, resulting in less attention being given to female-specific disease or health concerns (Morgan, 1998; Taylor & Dower, 1997). In research, the majority of the focus is on men, as they are seen as the norm, and the results are generalized to women and also to the medicalization of the childbirth process (Ballem et al., 1995; Muecke, 1996; Taylor & Dower, 1997; Zadoroznyj, 1999).

Proceeding on the basis that the differing health needs of women are solely related to the reproductive differences between the sexes also creates a narrow interpretation of women's health needs. As a result of this narrow

interpretation, reproductive differences are separated out instead of treated as an integral part of the whole (Muecke, 1996). In this framework, a woman's reproductive organs are not seen as part of the norm. Women's reproductive care is "...relegated to a subfield of medicine, obstetrics/gynecology" (Muecke, 1996, p. 386). The lack of a woman-centred approach to health care results in a health care system that does not adequately meet the needs of women. The defining of an "...experience that is universal to all women as a disease, is similar to requiring a y-chromosome for health—in other words, being a woman means being ill" (Gannon et al., 1997, p. 42). Consequently, medical control and treatment of pregnancy are justified by a medicalized view.

Well-women's clinics are an example that illustrates how women's health care is an add-on in a patriarchal approach. It is common in rural communities to offer well-women's clinics. These clinics are run by female health care providers who provide health care that recognizes the specific needs of women. My experience working in these clinics is that women find this format more comfortable then the regular physician clinics and are willing to attend the clinic. However, these clinics are seen as an "extra" in the health care system. They are offered only when there are enough women "signed up for the clinic" to warrant scheduling a clinic.

A woman-centred approach to health care is a philosophy of care which recognizes that women's health needs are different but equal to men's. It is holistic in focus, and recognizes women's knowledge and experiences (Ballem, Barnett, Braund, Dudley, Fryer, Kinnon, Mahy, Tucker & van den Dool, 1995;

Muecke, 1996; Taylor & Dower, 1997). Van Den Brink-Muinen (1997) defines women's health care as,

> to work consciously in care-giving to women from the viewpoint that women's problems can be related to their socialization and their position as women in this society, and to help women to develop strategies in order to get more authority over and responsibility for their own bodies and lives. (p. 1541)

By contrast to the current patriarchal approach, a woman-centred approach to maternity care would be holistic in focus, recognizing and acknowledging women's knowledge and experiences. This approach to reproductive care would not limit its interest to the biological processes of pregnancy; it would also incorporate emotional and family issues. However, despite efforts by various individuals and organizations such an approach is not the norm.

Colonization and its Effect on First Nations

Birthing within a rural Canadian context cannot be considered without considering First Nations people's experience. Given that a large portion of the study area are First Nations people, a brief discussion of the effects of colonization is an element of that assists to frame the study's data. This will help create an understanding on the impact of the current rural reproductive practice of having women relocate for birth, particularly First Nations women.

The modern colonized North American view of birthing has replaced traditional birthing practices. Colonization is described as a process that

> ...includes geographical incursion, sociocultural dislocation, the establishment of external political control and economic dispossession, the provision of low-level social services, and finally, the creation of ideological formulations around race and skin colour, which positions the

> colonizers at a higher evolutionary level than the colonized. (Kelm, 1998, p. xviii)

Providing medical help to First Nations people created a moral foundation for colonization (Kelm, 1998). The introduction of non-traditional medicine was seen as saving First Nations populations from the diseases introduced by the very people offering the cures. Traditional Aboriginal healing practices were ineffective at healing post-contact diseases; therefore Western medicine acted as the mechanism to "save" First Nations people. Rural birthing practices of having First Nations women relocate to another community for the medically supervised delivery of their babies is an example of how medicine has been instrumental in re-shaping First Nations health.

Contact with Europeans at the turn of the century altered the physical health of First Nations people. It led to epidemics that devastated First Nations populations. Aboriginal peoples' susceptibility to diseases (such as smallpox) associated with contact resulted in First Nations being conceptualized as inferior to the dominant "white" society (Benoit & Carroll, 1995; Kelm, 1998). First Nations people were seen as being in need of help and unable to survive without assistance from European and Europeanized North American societies (Benoit & Carroll, 1995; Kelm, 1998). Defining Aboriginal bodies as pathological justified intervention by Western medicine:

> At the end of the nineteenth century, medical men put Native bodies under close study, hypothesized that racial contact was dangerous, and argued that massive medical, cultural, and social intervention was necessary to save the so-called dying race. (Kelm, 1998, p. xv)

The introduction of the medical profession and the establishment of hospitals led to the abandonment of First Nations healers and traditional community midwives.

> "Capturing" pregnancy and childbirth became an additional critical dimension of the colonial government's struggle to dominate Aboriginal peoples of the Pacific Northwest Coast. Non-Aboriginal ways, including a model of rational science, complex medical technology and bureaucratic organizations of health services – meant that traditional midwifery was discouraged and eventually outlawed because of concerns about high mortality...The actual banning of midwives did not occur until 1949...Long before this date, however, government medical personnel had labeled Aboriginal midwives as charlatans, and dismissed their original birthing practices as outdated and harmful. (Benoit & Carroll, 1995, p. 239)

Modern North American medicine was not accepting of First Nations traditional healing practices.

Summary

Many practitioners providing maternity care express concern about the loss of perinatal care in rural communities and how this loss of service affects rural women and their families. The professional literature indicates that small rural hospitals in BC can provide safe and appropriate childbirth care and that relocation often inadvertently causes poorer outcomes for the pregnant woman and the fetus. Current birthing practices have a significant effect on the lives of rural women, with serious implications for their families and communities. Uncovering why these practices exist may lead to changes. Thus there is a need to examine the impact of the current rural birthing practices on the women most affected.

Notably absent from the literature were the perspectives of rural women. This thesis contributes to the current state of knowledge in the area of rural

reproductive practices by providing their perspectives. A critical feminist ethnographic approach has been adopted to provide a rich understanding of the impact of these birthing practices on rural pregnant women and their families and communities.

Chapter 3

Methodology

In order to address the central research question, "what are the impacts of rural birthing practices as they relate to having women temporarily uprooted from their home community to deliver elsewhere?", an ethnographic approach informed by feminist theory with a critical stance was undertaken. This approach was selected because it produces data through which a rich understanding of the participants' beliefs, meanings, and actions can be drawn out using analysis. This form of research allows the examination and analysis of a complex system of values, beliefs, and knowledge.

Ethnographic Research

Ethnographic research creates an understanding of the processes and structure of a social or organizational setting (Creswell, 1998). Hammersley and Atkinson (1995) describe ethnography as,

> ...referring primarily to a particular method or set of methods. In its most characteristic form it involves the ethnographer participating, overtly or covertly, in people's daily lives for an extended period of time, watching what happens, listening to what is said, asking questions—in fact collecting whatever data are available to throw light on the issues that are the focus of the research. (p. 1)

This is achieved by identifying themes, patterns, connections, and relationships that have meanings for those involved. This interpretive approach to inquiry explains the processes being studied from the point of view of the participants.

A characteristic of an ethnographic study is examining and discussing the research topic of interest in context (Hammersley & Atkinson, 1995). Detailing and critically challenging that which is taken as the context will create a holistic

account of the phenomenon being studied. The context includes an historical account and details about the physical environment, as well as the social construction of meanings given by the particular group being studied (Hammersley & Atkinson, 1995). Including the context of the phenomenon not only creates a deeper understanding but also an understanding of the reasons for the occurrence of the phenomenon. In ethnography, knowledge is believed to be subjective and representative of a particular moment and context (Hammersley, 1990; Hammersley & Atkinson, 1995; Muecke, 1996). Therefore, it is not representative of the whole phenomenon but rather of a particular aspect in a given context.

The particular geographical location which interested me was the northern part of Vancouver Island where the birthing practices of being sent down to urban communities dominates. The northern part of Vancouver Island is populated by a range of resource extract workers, government workers, and First Nations peoples. Given my research questions and this context, I undertook an ethnographic approach to my study using a critical feminist perspective that took geography, gender, class, and race into account.

Critical Feminist Theory

My research process was informed by critical feminist theory. Feminist theory postulates that women have a different worldview than men (Campbell & Bunting, 1991). "Women's experiences are seen as constituting a different view of "reality"—an entirely different "ontology" or a way of making sense of the world" (Campbell & Bunting, 1991, p. 126). This theory provides a framework to

explore women's ways of knowing. This framework fits with my interest, which is to explore childbirth from a rural pregnant woman's point of view. My study provided the women with an opportunity to voice their stories and the meanings they attached to their experiences. The women's subjective and personal experience of their rural perinatal care was the primary focus of my project.

Skeggs (2001) suggests that feminism and ethnography fit well together. "Just like any feminist research, the ethnographer maps out the physical, cultural and economic possibilities for social action and meaning" (Skeggs, 2001, p. 426). My research focused on the rural women's subjective and personal experiences of their childbirth care in the context within which it occurs. The context included an historical account of how the birthing practices of "being sent down" has evolved, details about the geographical environment, as well as how the meanings that rural pregnant women attach to their birthing practices have shifted over time. Providing the context of the rural birthing practice of having pregnant women temporarily relocated to have their babies led to a generally deeper understanding of the practice and its impacts. It also enhanced understanding of why current birthing practices are used.

The core principles of feminist theory are: validating women's experiences, examining the power relations that have excluded women from positions of power and influence, and making changes to ensure fuller participation in social interaction (Campbell & Bunting, 1991; Creswell, 1998). A feminist perspective values women's lived experiences. Feminists are interested in ensuring that women's voices are heard and included. In the recent past,

reproductive care was provided by women and based on experiential knowledge. Today, reproductive care is grounded in scientific knowledge and delivered in a medical setting by medical personnel including nurses and midwives (Arney, 1982; Happin, 1995; Oakley, 1981; Oakley, 1984). Knowledge based on women's experiences is criticized as being unscientific and not given much value. Though scientific knowledge has significantly contributed to medical care, the exclusion of other types of knowledge and social information have created a medical system that contributes to the disempowerment of women.

Feminist theory identifies and examines oppression and provides principles for eliminating inequalities (Nelson & Robinson, 1999). Feminist analyses of power and oppression provide an explanation as to how the biomedical model of birth is so strong and dominant. The voices of medical professionals are dominant in discussions of rural birthing practice. Power is understood as a capacity to influence the behaviour of others and thus is associated with control. Using this type of critical approach for my research topic allowed me to also link women's birthing experiences to broader social structures and conditions. For example the ways in which health care reform is being played out in the local particularities of rural birthing practices. It enabled me to develop an understanding of why the current rural birthing practices occur and what the broader implications are for the women, their families, and their communities, and ultimately the state.

Gender, class, and race.

Initially, I thought of rural birthing practices as an issue of gender oppression. Yet my analysis of gender alone did not capture the complexities of the historical and social aspects of oppression and power for rural women. Limiting the analysis to gender alone did not take into account the diversity of groups as well as the multiple interactions among them. Rather, it implied that all women are equally oppressed. This is not so. For example, Caucasian women experience greater privilege than First Nations women and poor women are not equal to more economically advantaged women. Bannerji (1995) argues that an analysis framed in gender alone "...obscures the real ways in which power works" (p. 69). A gender inequality analysis of power ignores race and social class, both of which are also central to women's experiences.

Feminist theories have shifted and expanded beyond being concerned only about gender. The newer theories attribute oppression to the idea of "intersectionality"—defined as the way race, class, and gender all intersect to produce conditions under which people live (Bannerji, 1995; Brewer, 1993; Nelson & Robinson, 1999; Varcoe, 1996). Theories that ascribe to this idea of intersectionality focus inquiry on the social dynamics of power and oppression.

This approach to feminist theories shifts the central focus from gender to the wider concept of marginalization. If gender is given as the reason for oppression, then rural birthing practices are a result of the relationship between men and women. That is to say that all rural women are equal, which is not the case. The manner in which oppression is theorized is critical to the way rural

reproductive care is examined. Being a person born or residing in a rural community engenders its own form of oppression in the context of access to health care:

> There are considerable rural-urban differences in health status, health behaviour, health-resource availability and health-service utilization. Generally speaking, the rural population has poorer health status, lower life expectancy, higher accident and injury rates and higher levels of disability. (Pong, Pitblado & Irvine, 2002, p. s52)

Conceptualizing oppression in the way that examines the intersections of race, class, and gender allows for an analysis that is broader in scope and examines the nature of the inequalities of power in more depth.

Through this examination of oppression from a feminist perspective a clearer picture of how power operates is achieved. Reproductive technologies provide a means for exercising power relations on women.

> These power relations are in turn institutionalized in several ways – not only through the development of medical centers that offer reproductive services, but also through the establishment of reconstructed legal rights and responsibilities of parents, donors, fetuses, and resulting children. (Balsamo, 1999, p. 82)

One important goal of feminist theory and research is making changes that lead to improved social conditions and interactions for women. Current rural birthing practices are dominated by scientific knowledge which focuses strongly on the biological process of pregnancy and childbirth, obscuring the social and emotional aspects of childbearing. These failures to recognize and value the other aspects of childbearing have negative consequences for women's pregnancy and childbirth experiences. If health care is to ensure the well-being

of all people, then women's perspectives and experiences must be included in all aspects of reproductive care.

Research that takes a critical theoretical approach is not interested simply in describing power relations and conditions of inequality. It also seeks to understand how power is distributed and maintained and what issues of geography, gender, race, and class are involved (Kincheloe & McLaren, 1998; Quantz, 1992). This allows the researcher to identify conditions or relationships that might be altered to change the examined situation. Using this type of critical approach for my research topic allowed me to link women's birthing experiences to broader social structures and conditions. It enabled me to develop an understanding of why the current rural birthing practices occur and what the broader implications are for the women, their families, and their communities.

Study Location

The geographical area in which the study took place is the northern part of Vancouver Island. This area comprises northern Vancouver Island and the smaller coastal islands off northern Vancouver Island, but does not include the British Columbia mainland coast adjacent to northern Vancouver Island. The communities located in this area are: Port Hardy, Port McNeill, Port Alice, Coal Harbour, Holburg, Alert Bay, and Sointula. Settlements not part of these communities but within the study area such as logging camps and resort lodges with year-round occupation were not included because these areas are sites of employment rather than residential settlements. These employees tend to be mostly male and reside outside the study area when not scheduled to work.

This study area was chosen for several reasons. Firstly, the area meets the criteria of being a "rural remote" area. "Rural remote" communities are those that range from about 80 to 400 km from a major hospital (Society of Rural Physicians of Canada, 1998). Secondly, the issue of reducing obstetrical care was an active issue in the area, since some of these communities were limiting the type of obstetrical care available, sparking many debates amongst health care practitioners. Finally, my familiarity with the study location resulting from my residing and working as a nurse in that area gave me some insight into the context of the maternity care being provided. It also assisted with participant recruitment.

Study area demographics.

B.C. Vital Statistics (2000) estimates a population of 15 602 for the northern part of Vancouver Island. There are a large number of First Nations people among the population. The majority of the people reside in Port Hardy, Port McNeill, Port Alice, and Alert Bay. Port Hardy, with a population of 6186 including approximately 800 First Nations people, is the largest of the communities in the study area. The population for the other communities is as follows: Port McNeill: 3110; Port Alice: 1345; and Alert Bay: 1456 (which includes approximately 900 First Nations people). The majority of the First Nations people live in one of the four Native Indian Reserves located in or around Port Hardy and Alert Bay. The First Nations' population figures may not be an accurate reading of the many Aboriginal people in the study area who do not

have status designation, who reside off reserve, or who do have status designation but are members of other Nations outside the study area.

Each of these communities has a hospital that provides limited obstetrical services, though none of them provide Caesarean section services. There are fourteen physicians in the area; however, not all work full time. Port Hardy and Port McNeill each have five physicians. Alert Bay has three physicians and Port Alice has one. Two of the fourteen physicians in the area support the provision of some childbirth care to first time pregnant women in the community, representing a new opportunity for the women in the area.

Currently, there are no midwives located in the study area. Campbell River is the closest community with midwifery services. The majority of the women on northern Vancouver Island have their babies delivered by physicians. In the years that I worked and lived in that area, I heard of only one woman experiencing a midwife-attended birth, which had occurred "down island".

The total number of births for the Vancouver Island North area was 202 for 1998 (PURFECT Database, 2000). This figure is consistent with figures from previous years. Out of the total number of births for the area, 189 were delivered outside of the area and 42 births delivered in the study area. Of these 42 births, 4 were delivered in Alert Bay, 27 in Port Hardy, and 11 in Port McNeill. The majority of the births that occur locally were deemed low risk and were planned to occur locally by both the woman and her physician. The approximately 28 percent of women who deliver locally are low risk multiparas. About 72 percent of the women from the northern area of Vancouver Island deliver their babies

elsewhere. Aboriginal live births account for 60 of the 202 or slightly less than 30 percent of the births in the northern part of Vancouver Island (British Columbia Vital Statistics, 2000). The breakdown of First Nations births occurring locally or out-of-town was not available.

The majority of the women from the northern part of Vancouver Island (the study area) deliver their babies in the Campbell River and Comox area (PURFECT Database, 2000). Campbell River is the first major community south of the study area. Campbell River is located on a paved highway about 200 km from Port McNeill, and about 240 km from Port Hardy. Travel from Alert Bay and Sointula requires an additional ferry connection of approximately 40 minutes to Port McNeill. Highway travel is available year round however occasional weather closures occur during the winter months. Highway closures result in transportation by air ambulance to other communities or "forced" home community births.

Residents of the study area.

The population of the northern island area includes First Nations peoples, government workers, resource extraction industry workers, and service industry workers along with their families. The employment demographics have changed in recent decades, and continue to do so, particularly those involving resource extraction workers such as those in fishing and logging. This is largely due to changes in resource extraction technology.

In the logging and fishing industries the increasing efficiencies resulting from mechanization have reduced the number of employment opportunities.

Increasing efficiencies have also resulted in harvests being reduced or suspended. Increased ease of access to remote areas has also reduced the requirement for families of workers to reside in remote areas. One result of these changes has been the elimination of most of the company-run communities (fishing and logging camps). The few remaining workers can easily be transported to the worksites from urban areas. The number of local workers who reside outside the area has increased.

The mining industry has also been reduced, due to a variety of influences. This has resulted in the elimination of one of the area's largest sources of employment (the Island Copper Mine).

With the modernized lifestyle (such as easier travel and availability of services including utilities and recreational facilities similar to those in the larger centres), the expectations and needs of an urbanized population can be met more easily than in the past. Thus, rural living is becoming more attractive to persons moving from urban centres. Examples include the families of government workers and service industry workers relocating to the rural northern island area.

Government services have become increasingly centralized. Facilities at remote locations (such as the Department of Transport facility at Bull Harbour and the Department of Fisheries and Oceans facilities at Dawson's Landing and Alert Bay) have been eliminated. Government workers at the remaining facilities remain somewhat temporary residents; often they are subject to "limited duration post" policies where they and their families are required to reside in the rural

communities for a short fixed period before deployment to a more urban area. These government workers often do not prefer the rural lifestyle but chose their postings for reasons of experience and career development.

Access

The research project was advertised on posters in the various health units and hospitals on the North Island. Community health nurses and pregnancy outreach workers who work with pregnant women and/or new mothers informed women of the potential for their input into my research project.

I had some initial concern about living in and working as a community health nurse in the geographical area of interest.[1] The area is small and I knew many of the women and health professionals and thought this might create some difficulty with recruitment and negatively influence the participants' responses. However, locating participants for this study was enhanced by my living in the area and working in the health care field. My close connections with the health care professionals in the area has created a close working relationship with many of the agencies and health care providers that work with pregnant women and women and infants. This in turn created a level of trust to advertise my project.

At the time this study was implemented, I had worked as a community health nurse in the study area for about five years. My social location (community health nurse, relatively new to the north Island, likely to move on and so on) shaped not only who participated in my study, but who did not, and not only what

[1] Although at the time I implemented this project I had been a resident on the North Island for about six years, I was still considered an "outsider"—part of the transient group of government employees. These employees often temporarily relocate to rural communities as a way to advance their careers and rarely become part of the "local crowd".

was said, but what was not. For example, the women with whom I was familiar with from my work as community health nurse might not have been as critical of myself, but also of what I represent – the health care system.

Several of the participants were women that I had provided community health nursing services, including pre and post natal care. Though I feel that the women were familiar with me and trusted me which facilitated my access to them, my role as a community health nurse may have influenced the type of information they provided. They may have held back criticism of the health care system more widely, may not have told me about 'resistant' behaviours for fear of judgement and so on. I also think that my working as a health care provider place a limitation that prevented certain women from participating in my study – in particular, those women who were more likely to be 'non-compliant' with the system. This tension that existed because of my role as both nurse and researcher in the study area was one that I noted in my reflective journal. As noted in my journal after interviewing a woman who I provided postnatal care to her third child,

> I noticed Kari did not say my name and complimented me, when asked to reflect on discussions with other health care providers about relocation. She stated, "the nurse who was here at the time was very good." Kari is not separating my role as nurse from that as researcher. This may be influencing the type of information she is providing.

During informal interviews with health professionals, I was also concerned that my presence as a researcher might make some of the health professionals uncomfortable as they would interpret my research role as that of a critic. I noticed over the course of observing a series of prenatal classes that the

instructor became less concerned about me as a critic. She initially commented, "I'm a bit nervous about being watched tonight. I'd like to know if you think of a better way I could do something." However, her anxiety soon eased when she started inquiring about my research findings and suggesting other health care providers to interview.

I bring perspectives of both an insider and an outsider to this project. I am an experienced nurse and have resided in the study area for an extended period of time thus I having some degree of insider knowledge. I am also an outsider as I have not experiencing pregnancy and childbirth and am in the role of researcher. Having both insiders and outsiders perspectives influenced the type of information collected, as well as the interpretation of the data. I found that with the women with whom I had previous relationships, with the interviewer-interviewee relationship was less formal than with the women with whom I had no previous experience. For example, when interviewing the women that I had previously known, I was offered tea or some other drink and the woman's partner and child remained in the home. This was not the case for the women with whom I had no previous relationship. We would meet at a mutually agreed upon place and the women would not bring their children along. When interviewing the women with whom I had no previous experience, the information was detailed and I rarely had to probe for more information. In contrast, the women with whom I had a previous relationship, they often did not provide as much information about their birthing experiences and comment 'you already know

about that'. I would have to remind them that I was there not as the community health nurse but as a researcher.

Although my multiple roles of nurse/researcher and insider/outsider in the study assisted my access to participants, these roles also influenced participation of participants and the type of information collected. My insider's knowledge may have allowed me to understand and see things differently from some of the participants. However, being an insider also coloured my interpretations and analysis because of my preconceived notions. I feel my various perspectives combined to provide more insight than is possible from either viewpoint alone.

Data Collection

The data for this study were obtained by a variety of methods over a period of nine months. Data collection was facilitated by my living and working in the study area. As in traditional ethnographies, interviews, observation, document collection, and reflective journalling were used to gather data in my study. Ethnographic data is rich in details and description. These methods of data collection provided insight and understanding of the rural birthing practices and their impact on the women.

Observation.

To provide a fuller insight into how prenatal care is accomplished and women's decision-making processes, I observed four out of a series of six prenatal classes. Field notes were made during and immediately after the observation of each class. The observations included interactions between the instructor and those attending the classes, between persons attending the

classes, and between the instructor and guest speaker. They included the content of the topics being covered, and the overall tone of the classes. I would have been interested in observing a woman receiving prenatal care from her physician during an appointment but an opportunity did not arise for me to accompany anyone to her doctor's appointment.

Document collection.

Documentary evidence relevant to my research subject was revealing and informative of the current state of rural birthing practices. The documents analyzed included news clippings from the two local newspapers, the program manual used by rural community health nurses, pamphlets and materials handed out in the prenatal classes, and the hospital by-laws and mission statement for the local health region (Appendix A).

Reflective journal.

When conducting ethnographic research, the researcher becomes a part of the world that is being studied. Given that I was a nurse in the study area, it was important to identify preconceived expectations and recognize the impact on the interpretation of the data. Thus I kept a reflective journal to note my feelings and understandings of observations, interviews and so forth. This helped me to challenge my biases, experience events, and keep a professional distance.

In addition to noting the impact of me as researcher in the setting, reflection upon what is happening within me and within the setting will allow me to develop greater depths of understanding.

Participants

Five adult women from communities on northern Vancouver Island participated in the study. Participants were selected who were pregnant at the time of the study or had had a baby within the past four years. They had either temporarily relocated to another community for a period of time to wait to have their babies or had their babies in a community in the northern part of Vancouver Island (north of Port McNeill). All the women spoke fluent English.

Although I did not set out to do a study of First Nations women's health practices, because there were a large number of women who are First Nations and giving birth within the study area I hoped that the participants would have equal representation of First Nations women and Caucasian women. This did not happen during the nine months of recruiting participants for my study. More Caucasian women participated in this study than First Nations women, with only one of the women identifying as First Nations. Three of the women had partners who were First Nations.

The women were close in age, ranging from 27 to 33 years old. Three of the women were employed outside the home fulltime. The other two women were stay at home moms. All the women completed high school. Some had attended college or university, though at the time of this study, none of the women had graduated.

Two of the five women were born in the study area. Two of the women moved to the northern part of Vancouver Island a year prior to participating in this study because of employment opportunities for their partners. One woman since

participating in this study has relocated to an urban community with her family because of her partner's work.

The women's childbirth experiences ranged from natural childbirths to Caesarean section, in either rural or urban settings. Their ethnicity was either Caucasian or First Nations. Three of the Caucasian women's partners were First Nations and therefore their babies qualified for status Registered First Nations designation. All the women but one had their babies delivered by a physician in a hospital setting outside her home community. One woman had her baby in a home attended by a midwife in a community down island.

Though only five women participated in this study, they had a broad range of birthing experiences having had from one to three children. Therefore the data collected for this study was not just from five birth experiences but rather about nine birth experiences. Four of the women were interviewed after their most recent births and one woman was interviewed both pre and postnatally.

Interview Process

Interviews were taped and lasted about an hour. Semi-structured questions[2] guided the interview so as to allow the women's description and interpretation of their experiences in their own words (Appendix B). The interviews consisted of a conversation based upon some pre-designed questions. These questions were intended to help the women to explore and describe the meaning of childbirth practice in relation to having to relocate

[2] Semi-structured questions allow "...a sequence of themes to be covered...Yet at the same time there is an openness to changes and of sequence and forms of questions in order to follow up the answers given and the stories told by the subjects." (Kvale, 1996, p. 126)

elsewhere to deliver their babies.

A follow-up interview in the form of a phone call was done for one woman. Her initial interview occurred prior to having her baby. I called the woman about a month after she had her baby to ask about how things compared to her expectations, her feelings about the policy of being "sent down", and any changes in her previous thoughts or ideas. The follow-up interview took about 25 minutes and notes were taken during and after the call.

The tapes were transcribed into text verbatim. Such things as pauses, hesitations, laughter, and fluctuations in the speaker's tone were noted in the transcriptions. Providing this degree of detail can further contribute to the analysis process (Silverman, 1993).

Informal interviews with health care providers who have experience with childbirth in rural areas were also performed. These informal interviews were conducted with two physicians and two nurses and ranged in length from a half hour to an hour. Notes were made during and immediately after the interviews.

Ethical Considerations

Several ethical considerations were examined, as this study required the involvement of human subjects. I received approval from the University of Victoria's Research Ethic's Committee for my study. The specific issues that concerned me as a researcher were:

- confidentiality of private information
- maintaining anonymity for participants from small communities

- the coercive effect that may result from the researcher being a community health nurse in the study area
- the creation of tension between the researcher and other health care providers in the study area
- accurate representation of the participants' voices.

These were all attended to and care was exercised to ensure the participants had their rights protected and would not be harmed.

Confidentiality.

Participants were assured of confidentiality and anonymity to protect their privacy and to prevent harm and any embarrassment to the participants as a result of the information they would share with me. Research in small communities may make it more difficult to ensure anonymity and confidentiality of the participant. Thus, pseudonyms were used to replace the participants' actual names in any written or published documents, and some personal details were changed to further mask identity. I had a discussion with one woman who chose a name that may not conceal her identity if anyone from her community read the study. I suggested she pick another pseudonym to prevent her identification but she did not want to change her name. Therefore I made changes to how I described communities to increase participants' anonymity.

The participants were informed that the document produced from my research findings would be a public document that would be located in the university library. Providing the participants with this information prevented

feelings of betrayal and embarrassment that may result from learning after the fact that their private information is available to the general public.

All the audio tapes, written documents, and computer disks that contain data from the participants were stored in a locked filing cabinet in my home. This was to ensure the identity of the participants and the data collected from their interviews remain confidential. The participants' names have appeared only on the consent form and all other information about them was coded. This ensured privacy and anonymity were maintained.

Coerciveness.

My past and present role as community health nurse in various communities within the study area could create some confusion and be misleading. Issues around power relations between community health nurse and client could result in some degrees of coerciveness. To minimize the potential coerciveness and the risk of the project being misleading, participation in the study was voluntary and consensual. Prior to obtaining written consent from the interested adult women, their required time commitment and the nature and purpose of the study were described to them. They were assured that confidentiality of the participants would be ensured and maintained, and that each participant could freely withdraw from the study at any time.

As this study required the women to describe and share their personal feelings and experiences, they might have experienced some psychological consequences that could lead to personal mental health issues or feelings of discomfort. To minimize any harm or discomfort that resulted from sharing

personal information, I continuously critically examined my "need to know" as it related to the research topic and let this guide the data collection process.

Exploitation.

"...[T]ypically, researchers investigate those who are less powerful than themselves..." (Hammersley & Atkinson, 1995, p. 273). Consequently the researcher receives all the benefits and those being studied receive nothing. Historically women and First Nations people have been exploited in previous research projects. To prevent the exploitation of those who participated in this study, my interpretation of each participant's data was clarified with that participant to ensure accuracy of the recorded words. To prevent any financial costs or hardships to the participants, I travelled to meet the participants at a mutually convenient location. I also took the opportunities to "give back" in ways that were meaningful to the women; for example, by sharing requested health-related advice and knowledge.

Representation.

Issues around inaccuracy and perpetuating stereotypes arise when a researcher attempts to "speak for others". The meaning of what is said by the participant is affected by the researcher's interpretation of it (Alcoff, 1991). Everyone has a different way of assigning meaning to what is communicated. Consequently, information provided by the participants may take on another meaning and result in misrepresentation by the researcher and by subsequent readers. Another issue that comes up is whether or not an outsider can accurately represent the group being studied. The researcher, who is not part of

the group being studied, as is the case in my research, runs the risk of perpetuating stereotypes which may result in the continuation of oppression for the group being studied (Alcoff, 1991). To prevent "speaking for" the pregnant women who participated in the study, I developed a dialogue between the participants and myself. The interview process consisted of a conversation based on some pre-designed questions. The same questions were used for each participant.

Analysis

The analysis process starts when the fieldwork begins. "Progressive focusing" is a technique Hammersley and Atkinson (1995) describe as moving the research analysis from the general to the specific. Data were drawn from transcriptions of taped interviews; from notes of informal interviews; from detailed field notes describing observations; from my reflective journal; and from collected documents. I familiarized myself with my data by reading and re-reading all my data. As my familiarity with the data was deepening, I compared my viewpoint with the themes coming from the data. Hammersley and Atkinson refer to this as "...us[ing] the data to think with" (p.210). They argue that several issues may influence the type of data provided and thus the analysis, including the audience to which the data is directed (for example, the researcher may influence what information is shared by the nature or structure of the interview), the temporal context, and who is providing the information.

In order to start to make sense of the data, I clustered the data into broad and general concepts. Reviewing all my data led me to identify a number of

themes. I then took these themes and classified them according to general type, for example, “silence”, “resistance”, “guarded compliance”, to list but a few. The data were continuously analyzed for connectedness to each theme or idea and for any similarities and differences (Huberman & Miles, 1998). As a result the data was further coded into more detailed categories. These categories were further examined and defined in relation to one another. Linkages of concepts to an idea were noted and modified. Feedback on my analysis from my thesis supervisor and several colleagues served as a means to better understand and broaden my interpretations of the data.

Validation of data.

Ethnographic research does not support the belief that culture is “out there” to be discovered but rather, culture is seen as interpretive (Denzin & Lincoln, 1997; Mueck, 1994). Many meanings can be attached to an experience. Meanings attached to experiences are socially constructed. The researcher’s own perspective shapes the type of information used and its interpretations. So the question arising here is how will the researcher ensure the validity of the data collected and its interpretation?

Validation of data was achieved through several means—triangulation, use of multiple sources, and a reflective journal. Hammersley & Atkinson (1995) describe data triangulation as “the checking of inferences drawn from one set of data sources by collecting data from others” (p. 230). I compared data relating to the same concept but collected from different sources at different times of the

research process. To enhance the reliability of the data collected in this study, multiple sources of data collection were used to gather information.

To minimize the threats to validity that may result from my own personal experience, such as my rural community health nursing experience and friendships with women who have had to leave the community to deliver their babies, I maintained a reflective journal. I used these reflections to interrogate my biases that may have influenced my analysis. For example, initially when I interviewed Dixie[3], a nurse, I believed her sense of responsibility and fear of something bad happening during a birth she attended stemmed from her own needs, "I had to live with the outcome and I don't want to." I felt some skepticism about the health care provider as being selfish. However, upon reflection I now understand she was drawing on dominant discourses without critical analysis.

Limitations of the Study

A small number of women participated in this study. The study also examined the research topic in only one geographical area. The results of this study will have limited applicability in another context but may provide insight in similar contexts.

The researcher as an 'outsider' also serves as a limitation in the study as I had no personal experience with childbirth during the time of the study and was possibly considered a transient resident to the area. Despite the efforts I took to maintain trustworthiness of the data, it remains that data were analyzed through

[3] All names are pseudonyms

my own perspective. Thus this study is to a large extent an outsider's perception of the participants' experiences.

Summary

An ethnographic approach to inquiry "examin[es] a culture in all its richness, intensity, colour, taste and volume [so] that new facets" (in this case of rural birthing) "can be uncovered, described and given serious thought and consideration" (Hunt & Symonds, 1995, p. 39). This method of inquiry was placed within a critical feminist theoretical framework. Data for this study were collected from interviewing a small number of rural women who experienced childbirth and rural health care providers, observing a series of prenatal classes, and reviewing documents that pertain to rural childbirth, such as community health nursing manuals.

This study was not just about describing rural birthing practices but also placing those practices in the broader context of health care and society in general. I have tried to avoid speaking on behalf of rural women. Instead, I have attempted to convey my understanding of the women's experiences, insights, and perspectives, based on my analysis of the different sources of data.

Chapter 4

Findings

> Horrible. It was, I think being in such a big hospital, I found and from such a small town, you get so used to the people around you and you're not good with people you don't know. You're not exposed to that and things. And being there you're just another number, I found, in [the city]. [My daughter] was, because of her being a month premature, they stuck her in the special care nursery and failed to tell me and I wasn't going to ask. I didn't know whether I had a boy or girl for the first, first couple of days. Not until the third day did I see her...Nobody – they came around, did their regular check-ups and so forth. And actually they were very cold. They were not nice people. The doctor was, the specialist that had come in to induce me and so forth, he was horrible. Nasty guy. There was, I think in the state I was in, not knowing where [my baby] was. I didn't ask the nurses, "where's my baby?" Or anything. And it was the third day the nurse came in and she said, "Well it's three days, don't you think you should feed your baby?" And that's when I finally got the guts up and said well, "where is she?" That's right, and that's when they brought her in and I kind of felt my way around once I had her.

Kari's story of the birth of her first child in a large urban centre is particularly compelling. It epitomizes the tremendous impact that relocating to give birth in another community has on rural women and their families. Attention of the rural women, their families, and health care providers is focused on the risk that rural location imposes on motherhood and childbirth. The provision of urban care is the only method used to reduce the perceived risks and improve reproductive care for rural women. This has a potentially negative impact on the health and well-being of rural women and their families.

During the course of my research, I conducted in-depth interviews with rural women who were or had been pregnant. My data also included

informal interviews with rural health care providers as well as textual data. From these data I was able to analyze the decision-making process respecting the location and timing of delivery for rural pregnant women. I was also able to describe the tremendous impact this process has on rural pregnant women, their families, and their communities. Sketching out this decision-making process and its impacts illuminates the power relations that exist and how these relations sustain the current rural birthing practices. A brief introduction to the participants is followed by an overview of the findings which detail this decision-making process and its impact.

Motherhood Profiles of the Participants

This section briefly introduces the women participating in the study. The woman's childbirth history, whether or not she relocated for birth, and the duration of the relocation are provided, as well as whether or not her partner was present for the birth. All the women had their deliveries attended by a doctor except for one who had a midwife attend the birth.

Kari.

Kari is a mother of three children. With her first pregnancy, Kari and her partner relocated to a community about 500 km away six weeks prior to her due date. With her second pregnancy, she relocated with her partner to a community about 300 km away for a total of about two and half weeks. They did not bring their first child with them. Kari delivered her third and youngest child in her home community.

Valerie.

Valerie became pregnant with her second child soon after moving to the northern part of Vancouver Island. Her first child had been born with the attendance of a midwife in a hospital setting. She did not know until after she was pregnant that very few women were delivering babies on the North Island. For her delivery, she relocated for a total of 24 days with her partner and child to a community about 300 km away. The first part of their stay was in a motel room and the later half was in a home they rented, where two midwives and a doula attended Valerie's homebirth.

Lucille.

Lucille relocated for the births of both her children. For her first delivery she relocated for about two weeks to a community about 220 km from her home. She resided for the duration in the hospital's old nursing residence. Her baby was delivered by Caesarean section.

For her second delivery, Lucille relocated for about 15 days with her three year old daughter to a community about 400 km away from her home community. Her partner could not take much time off from work, so they had planned for him to travel down once labour started. Lucille's partner and her mother made it to the hospital within an hour before her having her baby by Caesarean section.

Rebecca.

Rebecca, pregnant for the first time, relocated four weeks prior to her due date to a community in the lower mainland where she had

relatives. She was away from home for a total of three weeks. Her partner joined Rebecca hours before she delivered her baby. Her mother, whom Rebecca wanted to be present for the birth, did not make it.

Henrietta.

Henrietta became pregnant with her second child a short time after moving to a community in the region of the North Island. She had planned from the beginning of her pregnancy to relocate for the delivery to the community where she was from and where her first child was born. Henrietta relocated three weeks prior to her due date and returned seven weeks after the delivery. Henrietta's partner was not present for the birth. He joined her the day after the birth.

Health care providers.

Informal interviews were also conducted with two physicians and two nurses who provided pre and postnatal care to women in the area. Both physicians provided some limited delivery support to women in the area.

Overview of Findings

Everyone from the health care providers to the rural pregnant women and their families were joined in the quest for a healthy baby within a dominant medicalized[1] view of childbearing and childbirth. This quest for

[1] Conceptualizing pregnancy within a medicalized view defines birth as a pathological state, an illness that requires diagnosis and medical intervention to ensure a safe outcome. Birth is defined as potentially dangerous and requires medical guidance and technological intervention.

a healthy baby was about predicting, limiting, and lessening risk to the fetus. Rural childbirth was defined in terms of "what was best for the unborn baby". This quest was sustained by common understandings by women, health care providers, and the community; by policies that dictated physicians' remuneration; and by structures that both limited health care provider's experience with childbirth and the resources to provide childbirth services. These dynamics were self-perpetuating and congruent with a medicalized view of childbirth, yet overlooked the overall well-being of the women and their families.

A medicalized view of childbirth obscured concern for the health and well-being of the woman and her family and overlooked the overall cost of urban birthing to the women and their families. These costs included the women experiencing an increased workload as it related to producing a healthy baby and managing their family relationships, experiencing social isolation while away and, for First Nations women and First Nations children, experiencing separation from their traditional territory. A shift in health care costs from the State to the private individual also resulted with the birthing practice of relocation. A medicalized view of childbirth did not address these broader concerns as the sole focus was on the well-being of the fetus. Thus these health-related costs went largely unrecognized and unaccounted for in the planning and delivery of health care.

Because of the way in which the current medical fee structure is set-up, the rural physician's role is to predict and lessen the risk towards the fetus. The rural physician's job was primarily limited to this as he/she was not paid to manage a labour if a woman were to end up being medically evacuated out of the community during her labour. So a physician's cost/benefit analysis led him/her to predict risk.

The rural health care providers felt they came up against their own boundaries of competency with childbearing and childbirth. Their competency was primarily focused on the management of risk. They felt they were competent at predicting, estimating, and lessening risk to the fetus. However, they did not feel competent with deliveries. The rural women were very wary and acutely aware and concerned about the rural health care provider's level of competency with childbirth.

Over time "going down" became the norm. The findings indicated that the women and health care providers in this study saw urban birthing as the norm for women residing in the northern part of Vancouver Island. Should a woman residing in this area choose a different birthing experience from an urban birth, she would be going against the community norm.

The Quest for a Healthy Baby

The rural women, along with their families [2], communities[3], and

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[2] The term family(ies) includes parents, partners, extended family, or some combination of these.
[3] The terms community(ies) and public are used interchangeably in this paper. They refer to individuals residing in the rural community.

health care providers were all joined in the quest for a healthy baby within a medicalized view of childbirth. Within this view the goal of childbirth was the production of a healthy baby.

Discussions among various combinations of rural pregnant women, health care providers, and family members, centred on the prediction, estimation, and reduction of risk to the baby. These discussions contributed to the production of healthy babies by answering pregnant women's questions, providing information, sharing personal childbirth experiences, and drawing out questions, concerns, and ideas from the pregnant women. These interchanges led the women to ways of knowing what was best for the well-being of their fetuses when they were unaware, unsure, or required reassurance.

Lucille's story illustrates how her doctor reassured her about her fears with trying a natural birth after experiencing a Caesarean birth:

> ...I talked to [my doctor] about my concerns with trying [for a] natural labour and stuff and, he came right out and he explained everything to me. Because I had had a placenta previa with [my first baby] he explained that the risk of that is that the placenta can come out first and then the baby has no blood, there's no oxygen or anything. My ultrasound showed that my placenta was growing properly this time on the wall and everything. And then I asked about, because there's some risk....I can rip open my scars and so I asked him...I liked that he was straightforward...I could make my mind up from there...

Rebecca explained how her doctors, as well as the women with whom she worked provided her with information:

> If I want[ed] a question answered or if I ha[d] a question, I'd go and seek [the health care provider out]. I'm not one to just sit back and ponder the whole thing. I'll go to the people who are in that field. I'd

> go and see the health nurse or I'd, as soon as I found out I was pregnant... I went to [the public health nurse] right away or I got in contact with her and said, "well I'm pregnant, I guess I've got to come see you and find out what I need". She gave me a whole bunch of information and made sure everything was right and told me what I should be eating. [My doctor] was good too. You know, he'd ask was there any questions and what not, and I have good support here. Friends where I work... we're all women over there. We've all had kids except for one; that was even great too. [We'd ask each other], "Does anyone know if this happens?" "Oh that happened to me, don't worry about it or you should really go see someone." So that was good.

The women supported the need to protect their fetuses from harm. They became more interested in the health of their fetuses than the social-emotional aspects of rural childbirth. To learn more about what was best for their babies, the women networked with other women and health care providers to make decisions about their perinatal care.

Urban Birthing as the Norm

The majority of births for the North Island occurred "down island" (in urban centres further south), though some local births did occur. The physicians participating in the study indicated that the majority of the women residing on the north part of Vancouver Island travel to larger centres to give birth, while a small number present themselves to the local hospitals in the area. This is consistent with the reports of the women participating in this study, all of whom had experienced an urban birth, although Kari had also experienced a local birth.

A comment made by a physician participating in the study supported the view that urban births were the norm for the North Island:

> In one of the larger communities in this area the physicians, except for one, have stopped offering any elective child birthing care and in the other communities the number [of physicians actually doing deliveries] is low. (Interview notes, April 3, 2001 and October 22, 2001)

The lack of support for providing local obstetrical services was widespread, and was reflected in policies, protocols, and behaviours of health care providers. These policies and protocols set the standard of care to which health care providers are held. Rural health care practitioners work within these sets of principles laid down by authorities. Within these official policies and protocols, urban birthing was the accepted standard and thus the norm. A physician recounted during a Medical Advisory Committee meeting a proposed policy change in the withdrawal of all local first time deliveries:

> It was proposed by the Community Health Council that no first births are to be delivered on the North Island due to not being able to provide safe deliveries should a complication arise (Interview notes, October 22, 2001).

In May 2003, the VIHA announced a new policy that all births on the north part of Vancouver Island have been suspended. This means that all childbirth services have been withdrawn, no matter what the level of risk assigned to a pregnancy. Patient safety was cited as the underlying reason for the suspension of all labour and delivery services.

Prior to the announcement of the withdrawal of all childbirth services, the availability of local obstetrical services had decreased. For example, the new hospital facility being built in Alert Bay in 2001 no longer was funded for obstetrical services as the old one had been. An article in

the local paper, the North Island Gazette (Health Centre Step Closer, 2001) regarding the ceremonial ground breaking for the new hospital facility made no reference to the decrease in services but rather stated:

> "The funding for this centre reflects our government's priority to help improve access to health services for today's families," says North Island MLA Glenn Robertson...on behalf of the Health Minister Corky Evans. The new health-care complex will offer a range of treatment and diagnostic services and programs under one roof....(p.8)

The article implied that access to health services was increasing, with no mention of any decline in services specifically to rural pregnant women. The proposed policy changes to stop all local first-time deliveries and the lack of funding for local maternity care was consistent with the rural norm of having urban deliveries.

Another contributing factor influencing the provision of rural maternity care was the structure of the current medical practitioner's fee system. The current physician remuneration system of fee-for-service does not allow a physician to bill for the service of attending to a labour but not the delivery. The delivering physician is the only one who can bill for the delivery. A rural physician is thus not remunerated for his/her time spent attending to a labouring woman whose labour results in her being transferred out to another facility for delivery. Given this fee structure, this study found that the rural physician's role was to predict and lessen prenatal risk, not to manage labour. Comments made by physicians participating in the study supported this:

> There is no fee for attending a labour. So if a doctor transfers the woman out due to complications then the local doctor cannot bill for his/her time. (Interview notes, April 3, 2001 and October 22, 2001)

As well, the attendance of a birth during regular practice hours could take away from the physician's income. One of the physicians commented:

> First labours tend to be longer and more unpredictable. Therefore the doctor is away from his/her office or practice more. Also compounding the issue is that the doctor may not trust the skill set and knowledge of the nurses here and thus has to attend at the bedside longer. Thus taking him/her away from their source of income. (Interview notes, October 22, 2001)

The rural physicians' cost-benefit analysis led them to favour urban births. The lack of flexibility with the fee-for-service structure and the lack of alternate payment models supported urban birthing as a standard practice.

Another dynamic that supported urban birthing was the lack of experienced and skilled support staff such as nurses. The nurses were described by health care providers participating in this study as having fewer competencies in delivery care as they have very little exposure to delivery care. Having rural nurses with poor skill and knowledge in the area of rural childbirth was seen by the health care providers participating in this study as placing the fetus at risk should a local delivery occur. The skill and knowledge of rural nurses were described as unsuitable and inadequate. One physician commented:

> With the recent staffing crunch, the site manager of the hospital did not want to offer obstetrical care. There were two women waiting to have their babies locally. I requested that we call in an experienced

> nurse who had recently retired, be called out of retirement to assist me with these births. (Interview notes, October 22, 2001)

Another physician commented:

> Problems with rural delivery care are frequent staff turnovers and inexperienced nursing support staff. (Interview notes, April 03, 2002)

Documents about rural reproductive care.

Since the majority of rural births occur in urban areas, I examined documents that I thought might have protocols or practice standards that specifically address rural reproductive care. The documents examined were the Community Health Nurse's Program Guideline Manual for nurses working in rural First Nations communities and the BC Reproductive Care Program practice standards for the delivery of postpartum care in BC. The documents made no mention of rural women temporarily relocating to deliver in an urban community or of postpartum care for rural women who deliver out of their communities. One possible explanation for not making any reference to relocation for birth is that urban birthing was so much the norm that it went unremarked.

Since the focus of rural pregnancy and childbirth was primarily on eliminating the risk of harm towards the fetus which resulted from the lack of access to specialized medical intervention, it is less surprising that other aspects were not addressed in the documents. So issues around integrating rural and urban care through communication protocols, for example, were not mentioned.

Reasons for the Urbanization of Childbirth

Pregnancy and childbirth services in rural communities were understood by all to have a greater degree of risk attached to them than services in urban areas. Reducing the risk during childbirth for a rural woman was interpreted as meaning an urban birth. It appeared that women and health care providers in this study saw risk in terms of potential harm towards the fetus. Given this, rural reproductive care was primarily about predicting and eliminating risk to the fetus. It was not about predicting and eliminating risk in the broader sense of health and well-being of the woman and her family.

The degree of risk assigned to a pregnancy controlled the birthing location. If a pregnancy was deemed high-risk, neither the women nor the health care providers supported a local delivery. Whereas if a pregnancy was considered low risk then a local birth was an option, albeit one that was rarely acted upon. Statements made by health care providers participating in the study illustrated this.

> I will not deliver primips and anyone pregnant for the fifth time or more...My practice has not changed, I will only deliver low risk, and no primips. (Interview notes, April 3, 2001)

and

> If a first time pregnant woman wants to deliver locally and is low risk, I support it. Though this is the minority. Most first time moms say, "I want to deliver elsewhere". All primips are leaving, haven't had anyone want to stay. (Interview notes, October 22, 2001)

Another reason for the urbanization of childbirth was related to the perception that rural health care providers were not competent with

childbirth care, particularly labour and delivery services. The rural health care providers did not feel competent with deliveries. Because of this perceived lack of competency in labour care, the health care providers focused their attention on the management of prenatal risk. One rural physician explained:

> The doctor's experience and comfort are a factor in deciding whether or not to do obstetrics. I'm quite conservative. (Interview notes, April 3, 2001)

Another physician commented: "First time deliveries have a greater chance of being unpredictable" (Interview notes, October 22, 2001). And a nurse with an extended role who had worked in a community on the northern part of Vancouver Island for about five years commented:

> Nurses in rural communities are "Jacks-of-all-trades, masters of none". With delivery there's some mastery involved. I'm uncomfortable with attending labours, as I would be the only health care provider there who'd attend to the birth. I'd have no other helpers. The stress factor would be very high. (Interview notes, June 18, 2002)

The rural health care providers felt they had fewer competencies in childbirth. Their perception of lack of competency reinforces the norm and supports that urban birthing is the right thing to do to ensure a healthy baby.

The rural pregnant women felt that the rural health care providers lacked competency in the area of childbirth. The women drew from previous experiences with the rural health care system and providers and from other women's childbirth experiences to conclude that rural health care providers were not as competent as their urban counterparts. For

example, Lucille drew upon an experience with her child who had to be medically evacuated out of the community in her decision-making regarding relocating to deliver. Lucille explained:

> ...[B]ecause of having a Caesarean with [my first pregnancy] there was just, I wasn't staying here. I was definitely going down Island to have my baby...[My doctor] had asked – no I'm not staying here, no. I'm going out of here because it had only been a year and a half, two years maybe [when my child] had fallen down with a stick in her mouth and it had scraped all the roof of her mouth and down her throat a little bit. And they flew us [out] for fear that her throat would swell up in the middle of the night and she wouldn't be able to breathe. And so that had me on guard forever that they just don't have life saving equipment for kids here so I just, no, no, no and I don't want to be, you know, stitches in my vagina, and flown out of here, [or] something wrong with my baby, or you know, labour is not progressing and doing labour in a chopper somewhere, something so I just – no, I have a place I can stay, I'll go and stay there.

Kari described why she relocated for her first two births:

> At the time I thought I'd prefer not delivering [my baby up here] just for that you don't seem to view the nurses as nurses when you see them in their other occupations you know: Working [elsewhere] and then you see them in the hospital you just – there's that conflict of 'is she really a nurse?" You know? Obviously she is but it's just hard to visualize her as that. So I always felt it would be better to be out of town until you're actually there.

The women were wary of the rural health care providers' delivery skills, which were strongly believed to not be as good as those of urban health care providers.

Focus of Discussions Limited to Where and When to Relocate

Discussions of urban deliveries for rural women were focused on a safe and healthy delivery, rather than extending, for example, to postnatal care in their home communities. Choosing an urban location for delivery was the primary focus of discussions with health care providers and

others. Kari's comment typified the responses of the women when I asked them to reflect on what discussions they had with their physician about going elsewhere to have their babies,

> The discussion and the questions asked to me was where I was going to have them. Courtenay? Campbell River? Nanaimo? Victoria? And so forth. ...The only decision that we [had] was where do we want to have them.

I similarly asked the health care providers participating in the study to reflect on the discussions they had with pregnant women about relocation. The focus of the discussion was primarily on the identification of an urban community. A physician commented, "I ask her, 'where do you want to have your baby?'" (Interview notes, October 22, 2001)

The women were asked if they recalled discussions with other health care providers, for example, public health nurses, or during prenatal classes, about going down island that were not related to location. Valerie's comment typified the women's responses: "No nothing."

Discussions among rural pregnant women and between pregnant women and community members were also mostly limited to the location of the birth. For example Kari noted with her pregnancy:

> There was always the questions—oh everybody asked: "Where are you having the baby?" That was an automatic question that everyone asked.

During the prenatal classes that I observed, the instructor introduced the notion of leaving to have a baby[4]. The instructor was met

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[4] The prenatal instructor was aware that my interest was identifying what the impacts of relocating for childbirth had on women. Given this, I believe my presence may have influenced the discussion around relocating.

with silence from the group and attempted to broaden the discussion to more than the geographical location of the delivery. Once again she was met with silence from the group. Out of eight hours of observation of the prenatal classes, the topic of relocation was designated only a few minutes. I noted the following:

> The topic of leaving the North Island was allotted three minutes for discussion between couples to discuss their concerns about leaving. The couples broke up into three groups of four to share concerns about leaving for childbirth. The three groups' discussions centred around the question, "where are you going to have your baby?" One woman commented, "I'm planning on going to Campbell River. What about you?" The instructor called the group together as discussions between the couples started to slow down within 90 seconds after beginning. (Observation notes, April 18, 2001)

I further noted:

> Upon calling the group back together the prenatal instructor also posed the following questions to the group. "Figure out: How soon prior to [your] due date you will be leaving? Where you will be staying? Where to stay if you do not have family down island? When [your] husband should go down?" There was no response by the group to any of the questions and the instructor moved on to another topic—How do you know when you are in labour? (Observation notes, April 18, 2001)

Though some time was allotted to discuss relocating for childbirth, only a superficial discussion could occur within such a short period. Also, the discussion was limited to location and timing of leaving. There was no discussion of other important related issues such as the associated costs of going down island or making arrangements for childcare during the

mother's absence. When the group discussions stopped, the prenatal instructor did not attempt to expand the topics or lead further discussion.

After it was established that the delivery would occur down island discussions between the woman and her doctor focused on the timing of relocation. The unpredictability of the precise date when labour would begin meant that judgments had to be made about a relatively safe period within which to relocate. A month before the due date was considered safe to remain home; however, remaining home a week prior to the due date was seen as taking a chance on risking the baby's safety. Rebecca recalled:

> ...[W]e came back [home] for a week [with my doctor's permission]....I went back down a week later...and [my doctor] said that's it, you're staying here.

Usually, if a woman was not experiencing any prenatal complications indicative of an early labour, then she left her home community two weeks prior to her due date. However, the total length of time away from home varied, depending on when the woman went into labour. For example, if she went down island two weeks before her due date but went into labour two weeks past her due date she could be away for a month or even longer.

The following details the total time away for the women interviewed:

- Kari: Relocated six weeks prior; away for a total of four weeks. With her second pregnancy, relocated four weeks prior; away for a total of seventeen days. In both cases she delivered early.

- Valerie: Relocated two weeks prior; away for a total of twenty-four days.
- Lucille: Relocated (with second pregnancy) two weeks prior; away for a total of fifteen days.
- Rebecca: Relocated three weeks prior; away for a total of two and half weeks.
- Henrietta: Relocated three weeks prior; away for a total of seven weeks.

There was an attempt to accurately predict the period of relative safety for relocation and delivery, and although the last few weeks prior to the baby's due date were considered to have a greater degree of risk attached, the precise date of relocation was to a limited extent negotiable between the woman and her doctor. For example, Lucille commented,

> [My doctor] wanted me to leave on the Wednesday and I said "I can't"...[my doctor replied] "That's fine but you're going on Saturday"...and I said, "Yes, I'm leaving on Saturday"....

Challenging the Norm of Urban Birthing

The current health care system supports urban birthing and has withdrawn health care resources from rural birthing. This results in making rural childbirth obsolete and urban birthing the norm. This decrease in rural childbirth services did not go unchallenged, although the decrease was only questioned and challenged in minor ways by a small number of health care providers and rural women.

In an attempt to allow for local deliveries, health care providers in one community on the North Island made structural changes to a new hospital facility which was not designed to offer these services. They undertook a local initiative to make changes to an existing room to allow it to double as a delivery room. A physician described minor changes made to a room that were not approved by policy makers or the funding sources:

> ...[S]ince there is no physiotherapist, the physio[therapy] room has been equipped with oxygen, suction, scrub sink, and lights to make it into a delivery room. (Interview notes, October 22, 2001)

The low numbers of local deliveries, proposed policy changes that support fewer local obstetrical services, and the decrease in funding for obstetrical services have led to the slow erosion of rural obstetrical services for the north part of Vancouver Island. One health care provider described the response when he/she questioned the proposed policy change of withdrawing local delivery services:

> I was silenced by being told [by the Community Health Council] not to speak [out] about the loss of [obstetrical] services...as this would slow down building of the new facility and perhaps even lead to a review and loss of money.... (Interview notes, October 22, 2001)

For the most part the women complied and agreed with the current rural birthing practices. If a woman chose anything different, going against or challenging the norm, health care providers, other women, and family members attempted to change the woman's mind through the use of a risk discourse. The degree of resistance by rural pregnant women varied, ranging from resisting the whole notion of having to temporarily uproot, to

resisting the timing of relocating. Valerie recalled an incident with a woman who resisted going down island and ended up giving birth locally:

> I know she was supposed to be sent down island. Oh [her doctor] said she was high risk because I forget what, but what she does with all her kids is she doesn't go [to the local hospital] until [the baby is about] out you know they're out. I think she got [to the hospital by] 5:32 and at 5:36 [her baby] was born...She told me, she was supposed to be sent down island but she doesn't want to go down island.

The use of risk discourse.

Health care providers, other women, and family members invoked the use of a risk discourse to persuade a woman to change her mind about what others saw as not being in the best interest of the unborn baby. The risk of the baby dying were part of this discourse. Health care providers, other women and community members perceived the use of risk as motivational in reducing risk and supplied information to facilitate this. Valerie described her physician's response to her challenging her physician:

> ...[My doctor] gave me the spiel about you know not having a neonatal resuscitation thing...told me about, you know flying in, flying out, if there was a problem...[the doctor said that he/she] could do an emergency C-section if...the book [was] in front of [him/her]...I said that's fine. Okay I'll have it here anyways...There was no subtlety about it, [my doctor] was amazed at my wanting to stay here [for delivery]...[my doctor] was arrogant...The next time I went in [he/she] apologized.

Rebecca shared a story about her sister challenging her physician's request for her to leave:

> ...[M]y sister had a conversation with [her doctor], and she really wanted to stay...But [the doctor] said to my sister, would you rather chance delivering here, ...everything could go hunky dory,...but

> that's a ninety-five percent chance. It's even a ninety-seven percent chance. Would you risk that three percent [on] your baby dying and my sister, said no and she decided to go down island.

Rebecca further commented:

> ...[W]hen she came back...I said, you're right...would you chance the three percent? You don't know. I said you got off lucky when you delivered here the first time.

The way the women talked about their fears and their family members' fears was not the same as the way that the health care providers described the same risks. The women spoke about their fears of things going wrong with the well-being of their babies, whereas the health care providers' focus was on the slight chance of difficulty associated with the childbirth process. The health care providers' perception of possible difficulty worked towards lessening resistance and enhancing compliance.

Most of the women displayed a cautious, guarded tone rather than a completely uncritical acceptance of having to leave. Kari recalled a conversation with the public health nurse when inquiring about a home birth:

> I talked to the health nurse at the time and she said – she kind of put a few things in perspective and had mentioned you know, what would happen, how would you feel if something happened during the delivery and my thought was it's five minutes away from the hospital. You know, she said, well five minutes is a long time if something happened to the baby....I was disappointed but I didn't go any farther, I mean after the talk with the nurse. She had good points.

The use of risk discourse played a role in sustaining the normal practice of urban birthing. Though some of the women challenged the norm, health care providers encouraged the women to have an urban

birth. For example, Dixie, a nurse in a small community in the north part of the island, described confronting a pregnant woman she refused to leave as medically advised. Dixie confronted the woman to persuade her to leave and to convince her that this was the best thing to do for her fetus' health:

> I heard from someone she hadn't left and was hiding in her home. She was to leave four days earlier. I called her and asked that she see me at the health unit. At first, she was hesitant but came in. She said she didn't want a confrontation and "I don't want you mad at me". I told her [it's] not about the nurse getting mad but what's going on for you. When she heard me say this, she disclosed the costs, having another child to deal with, and [her] first baby born on the due date prevented her from leaving. I explained I didn't have the expertise to deliver and couldn't live with myself if something went wrong....The next day the woman left the community.

The above story and the stories shared by Valerie earlier demonstrate how some women who did not want to leave attempted to exercise control over their pregnancies and went as far as to go "underground" to experience a local delivery. Such an action could have tremendous impact on the quality of the woman's prenatal care.

A rural physician described how he/she responds to women who want to deliver locally.

> [The] decision [is] between the doctor and the patient. If over numerous discussions the woman is adamant she wants to remain in the community then, I tell her, "you'd better find another doctor who will deliver your baby."

There really was not a choice for a rural woman to go totally against her doctor's wishes. The choice given to rural women was superficial and related only to geography. If a woman persisted in wanting a local delivery

even when her doctor strongly advised against it, the situation intensified to the point of removal of options for the woman. Valerie described her physician's response to her wanting a local delivery:

> [My doctor] implied I was not being reasonable or know what was best...[my doctor] just said, "well I'd be delivering it by myself."

Disagreements between a pregnant woman and her doctor could have a significant impact on the quality of a woman's prenatal care. If the woman sensed her health care provider questioned her behaviour or she felt her choice was not allowed, the woman experienced mixed feelings and was indecisive. Valerie described her response to her doctor who was not supporting her birth choices:

> I don't know, I'm going to leave it alone and go along [with my doctor]....I thought, just forget it...[he/she's] going to send me down anyways.

Community members played a role in the quest for a healthy baby. If a rural woman was seen as placing her fetus at risk, community members would attempt to convince the woman to change her risky behaviour. Henrietta was planning to leave the community two weeks prior to her due date, but her physician and community members – family, friends, and the general public - felt she should leave a month prior. Henrietta described how community members pressured her to change her mind:

> ...[P]eople were sort of joking with me, "oh you're staying here, you're gong to leave here only two weeks beforehand? Oh, that's not giving you a lot of time"....[P]eople as in doctors and the community were kind of harassing me for putting it off....

As this example shows, family and other community members played a role in convincing the woman to leave if they felt the baby was at risk or the woman was going against the norm. Community members drew on discourses of risk and responsibility in order to convince the women to do what they felt was best for the unborn baby. The public's involvement in a woman's pregnancy indicated a shift in pregnancy from a private affair to a public one. The public had a role to play in the safekeeping of an unborn baby.

Traumatic birth stories as tools of persuasion.

When women questioned relocating for delivery, health care providers shared stories of negative rural birthing experiences they had personally experienced or of which they had knowledge. The use of stories served as a tactic to make a woman understand the importance for her to deliver elsewhere to ensure a health baby. One nurse commented:

> I would share this story to encourage women to leave. A woman while in her home community had a prolapsed cord. The first aid attendant escorted the woman to [a larger community on the North Island] via ambulance. He had his hand in the woman's vagina to alleviate any pressure and encouraged the woman not to push at all. The woman was immediately transferred via helicopter to [a community about 300 km] for a C-section.

Stories of traumatic local births or other birthing stories circulated within the community. In some cases these stories took on the form of rural myths. The use of traumatic stories served as tools in the rhetoric of risk and safety to ensure the current rural birthing practices continued. These stories contributed to educating the community at large about the

heightened intensity of risk associated with rural pregnancy. These stories also served as a mechanism to ensure a rural woman would do what was "best" for her baby's health—have an urban birth.

A description of a traumatic birth story appeared in the obituaries section of the local newspaper, the North Island Gazette (Obituaries, 1999). This traumatic birth, which ended with a baby dying on route to an urban hospital, contributed to the general public's knowledge about the risk associated with a rural birth, and became one of the stories that was repeated by women. The newspaper announcement was:

> On July 23, 1999 an event took place that has had a profound effect on the lives of Gordon and Eleonora Brown and their family, friends, and the lives of many North Islanders. Jonathan Aaron Brown, a soon to be resident of Port McNeill struggled hard to be born. In his haste to be part of our lives he reached for us with his hand and arm as to shake hands and introduce himself. I, his father, held his hand as he did mine. We travelled by ambulance to Campbell River for help during this birth complication but the trip was too far. His struggle ended, and he passed away near Eve River. As parents, we would like to thank [the doctor], the nursing staff of the Port McNeill hospital and the ambulance crew for their work towards his birth. Over the last several weeks that have passed, we have had tremendous community support which has come in many ways. We would like to thank you for all your help, food, thoughts and prayers. Jonathan was laid to rest at the Port McNeill Cemetery on August 3, 1999. You will be forever in our hearts our little Jonathan. (p. 33)

Disillusionment and Difficulties with Urban Birthing

The disappointments associated with urban birthing did not fully present themselves until after the delivery of the baby. Focussing on the fetus and the production of a healthy baby obscured concern for the health and well-being of the woman and in particular the well-being of other

children and the woman's partner. The women and their families experienced tremendous challenges and hardships in order to produce a healthy baby. They endured periods of social isolation, additional work, and financial hardships. The current rural birthing practices associated with relocation did not take into consideration the impacts that relocation had on the women and their family.

The women and the health care providers operated within a narrow notion of good care. This meant the production of a healthy baby was interpreted as being limited to the labour and delivery aspects of childbirth. It did not extend beyond "getting the baby out". Because of this, other aspects of pregnancy and childbirth were obscured. Lucille's comment demonstrates that the women and their partners overlooked or did not think about other burdens associated with relocation:

> I think at first because we're on this small island and we think 'woohoo, we're going to Campbell River', and we're going to be in Campbell River for two weeks, you know. I'm going to buy baby clothes, I'm going to buy the rocker or the crib or whatever. I think it's kind of a, a little bit of an excitement when you first get to go. I get to go, you know, and I'm going to do some shopping because there's no baby stuff here. But I think that they don't realize the impact until they come back. So, I don't think many questions are asked before they go down because they are just excited to go, they are going to have their baby, you know? I think that when they come back they realize that was the longest two weeks of my life, you know. It wasn't any fun. I didn't like staying in a hotel for two weeks.

Prior to leaving, the women were not thinking about the down side of relocating to have their babies. Their focus was on creating a healthy

baby. It was not until they returned home that the women described experiencing hardships endured while away.

Hidden burdens of relocation: increase in workload, family responsibility, and financial costs.

The normalizing of urban birthing obscured the women's own work of predicting and managing risk to the fetus. The women were travelling back and forth between medical appointments, faxing information to their doctors, and arranging their medical appointments, as well as monitoring their own behaviours. The current medical system did not recognize the work the rural women undertook to ensure healthy babies. Valerie described how she handled and arranged her care:

> ...I faxed [my doctor] because I called twice and [my doctor] never returned my call, so I finally faxed [him/her] and said, 'you know I'm faxing you because you're not returning my calls. I've made an appointment for another ultrasound because [you] told me I should get another ultrasound and you haven't told me anything about the results from the last one.'

Valerie continued to explain:

> ...I left messages for [my doctor] to call me concerning the results of the ultrasound, [my doctor] didn't call me [back]. So I faxed [him/her] and just said I've made another appointment down in Comox for another ultrasound you know I'm going tomorrow thanks. I go down there, we have no [requisition], [I suggested to the technician] to call [my doctor for the OK]. Of course [my doctor] OK'd it.

Since the decision making process was about when and where to relocate and minimizing the risk to the fetus and not about burdens placed on the women, the impact of relocating did not figure into the discussions with health care providers or others. Consequently, the women just went

ahead and actively took on additional tasks of managing the risk towards their fetuses, as they understood them and within a medicalized view.

Given that the focus of rural perinatal care was primarily the production of a healthy baby, other aspects such as the well-being of the family did not come into play with the health care providers. The women's sense of caring for and managing her family relationships were not part of the discussions with health care providers or others. The health of the fetus and managing the risk towards the fetus overshadowed concern for existing children and for the well-being of the family relationships. The current medical system was not set-up to deal with these issues. This was not the case for the pregnant women. They continued to pay attention to the well-being of their partners and other children. Valerie described her physician's response to her questions about the care of her child should she need to be transported out the community during childbirth:

> I'd ask, I mean if I had to be flown out, about [my daughter] and the dog. No nothing, nothing was ever discussed. So that's sort of my problem.

The health care providers were not concerned with the rural women's other children or how the women's family would fare without her during her time away. Interactions between health care providers and women and the health care system and women did not address the management of family and children relationships. In addition to producing a healthy baby, a rural woman took on the additional responsibility of

ensuring the survival of family. Lucille described her concerns with managing her family's well-being while away:

> I was really worried about how [my other child] was going to behave when we got home with the baby and so I didn't want to be down there without her because then when I come back she's going to be double wanting mom because mom's got this other little baby too and also her being away from me for two weeks and so I was concerned about that. But on the other hand I thought how am I going to be? Irritable. You know, it's warm, it's May, you're down there so do I want her down there you know? And then when she's down there with us, what? Where is she going to go when I go into labour, cause [my partner] had to stay here and work and my cousin who I was staying with, she works also so we were all kind of – how is this going to work? I will be home with [my cousin's little boy and my daughter] and then if I go into labour, you know, what am I going to do? We've only got the one vehicle. [My partner] kept the vehicle up here for when I go into labour so he could whip down to see me and stuff so it was – it was a big concern. What am I going to do with the rest of the family and you know, [my partner] doesn't eat properly so I'm making meals for the freezer and stuff for him. Making sure that everything is all prepared for when I come back that [my partner's] still alive and healthy and whatnot. So, it was a tough decision. We ended up taking [our daughter] down there with us.

The health and well-being of the whole family were not the focus of rural reproductive care. The women struggled with the management of their families at the same time they were planning for their time away. The women continued to feel a sense of responsibility for the well-being of their families while living away from home. This meant ensuring their partners were taken care of, organizing childcare, preparing their home for the baby, and planning for partners to join them when labour began.

Another burden of relocation was the costs associated with relocating to give birth. If a woman resides on the north part of Vancouver Island, the fact that no hospital there can provide labour facilities results in

costs that are borne by the pregnant woman. Except for Status First Nations women, a rural woman must pay all expenses associated with relocating for an urban birth, such as travel and accommodation, and even for First Nations women, many costs are not covered.

A large financial burden was placed on rural women and their families when they temporarily relocated away from home. These costs were obscured and were not discussed prenatally. The cost of an urban birth varied for each woman. Valerie commented on this, saying:

> We spent the first two weeks in a [motel] suite, twiddling our thumbs. It was our holiday because my husband ended up using all his vacation time. It was great for him and [our daughter] because they played together while I just waited around. Financially going down island was a drain. It cost thousands and thousands of dollars.

Though First Nations women qualified for the First Nations and Inuit Health Branch, Health Canada Patient Travel program, the amount provided did not cover all of the costs. This program covers the costs of accommodations, meals, and travel expenses. This program is provided for Registered First Nations women. A First Nations woman participating in the study, commented:

> Being in the financial position that we were in at the time. I mean we didn't have any money to go out and do things so we spent pretty much all day and night in the hotel playing cards, playing cards and that was about it you know, cards and cards and cards. I don't recall off hand if [my partner's] meals were covered or not. It was more I mean we weren't starving. They covered the meals and so forth but there was no money for, you know, to go to a movie.

Other hidden burdens: social isolation and separation from traditional territory.

What was also overlooked and not taken into account in the process of an urban birth or "going down island" was the social isolation experienced by the women. Ironically, the women were far more isolated in the urban settings which theoretically provide opportunities for a larger range of social activities and outings. Lucille's story quoted above illustrates this.

The rural women had their babies away from home, away from familiar surroundings, and often without their partners. Henrietta described delivering her baby without her partner.

> He really missed being there definitely and I missed [him] being there, you know, sort of missing everything. When he was down a couple of weekends, we're trying to induce labour—all that pressure. Like when he'd go. Oh no, I'll have to hold off for another week in case he can't get down again. So, yeah that was a big impact on him. I know he really missed [being there], cause he really liked being there [with our first child].

Kari's birthing stories illustrated the impact that not knowing anyone and unfamiliar surroundings had on her birthing experiences. She experienced isolation from her family and children, unfamiliarity with the surroundings and the health care staff, and separation from her baby with her first two deliveries. When Kari was requested to reflect on her three birthing experiences, she identified her third birth as her best experience. Kari delivered her third baby locally with her partner and other children

present, whereas she delivered her first two children outside her home community. Kari described her first birthing experience.

> It wasn't fun. No, we were stuck with [my partner's] family in an apartment, small apartment building—her two twins, or her set of twins and a little boy. [My partner] was there and I didn't know [my sister-in-law] pretty much from a hole in the ground, it was quite—and being so young, I was quite uncomfortable there.

About her second delivery, Kari commented:

> [My second pregnancy] was a bit different in the sense that we were in [a community closer to home] and we were in a hotel room. So we had the hotel room to ourselves. We didn't have to worry about coming in or going or having those things to worry about also. And we were right across the street from the hospital. With [my second delivery] I wasn't induced like with my first one, so that was a bit different. It was a bit, it was a little less stressful in the sense that you don't have all the special medical personnel telling you what to do. You're kind of deciding on your own…It was a little nicer. I think it's a smaller hospital. You get a little more personal attention there than you did in Victoria. We did not have our daughter with us. She stayed back home with her grandparents.

Kari delivered her third baby locally and described this delivery as the best even though both she and her baby were transported to Vancouver within twelve hours of giving birth. Her baby had been born with an unexpected congenital abnormality that required emergency surgery. Kari described her local birth experience:

> Great. Amazing. I wish I'd had the other two here, now that I've actually experienced what it's like to have kids here. It was so comfortable. I always wanted to do the at-home, count your contractions, the whole delivery thing, you know the labour thing which I've never been able to do. With [my third], I was able to do that and again, the health nurse had come over and she had been there – she talked – because [my baby] was a month premature, we'd had a couple of pre-natal visits with her. But with him being early, she'd ended coming over earlier and doing a crash course while it was happening. So finally I was in labour with him for three days and it was on the second evening, that I said, 'take me to the

> hospital, I'm having him now'. I got to the hospital and I was two centimeters dilated. I cried and the next morning we were able to get up and they said, you know, if you don't want to stay - you can go for a car ride, do what you want. So we went for a car ride, we went for lunch at the [local café] and we went back to the hospital. We had that freedom. We had the whole ward being that [we were] the only ones having a baby in [the town]. Friends could come over and visit and hang out. They brought a cot in for [my partner] to watch the game while I was in labour.

She continued to explain:

> When my [baby] was delivered the doctor did not know what was wrong with him and I could obviously see what was wrong with him but he didn't know the name or how to treat it. [The doctor] put him on my stomach, he grabbed him and moved him and at that point they realized he was not breathing and they took him. They did whatever doctors do, you know, they got him breathing and he left the room. The nurse at the time had come over and talked to us and said [my baby] was having complications and the doctor was heading off to call Children's Hospital. At this point they had no idea how [my baby] was going to be transported out to Children's—whether it be by helicopter or airplane. If it was by helicopter we couldn't go. We wouldn't know until it showed up.

I was surprised to hear that Kari described her third birthing experience as her best one. I would have expected Kari to talk about her third delivery not as a good experience, since the baby required urgent surgical intervention that was not available locally. In fact, I would have thought that all the uncertainty about whether or not a parent could accompany his/her baby would have taken away from his/her experience. This was not the case. Kari described having her family and friends and an established relationship with the health care providers as contributing to her local birth as her best experience. The more familiar the surroundings and involvement of family in the childbirth experience the more favourably Kari described her experience.

Given that the majority of First Nations communities in BC are located in rural areas, the number of First Nations women delivering their babies outside their community is high. My work in First Nations communities has taught me that the connection with family and territory for First Nations people is fundamental to their well-being. It came as a surprise that the First Nations woman participating in this study did not raise the relational aspect of community and family as important during childbirth.

Since the First Nations woman and her family was also operating from the dominant stance that the fetus was the sole focus, all other aspects were not of immediate concern. Birthing outside of one's traditional territory was not raised as a concern for the First Nations woman as she was focused primarily on the production of a healthy fetus. Rural pregnancy and childbirth did not incorporate the broader aspects of the connection of a healthy community, culture, and continuity with land. There was no space to worry about spiritual dislocation or think it was important. The First Nations woman participating in the study commented:

> I was born here, my brother who was born in 1983 was born [here], and my mom was delivered [here].

When probed further about the effect this had, she did not elaborate or make any further comments. The First Nations woman participating in this study did not raise the role of birthplace for First Nations people, nor did the women with First Nations partners.

In all cases, the emotional and social costs to the women and their families are overlooked. For most of the women in the study, their feelings about temporarily relocating were mixed. The women sought childbirth care in urban centres because it was best for the health of their unborn babies, but the emotional costs of relocation the women experienced included feelings of isolation and dislocation were unseen.

Summary

The current rural birthing practice of being sent down to an urban centre was a self-sustaining process with very few opportunities to question the practice. The current practice of relocation for childbirth was congruent with and contributed to policy shifts. The risk management approach served as an effective tool to refer rural pregnant women to urban communities for birthing. Women requesting a rural birth or going against their doctor's advice were perceived to be placing their babies at risk and were persuaded to comply with the norm.

Chapter 5

Discussion and Implications

Discussion

This study of five rural women's experiences of childbirth exposed many issues they had regarding the nature of rural birth, health care providers, pregnant women, and community members in relation to rural motherhood. Based on the findings described in the preceding chapter, four major topics for further consideration from this thesis are:

- Rural birthing was a contested site where gendered work was played out.
- The medicalization of childbirth obscured consideration of the health and well-being of the women and their families.
- There was a shift in the costs of health care from the public domain to the private, and the transferred costs were borne by the rural women and their families.
- Rural geography was designated as a form of risk in pregnancy and childbirth.

In this chapter, the study's findings will be considered within the broader context of health care delivery, particularly birthing practices. The findings will also be examined within the broader cultural context of patriarchy and health care reform to illustrate the effects current birthing practices have on women residing in rural communities. This examination will answer the central research question: What are the impacts of rural birthing practices as it relates to having pregnant women temporarily uprooted from their home community to deliver in

another community? The social control of women through medical practitioners and the medicalization of childbirth are central to the topic and provide the basis for this discussion.

Synopsis of Findings

This study found that there was little support among rural health care professionals or the rural women for local rural deliveries, and the decision of whether or not to have a local birth rested for the most part with the physicians. To maintain this control by the physicians over childbirth, the participants—health care providers, pregnant women, their families, and other community members—repeatedly invoked discourses of risk and responsibility. These discourses played a significant role in influencing the pregnant women's decision-making as it related to the health and safety of their fetuses.

The administrative structures responsible for health care delivery in the northern area of Vancouver Island further legitimized urban births as the desirable norm by supporting the elimination of maternity services for rural first-time-pregnant women. Though no written policies existed, health care providers participating in the study made reference to meetings where the creation of these policies was discussed, and they acted in concert with these unwritten policies.

On the premise that rural pregnancy and childbirth were risky by nature, urban births were advocated as a means of providing "the best possible" birthing care. Once this practice became the predominant means of birthing for rural women, health care providers, the women, and their community members reinforced the message that rural births threaten the safety of the fetus.

The trend to send rural women to urban communities to have their babies has steadily increased with improved access to urban areas. One rural physician recounted:

> Prior to the road being built around 1978 to 1979, [I would] often performed C-sections with [one of the other doctors in the area]. When the road went through this resulted in making transferring [pregnant women] out of the community easier.

The ease of travelling inadvertently contributed to increasing the number of out-of-town deliveries for the northern part of Vancouver Island.

With the decline in local deliveries on the North Island, a referral process for sending women down island for deliveries was established. The formalization of this referral process has made it easier to organize out-of-community birthing. Over a relatively short period of about thirty years, local rural deliveries have become an anomaly and urban births a common practice. With more births occurring in communities down island, the physicians in the northern communities on Vancouver Island were delivering fewer babies.

Rural Birthing as a Contested Site of Gendered Work

Women's bodies increasingly have been medicalized as medical intervention into women's bodies, including reproductive health, has become normal (Balsamo, 1999; Goslinga-Roy, 2000; Oakley, 1986; Rothman, 1996). This increased medicalization has presented women with more choices as well as increasing social control over women's choices. Medicine has come to play a greater role in the regulation of women's lives. Women's bodies can be described as "...maps of power and identity" (Goslinga-Roy, 2000, p. 117). The way in

which women's bodies are characterized during pregnancy and childbirth shows the manipulation of motherhood to achieve certain social ends.

In this study the goal of childbirth was found to be the safe delivery of a healthy baby. This goal can be interpreted as working against the notion of reproductive choices for women, as well as shifting control towards the health care providers, allowing them to have power over the birthing process. This study found that the women's previous childbirth experiences were not valued or given a voice. The result of "silencing" rural women has been that the authority for decision-making has been turned over to the medical practitioner.

Social control of mothers.

While there are personal implications that result from the current rural birthing practices, these practices also play a role in the social construction of motherhood. Motherhood is socially constructed through interactions with the medical system, health care providers, and the general public. When pregnant women adhere to strong rules in order to protect their fetuses, their actions and behaviours confirm their identities as good parents. In other words, women are socially defined through their behaviours.

Reproductive care is embedded in complex social relations. Power relations are expressed through medically managed pregnancies, legislated fetal rights, and maternal responsibility (Balsamo, 1999). The profession of medicine takes on the role of an agent of social control. With this in mind, reproductive technologies serve as tools to exercise power and control (both social and physical) over the pregnant woman. The emphasis on "...watch[ing], guard[ing],

intimidat[ing], and polic[ing]..." (Balsamo, 1999, p. 85) of maternal bodies implies that mothers require assistance to fulfill their public duty of producing healthy infants.

Today mothers have the duty and responsibility to produce a healthy child (Balsamo, 1999; Greaves, Varcoe, Poole, Morrow, Johnson, Pederson, and Irwin, 2002; Oakley, 1981; Oakley, 1986; Rothman, 1996; Thurer, 1994). Consistent with this view, women are held responsible by society if they do not fulfill their social duty of producing healthy children. This view is pervasive throughout society and often goes unquestioned or unnoticed.

As pregnancy has been increasingly defined in bio-medical terms, a link has been formed between medical professionals and pregnant women. The physician serves as an agent of social control within the medical system. Foucault (1972) describes a social system in which power is embedded, resulting in an increase pervasiveness of social control. The daily practices of the social system, including the practice of medicine, contribute to and assist in the management of people. This form of power, which Foucault called "governmentality", is highly effective in controlling populations to contribute in particular ways to society.

Further, Foucault (1972) believes that the medical profession, through the form of disciplinary power, plays an influential role in the social construction of an ideal person. An ideal person is defined as having good health and displaying appropriate "normal" behaviours, such as contributing to society by participating in the labour force (Gastaldo, 1997). The medical management of the maternal

body serves as a means to control maternal behaviour to ensure a healthy baby. For women participating in this study, this meant relocating to give birth.

"Scientific motherhood".[1]

It is through risk management actions that health care providers participate in the construction of the ideal person and thus assist in regulating the population (Rose, 1996). The apparatus of rule "does not seek to govern through 'society', but through the regulated choices of individual citizens" (Rose, 1993, p. 285). The profession of medicine contributes to the transformation of society through productive, healthy individuals or management of medical problems. There is an overall acceptance and valuing of the ideal person by society in general, which results in the legitimization of the concept, furthering medicine's hegemonic authority.

The interpretation of rural motherhood as dangerous further defines pregnancy as pathological. Pregnancy and childbirth are defined in terms of "risk ideology" which focuses on the potential for harm to the fetus due to the mother's physical and lifestyle behaviours. This, in connection with increased medical technology, implies that pregnancy and childbirth require management by an expert. Reproductive care becomes a strategy to monitor and intervene in pregnancy in "the best interest of the unborn child". Maier (1992) argues that the new reproductive technologies and the concept of the best interest of the unborn

[1] The term "scientific motherhood" is used to "describe a system of mothering which ... came to be increasingly based upon principles of efficiency, logic and reason...and that science was capable of finding answers to society's problems" (Brennan, 1998, p.12).

child may lead to "reproductive wrongs" in which the woman's basic human rights are violated under the "guise of child protection" (p. 149-150).

Motherhood is understood to encompass the woman's sole responsibility for the well-being of her child (Arney, 1982; Kaufert & O'Neil, 1993; Malacrida, 2002; Oakely, 1986; Rothman, 1989; Thurer, 1994). The notion of a "good mother" implies that a woman will produce and rear a healthy, well-adjusted child (Rothman, 1989; Thurer, 1994). A mother is faulted should she not produce or rear a healthy child. The concept of mother-blaming is common within the fields of psychology and health. Nelson and Robinson (1999) note:

> ...even today, mothers are held responsible for almost any disorder that their offspring might develop, including bedwetting, schizophrenia, aggression, learning problems, and homicidal transsexualism. The concepts of competent motherhood and incompetent fatherhood are nowhere to be seen in the clinical literature. (p. 402)

The women in the study supported "scientific motherhood" particularly through their support of the need for physician-managed pregnancies. Though the women knew they were pregnant, they had their doctors confirm their pregnancies. Though one woman participating in the study was planning a home-birth attended by midwives, she continued to see her doctor throughout her pregnancy. Physicians had access to equipment and technologies that others did not. Much of the physicians' information was gathered through the use of reproductive technologies, such as ultrasounds. Reproductive technologies continue to reinforce scientific authority over pregnant women and the women of this study saw the physician as the expert authority. "Reproductive technologies

provide the means for exercising power relations on the flesh of the female body" (Balsamo, 1999, p. 82).

Mothering—enacting a moral obligation in a rural context.

Additional hardships are placed on rural pregnant women in contrast to urban pregnant women, in the name of harm reduction and safety of the rural women's unborn children. As a result of the current practice, women are seen as "behaving badly", in other words, as willing to place the fetus at risk of harm, if they even suggest that they might like to have their babies in their home community. Women who do raise this issue experience intense pressures by health care providers, family, and community members to conform.

As with the other women participating in the study, Henrietta's comment about "of course we have to go out" demonstrated the extent to which pregnant women have come to take for granted the fact that they really have no other option. The rural women were left without birthing alternatives. An article in Today's Parent Prenatal Guide (1999) states, "if you live in a small community your choice of caregiver may be limited" (p.28). For the rural women participating in the study, birthing options were limited to identifying a community other than their own in which to give birth. In the not too distant past, childbirth regularly took place in rural communities. This raises two questions: what evidence *really* exists to support this practice of relocation for birth and why have very few thought to question it? Though the lack of local birthing options has produced copious discussions and debates amongst health care providers and the BC Reproductive Care Program, there have been few solutions.

Given the apparent choices available to rural pregnant women, closer examination raises the question "are the choices *really* choices?" The perception by women and society is that the well-being of unborn babies rests solely with the pregnant women (Nelson & Robinson, 1999). Given this heavy burden, apparent decisions around childbirth seem more likely to be compromises or a result of being overpowered. The rural women participating in the study based their decisions on the strongly embedded belief that urban birthing was the best option available to receive quality reproductive care and ensure a healthy baby. Within this framework, it would seem that rural women made decisions about delivery location in response to an offer they could not refuse—the safe delivery of a healthy infant. To choose otherwise would be to ignore their moral obligations.

The notion of calculated risk has long been associated with pregnancy and childbirth in an attempt to control the unknown (Arney, 1982; Hall, 1994; Hardin, 1997; Oakley, 1984). The participants in this study were aware of the degree of risk assigned to their pregnancies by their doctors. At first glance, the notion of risk appears to be very simple, "...risk exists as a statistical construct, a product of analyzing aggregate data..." (Kaufert & O'Neil, 1993, p. 32), and is used to justify an intervention or action.

The notion of risk creates the illusion that untoward events are predictable and avoidable (Greaves et al., 2001). The use of risk discourses implies that risk is controllable. Events that were at one time simply described as harmful are now often described in terms of calculated risk. Since pregnancy and childbirth are

unpredictable, it is not surprising that risk has been applied to these events. "The current understanding of risk sets the stage for an acceptance of a "science" associated with risk that can allow us precision in estimating and predicting aspects of human behaviour" (Greaves et al., 2001, p. 11).

Reduction of risk in pregnancy took on the form of moral behaviour on the part of the mother. In this context, pregnant rural women in this study were obligated to act responsibly. In response, they went the extra mile and initiated the process of medical management for their own pregnancies.

For the five rural women in this study the primary responsibility for producing and rearing children rested for the most part with them. The women acknowledged the tremendous hardships and additional work associated with leaving to give birth in another community. Leaving behind the family vehicle and meal pre-preparation for their partners are examples of the additional work placed on the study's participants. Rarely did their partners experience similar additional burdens. The presumption that mothers are solely responsible for their children's welfare ignores the role of the father, the social environment, and other social forces. Common sense indicates mothering does not occur in isolation.

Narrowing the focus of the responsibility of the well-being of children to the mother only, is to suggest that complexities and difficulties are non-existent and ignores the impact of gender, class, and race. For example, when First Nations women relocate for childbirth to an urban community, they are separated from family and community. As a result they are not exposed to traditional childbirth practices, beliefs, and traditions which could negatively impact their birthing

experiences. The impacts of this separation from traditional territory and practices are not taken into account within the current medical practices of relocation. Since the focus by society and the medical establishment is on the individual – in this case the pregnant women, instead of on the medical system, attention is diverted away from the social issues. This narrow focus obscures differences and inequalities by not paying attention to dynamics of gender, class, and race. A deeper understanding of the multiple impacts of social inequalities on rural women, their families, and communities could result in a shift towards a system that recognizes that the needs of women, children, families, and communities are interdependent.

Standards of good mothering are vague, constantly changing, and unattainable (Rothman, 1989; Thurer, 1994). The role of motherhood is ambiguous. Mothers are often viewed as protectors of children but current rural birthing practices have resulted in an altered sense of motherhood. Current rural birthing practices imply that motherhood and pregnant women are dangerous to their children if the women deliver locally.

In this study the practice of "going down island" could be seen as being maintained at least partly because concerns for the safety of the baby predominated for the participants, The rural women in this study contributed significantly to this situation, even doing much of the work that is needed to facilitate the delivery of their children in urban settings. The reaction to the dominant view of rural motherhood by the study's women was to organize their prenatal care and temporarily relocate for delivery. When the women complied by

doing what was seen as best for the baby, they were seen as acting responsibly and as protectors of their children.

Enforcing responsibility.

Placing reproductive care in social context has served to provide an example of the exercise of power in a systematic way. In this study, the use of risk scoring was directly connected to how reproductive care was provided to rural pregnant women. The power relationships were played out through the limited options of birthing location for the women in the study. If a pregnancy was scored high on risk assessment then a local birth was not an option. Power was integral to the practice and was exercised via the medical system. The process of risk assessment has become diffuse and embedded within the medical structure and power circulates within the healthcare system producing inequalities. It is difficult to isolate the nature and the source of the power since all health care providers, women, and their families, and community members participate.

The coercive characteristic of medical intervention often goes unseen and unquestioned. The use of the dominant discourses of risk and responsibility served as a means to produce conformity. Any resistance by the study's women to the advice given by their rural practitioners was met with tactics of coercion and discourses of risk and responsibility on the part of the women's families, communities, and health care providers. Mothers were perceived as placing their children at risk by expressing a desire to deliver in their own community. Oakley (1981) refers to this resistance as "maternal culpability" (p. 205).

Henrietta, who planned to remain in her community until only two weeks prior to her due date as opposed to the four weeks recommended by her doctor, had members of the community express concern that she was leaving “things” a bit too close for comfort. She was seen as placing her baby at undue risk should she choose to disobey. This stance by the public towards non-compliant women was strong and intensified as their resistance increased. The participants' families and communities played a role in ensuring the relocation of the mother prior to birth. Surveillance by physicians and the public was the primary tool used to control the pregnant women's behaviour. It was based on the moral principle of responsibility. Reproductive care was pushed past the medical domain and into the public domain and beyond, into the personal domain of the participants. The women's behaviour was scrutinized to ensure that they did what was perceived to be the best for their fetuses and acted responsibly.

Refusal to comply with the physician's recommendations for an urban birth resulted in the invocation of a more intensified risk and responsibility discourse. Rural women who willfully disobeyed the medical authorities' recommendations regarding birth location were often faced with intense scrutiny from health care providers, family, and community members. By remaining in her home community to deliver her baby the rural pregnant woman is held responsible by her health care provider, family, and community for placing her fetus at risk. Discourses of inadequate mothering operated when the pregnant women did not comply. Women who chose not to comply went to such extremes as hiding or

"going underground" so that they would not be seen in public until they presented to the local hospital in active labour.

Though few, those participants who attempted to challenge their physician's directions experienced intense pressures to conform. The physician's responses ranged from ignoring or placing little value on the women's direct observations or interpretations, to placing a moral judgment on their behaviours. Non-compliance was read as risk taking. If the participants continued to "behave badly", they faced intense pressure and scrutiny from other health care providers, family, and community members.

Further, women at times had to justify actively declining medical intervention as if it were a duty. One of the women in the study, who insisted on a midwife-attended birth, repeatedly had to justify her decision with her rural practitioner. Her physician responded to her request by implying she was not acting responsibly and did not have the knowledge to make this decision given the circumstances surrounding her pregnancy. The use of risk discourse persuades women through fear to deliver outside of their small rural communities. A similar process occurs with alternative non-medicalized birthing movements such as midwife-attended births and home births. They are described as having a higher degree of risk attached, and therefore discouraged by the health care providers. Discourses of risk and safety now form the basis of reproductive care.

The rise in the use of risk discourse during rural pregnancies has contributed to the decline in local rural deliveries, and the concurrent assumption

that urban birthing is doing what is best for the fetus. Comments made by the participants demonstrated the coercive nature of rural reproductive care. Through discourses of risk and responsibility, health care professionals attempted to persuade and encourage individuals to make “correct” choices—in the case of this study, an urban birth.

The use of birthing horror stories served as a means of sustaining the current rural birthing practices. Successful local rural birthing stories were seldom if ever mentioned, while unsuccessful ones were sensationalized and widely circulated in the rural communities. Many of the participants in the study made reference to tragic local birth stories. These stories were repeated and used by health care providers, family, or community members to keep rural pregnant women in line when these women were perceived to be non-compliant with their physician’s recommendations. The stories reinforced the idea of danger associated with rural motherhood, thus sustaining the practices of out-of-community birthing. In summary, rural birthing was a contested site where gendered work played out. Rural pregnancies resulted in reconstructing and viewing women’s bodies in terms of physiological and moral status. Given the acceptance of medically mediated pregnancies and the moral obligation associated with pregnancy and childbirth, the women were both governed and governors.

Medicalization of Childbirth Obscured the Well-Being of the Women and Their Families

This study further finds that the medicalization of childbirth obscured the well-being of women and their families. Within in a medicalized approach to maternity care the fetus is central and as a result the woman's needs are placed secondary to the fetus. Thus the health and well-being of the women and their families and communities are not taken into account. The women in this study experienced significant emotional, economic, and social hardships as a result of relocation. For First Nations women there may be an additional dynamic that is obscured by having to relocate for childbirth. Relocation for childbirth may be seen as a form of cultural assimilation.

It is important to acknowledge that historically, motherhood has meant different things, in different settings. With the introduction and application of new reproductive technologies, motherhood has yet again undergone transformation. It has been reinvented. "Good mothering" is broadened to include pregnancy and childbirth as well as child-rearing. In analyzing the relationship between health care providers, the medical system, and pregnant women, it is possible to map the impact of provider's practices and the delivery of care the overall health and well-being of women and their families.

The medical profession has the power and control over the domain of reproductive care (Arney, 1982; Oakley, 1986; Rothman, 1989; Thurer, 1994). The mother's knowledge and opinion are not valued as much as the medical practitioner's and there is little if any room for any consideration or discussion of

the potentially negative impact of relocation on rural mothers, their children, and their communities. The needs of the health care provider should not override what is best for the rights, wants, and desires of rural pregnant women and their unborn children. It is not easy, however, to shift the dominant way of thinking and expose the current power imbalances that favour health care providers.

Current reproductive care separates the pregnant women from the fetus, creating two individual patients. The fetus is the primary concern in the mother-fetus dyad. A strong fetus-centred approach to reproductive care places the woman's needs secondary to, or competing with, the fetus' needs. "The centrality of the [fetus], decontextualized from his or her relationships serves to pit the "rights" of the [fetus] against the "rights" of [the mother]" (Greaves et al., 2001, p. 46). Within this context, for example, the relationship of family and community and in the case of First Nations, cultural identity are not taken into account. Though this approach to childbirth is interpreted as "doing good" for the fetus, it also justifies medical control over the birthing process, obscuring the well-being of the woman, her family and, ironically, the fetus.

Birthing as a form of cultural assimilation.

Although not focused on rural First Nations women's childbirth experiences, this study suggests some of the particular ways in which the well being of First Nations women might be obscured by current birthing practices. One of the women participating in the study was First Nations, and several others had partners who were First Nations and babies who would qualify for First Nations Status designation, but none of these women experienced traditional

birthing practices and all relocated for birth away from traditional territory, Aboriginal birth cultures and practices are not supported or encouraged by the Western model of reproductive practices. The Western approach to birthing dismisses Aboriginal ways of knowing by giving priority to truths substantiated by medical professionals but not necessarily by research (Kelm, 1998). The study's participant of First Nations ancestry did not experience any traditional childbirth practices during her pregnancy. She was separated from extended family while she waited in an unfamiliar community for labour to begin. This limited any potential exposure to traditional childbirth practices and knowledge.

The current model of reproductive care contributes to the maintenance of Canadian colonial relations with the First Nations (Benoit & Carroll, 1995; Brown, Fiske & Thomas, 2000; Kelm, 1998; Shah, 1998). The regimes of the current medical system and health care providers work towards the assimilation of First Nations people. Taking the view that bodies are social constructions—that is, they are "...unfinished, always under construction by the forces of society and culture" (Kelm, 1998, p. xvii), First Nations bodies are subject to influences from political and medical organizations.

First Nations people are marginalized from the mainstream and represented as the "other" (Browne, et al., 2000). Centuries of colonization have taken their toll on the health and well-being of First Nations people. The power relations embedded in the dominant health system reinforce the inequalities between First Nations and non-First Nations, so that First Nations people have

significantly lower health status than the dominant group (Kelm, 1998; Shah, 1998).

> [A health care system that is] based on the belief that ethnic minorities should simply assimilate to the Canadian health culture, and that the health care system should not be responsible for ensuring the accessibility of services to members of cultural communities....ignores the health implication of forced assimilation. (Shah, 1998, p. 436-437)

For First Nations women or families, giving birth outside their traditional territories results in separation from family, from Elders, from their community and perhaps most importantly from their culture. This practice of relocation for birth has the potential to systematically erode the meager gains that have been made in the revival of First Nations culture and blatantly works against the sustaining of Aboriginal culture, knowledge, and language (Kelm, 1998; Reynolds Turton, 1997; Terry & Calm Wind, 1993). This practice could have a profound impact on the next generation of First Nations people and contribute to the total eradication of traditional practices. It is possible that the fact that the First Nations woman in this study did not talk about these impacts demonstrates the extent to which assimilation has been successful. However this study was not specifically focused on First Nations pregnant women or cultural assimilation, so it is also possible that she did not discuss these issues because the questions asked did not create such opportunity.

<u>The burdens of relocation for birthing.</u>

At an individual level, rural birthing practices, particularly relocation to an urban centre for delivery, not only create an inconvenience for rural women but also cause significant emotional, economic, and social hardships for them and

their families. Rural pregnant women experienced lengthy separations from their families during times of temporary relocation to another community to give birth. The participants experienced feelings of isolation during times of living elsewhere to wait for their labour to begin. They often resided in unfamiliar surroundings, with little social support, and limited financial resources during times of waiting. The women in the study described their time away waiting to have their babies as the most difficult and unhappiest times of their pregnancy. The women felt the hardships associated with relocation were to be expected if they wanted to ensure a healthy baby. Personal tradeoffs were made by the women to ensure the best for their babies.

For rural pregnant women with other children, childcare was identified as a problematic issue. If there were other children involved, the woman either parented them on her own in new surroundings or she was separated from them. This was an additional stress placed on women during a time already naturally high in stress, and raises the question of the impact of this separation on the new baby and on the relationship between the baby and his/her older siblings. The women experienced feelings of guilt around disruption of the lives of their other children. The women demonstrated that their only choice would be to sacrifice the needs of their other children, as the potential negative impact on them would be less than the much more well-defined risk of damage and even death to their unborn babies. This was added to their feelings of responsibility for organizing their reproductive care, having to physically relocate, and ensuring a healthy pregnancy and infant.

Out-of-town birthing all too frequently required the women to leave their partners behind in order for them to continue to work. The women in the study who were separated from their partners described feelings of loneliness and isolation. Though often plans were made to try to have the partner present for the delivery, a number of the women's partners missed participating in the birth experience. These women either attempted at the last minute to locate someone who could be with them, or they delivered without any social support. Research indicates labouring women lacking social support during labour experience lengthier and more difficult labours, poorer pain control, and describe their birth experience less favourably than women with support (Campero et al., 1998; Hoddett, 1999; Nesbitt et al., 1990; Tarkka & Paunonen, 1996; VandeVusse, 1999). While the unaccompanied rural women still felt a sense of satisfaction with the birth of their children, the satisfaction was focused on the outcome of a healthy child, not with the birth experience itself.

The bio-medical approach to reproductive care ignores the complexities associated with motherhood (Symonds & Hunt, 1996). The narrow focus of the well-being of the fetus completely lacks focus on the role of the father, family, and community in the well-being of the child, and the negative results of this inattention. The short-term effects of relocation were demonstrated in the emotional responses by many of the study's women. They did not mention any long-term effects. This could be because relocation for birthing is a relatively new phenomenon and any long-term effects may manifest later.

Shifting of Costs from the Public to the Private Domain

In this small study focused on rural birthing practices, we can see the dynamics of how health care costs shift from the public to private domain. A result of the centralization of maternity care into urban areas is that costs previously borne by the health care system are borne by individuals, in this case by the rural women and their families. The replacing of rural care, when seen as inadequate, with urban care, thus shifts costs from the public to the private sphere. Women residing in urban areas do not have the additional costs that rural women have as a result of relocating for childbirth. Urban pregnant women often only have to travel a short distance to the hospital when in labour. In contrast rural pregnant women are expected to leave their home communities weeks prior to their due dates in order to access childbirth care. The costs of transportation, lodging, and meals away from home are borne by the rural women and their families and are often significant. For the women in this study costs averaged thousands of dollars with some reaching as high as ten thousand dollars for stays of four weeks or longer. Hotel room rates are high, especially during the tourist season when they significantly increase their rates. Although some participants stayed with friends or relatives rather than residing in hotels they contributed financially to the host household. During relocation the women were paying for their temporary lodgings as well as for their homes in the rural communities.

Another economic cost associated with relocation privately absorbed by the women and their families was the costs associated with childcare. The

women were responsible to locate and cover the costs of temporary childcare services when residing outside their home communities. For the women in the study with other children, locating childcare services for when they had to go to hospital for childbirth became an issue. The lack of publicly funded childcare services for rural women relocated for childbirth is not supportive of improving women's health, social relationships, and economic situation. Changes to health and other public systems need to be made so that responses to the needs of rural pregnant women and their families can be caring, supporting, and respectful.

Reproductive care is a fundamental aspect of health care. The health care system should ensure that all services are sensitive to diversity in gender, race, and class. Moving maternity care to urban centres creates hardships for rural women and their families. Rural women are expected to bear the expenses associated with accessing reproductive care. As a result of the costs associated with rural pregnancy, there is a shift in health care costs that adversely affects rural women, particularly those with few financial resources. This gives rise to concerns for rural pregnant women's ability to act, speak, or think independently. Rural women's freedom could be limited simply by not having the means to relocate for birth. For example, if a pregnant teenager unable to afford to relocate is seen as placing her unborn child at risk for harm, what might the consequence be?

Persons living in rural areas have average higher rates of poverty than their urban counterparts (Douglas, 1999; Troughton, 1999). Women, especially

First Nations women, are vulnerable to experiencing low-incomes (Kelm, 1998; Larson, Goltz & Munro, 2000). The Medical Service Branch of Health Canada provides funding to assist with travel expenses associated with medical travel for Status First Nations women. This includes providing funds towards travel, accommodations, and meal expenditures related to relocation for childbirth. However the First Nations woman participating in the study described the amount of the funding received to cover her costs as inadequate. The quality of life for rural mothers declines because of the physical, psychological, and economical burdens associated with out-of-community childbirth.

Rural Locations as a Form of Risk

This analysis of current rural birthing practices illustrates how the decline in the range of services and quality of rural health care is taken up as a risk factor in pregnancy and childbirth, thus reinforcing and supporting the decline. In this study geography, specifically rural location, was seen to be a risk factor in pregnancy and childbirth. The characteristics of rural health care—limited health resource availability, lower health-service utilization rates, difficulty in attracting and retaining health care providers, and lack of rural-based health research and policy—are the basis of the risk element. The context of rural health care delivery negatively affects, both directly and indirectly, the quality of rural health care (Manson & Thornton, 2000). The current governmental cost-saving strategies and health care reform have resulted in the unravelling of rural health services (Manson & Thornton). Consequently, the quality of rural health care has been declining.

The trend to centralize health care in order to cut costs is occurring throughout the provincial health care system and not just with reproductive care. Sustainability of rural health care has come into question as a result of the declining number of services. The diminishing of reproductive care in rural communities is the most significant cut in rural services (Hutter-Czapski, 1998; Iglesias, 1998; Rourke, 1998; Sawchuck, 1998). This decline is continuing. For example, a recent decision by the Interior Health Authority in the province of British Columbia to concentrate specialty services in Trail, resulted in the community of Nelson losing local maternity services, which included one of the few rural midwifery programs in the province (Howard, 2002).

The dominant view of the majority of the study's participants was that rural reproductive care was risky in nature. The features of rural reproductive care—limited access to new and advanced reproductive technologies and obstetricians and the lack of Caesarean capabilities—were identified as making rural pregnancies riskier. Further contributing to the perceived risk of rural childbirth was the health care providers' assessment of their obstetrical skill levels. The rural health care providers expressed that their own inexperience and outdated obstetrical skills contributed to placing the unborn child at risk. It was understood by the participants that urban health facilities were "safer" places to manage birth than rural ones since urban physicians attend more births, making them more experienced and therefore proficient.

This study found that other factors besides maternal markers were used to calculate a risk score. The assignment of risk scores to rural pregnancies

extended beyond the woman's body into far wider extra-corporeal spaces: nursing obstetrical skill level, geography, and the physician's perceived level of comfort and experience with deliveries. Rural geographical terrain was one factor that contributed to the classification of a rural pregnancy as high risk due to difficulty of access to specialized expertise or technological assistance in emergencies. As a result of this notion of "rural terrain as risk", pregnancy has been redefined so that a constant state of risk exists for rural pregnancies. This differentiation of risk levels associated with rural versus urban pregnancies is used to justify relocation for delivery care.

When rural health care is seen as problematic and the solution is to replace it with urban care, rural care is not improved but rather erased. The replacing of rural reproductive care with urban care is presumed to benefit the health of the fetus and the mother while ignoring associated disadvantages and costs of relocation and the possible benefits of local births.

Recommendations for Policy and Practice

Rural reproductive care, by structure, creates challenges and obstacles for rural pregnant women. The system prevents women from easily accessing reproductive care that is sensitive to their needs, and limits their decision-making, exposure to birthing options, information, and new ideas. Traditional imbalances and inequality in gender, race, and class permeate medical care and policies affecting women, their experiences of childbirth and the services designed to help them. The lack of attention to sexism, racism, and classism obscures differences and perpetuates inequities. Particularly of note is the way in which

discourses of risk and safety in rural pregnancy and childbirth obscure the inequalities that characterize the health care system as it relates to the urban-rural differences in access and delivery of health care. Geography, particularly rural geography, is a factor of marginalization. The current delivery of reproductive care explains the causes of ill health or poor pregnancy outcomes as arising from the individual woman and not from the social causes of health problems.

Notably absent from current rural birthing practices are protocols and policies discussing the preparation of a rural pregnant woman to temporarily relocate to deliver her baby. There is a tendency to overlook the impact of these practices on the rural woman and her family as well as to overlook the importance of the infant's relationships with other family members and the bonding and attachment process, the stress on the mother, and the impact on the future of First Nations communities.

The Need for a Rural Approach to Health Care

This study provided insight into the impacts rural women experienced as a result of out-of-community birthing. Clearly there are important challenges to address. A specifically rural approach is needed to address challenges that exist for rural pregnant women. The unique characteristics of rural communities must be acknowledged. Nursing can play an important role in improving health care for rural pregnant women. The policy and practice implications identified are grounded in the findings of this study and aim to improve health services delivery to rural pregnant women.

Rural health care must deliver health care at two levels. The health care system must deliver appropriate health care to individuals and families, as well as, "...work to foster resiliency in the community as a whole" (Ramp, 1999, p.10). The health care system must move beyond the individual to empower rural communities to create a sense of ownership and a voice in their health care interests or concerns (Kulig, 1999; Stout, 1999).

A rural approach to health care must take into account the sustainability of rural communities. Key values of the rural ideal such as "...the human dimension, focusing on the linkages that exist between land and people, and the sense of community and cohesion" (Troughton, 1999, p. 32) must be central to the development of a rural approach to health care. When a link is made between people and land then both the economic and health aspects are addressed. Directing the focusing on internal rural resources will support decentralized and deurbanized in all areas, including health care, and thus support sustainability of rural communities. If the concept of sustainability is to be meaningful for rural communities then "...it must be based on a combination of characteristics and relationships that pertain to the natural environment and human activity – operating together, over space and time, in harmony and to their mutual benefits" (Troughton, 1999, p. 33).

Rural health services must "...parallel this rural-system sustainability and community viability structure, conceiving of and supporting the rural community not only in conventional medical terms but as a adjunct to its environmental, social and economic health" (Troughton, 1999, p. 35). Health services would be

geared at both the health of the individual and the health of the community as a whole. As a result of adopting a rural approach to health care, the local government would understand that this holistic approach would incorporate the social dynamics of health in general and support the sustainability of rural communities.

At a health services level, a rural approach to policy development is needed to address the unique needs of rural communities. The predominant application of urban approaches to rural communities fails to recognize the uniqueness of rural communities. In fact using mainstream policies and programs to address rural health needs may actually make the situation more difficult. For example, health care providers are required today to have specialized training. The focus of this training is often geared towards "high-tech" medicine which is required predominately in larger urban hospitals. Rural health care providers require generalist skills and specific training and experience in rural medicine rather than high-tech skills. "Priority must also be given in medical schools to training family practitioner specialists in gynecology, anesthesia and emergency medicine. In addition, programs must be designed to address the shortage of general surgeons for rural practice" (Scott, 1999, p. 182).

To improve the quality of rural health services, policies and strategies must be made more appropriate to rural communities. This translates to creation of communication protocols between urban and rural reproductive services, especially in the area of discharge planning; examining the issue of rural midwifery care; examining the role for tele-medicine; improving obstetrical

training for physicians and nurses in an interdisciplinary context; and funding to assist with relocation costs. "Achieving equity in health so that income, geography, age, gender, or cultural background is not a limitation involves a re-ordering of priorities" (Shah, 1998, p. 434).

Implementation of a rural approach to health care would provide rural women with expanded birthing options and widen women's perceptions of their birthing options. Rural pregnant women's birthing options need to be supported by the health care providers and the health system. At an individual level, the first step in providing this support would be an acceptance and respect by rural health care providers for rural women desiring local deliveries. This would result in a relationship between the two that is open and encouraging the active involvement of the rural woman in the delivery of childbirth services. At a system level, investigation is needed to examine the amount of training and credentials that are needed to successfully implement rural maternity care services. This could open the door for the use of paraprofessional staff with different training backgrounds and skills. Drawing on knowledge from the community will deal with the issues of recruitment and retention of professional staff to rural communities.

In looking to end inequalities in the health care system for rural mothers and their families, importance must be placed on creating deep-seated changes in the power relations that exist for rural mothers and women in general. The belief that the safety of the fetus can be met exclusively by urban health care obscures other problems within the medical system. Recognition of the other

aspects of motherhood beyond the physical well-being of the fetus is needed to end the inequalities that exist for mothers not only within the medical system but also within society. The development of policies integrating a woman-centred approach to health services may be a way to support health care agencies to start to consider the broader influences of health care on rural pregnant women and their families.

A Framework for a Woman-Centred Approach to Rural Maternity Care

I propose a woman-centred framework for rural maternity care. The framework has the following two aspects:

- woman-centred principles
- strategies for actions

This framework is designed to improve health practices and policies by recognizing the unique needs of rural pregnant women.

Woman-centred principles.

The guiding principles of a woman-centred approach to health care will be discussed in this section. These principles provide the foundation for creating a woman-centred approach to rural maternity care in relation to service delivery and policy development. Woman-centred health care "is a holistic approach that empowers through validation of women's self-defined beliefs, experiences, and health goal, challenging current health care reform" (Boundary Women's Coalition, 2001, p. 66). A woman-centred approach to rural maternity care will shift focus away from a two-patient health-care delivery model, which falsely creates opposition between the interests of the mother and the fetus. Central to a

woman-centred perspective to maternity care is the relational aspect of mother-fetus. A woman-centred approach to rural maternity care:

Respects women's own knowledge and experiences

Considers the woman's personal and social factors

Recognizes that health is an integration of the mind, emotion, and body

Acknowledges the diversity of women

- Encourages supportive interpersonal connections with health providers
- Encourages women's self-responsibility and self-determination.

(Boundary Women's Coalition, 2001; Hoffman, 1995; Taylor, 1997; Van Den Brink-Muinen, 1997).

Implementation of these principles in health care necessitates a new way of thinking about women's health and involves more than a superficial shift towards inclusion of the mother in rural maternity care. Health services based on these principles support a more holistic and integrated approach to women's health care, and specifically maternity care.

Aims and bases of the strategies for action.

The strategies for action I identify here serve as a starting point for the development of a woman-centred approach to health care, particularly maternity care. They are aimed at both the broader health care system and the community level, and reflect ways in which maternity services can be improved for pregnant women residing in rural communities. The listed strategies are also grounded in my findings in this study.

Context-sensitive rural maternity care.

Since current health care restructuring and reorganization in British Columbia are primarily driven by fiscal restraint, attention has been shifted away from the social and political contexts of health care. Often maternity care is the first health care service to be centralized (and for rural communities, urbanized). Social, family, community, and territorial aspects of maternity care are ignored when this occurs. If this is to change, a shift in values is required. A rural lens must be applied to policy and program development (Troughton, 1999). This will assist in the creation of a new foundation that supports a shift in values. Restructuring and reorganization must address the uniqueness of rural health care, making such care context-sensitive.

Input into health policy.

One way that rural health care can be made more context sensitive, is by involving rural and First Nations women in the process, providing input into system changes. Existing structures exclude women, especially rural women, from policy development. The health care system needs to develop mechanisms and processes that would ensure meaningful input by rural women into local health policies and protocols (Browne et al., 2000). An example of creating meaningful input is the creation of a local steering committee consisting of rural and First Nations women with personal experiences of being pregnant, and rural health care providers. This steering committee would discuss and deal with issues around rural maternity care and advise the Regional Health Authorities in the area of rural maternity care policy and protocol development.

The inclusion of women with relevant experience would ensure meaningful input into policy development. This collaborative approach to policy development as a strategy is an important component of a holistic woman-centred approach to maternity care. The involvement of rural and First Nations women in the development of policies and protocols would provide the women with a voice and assist with identification of what the women themselves consider to be the important issues. Also, there are a number of examples of midwifery practices in Aboriginal communities that could inform this development.

Policy development.

There is a need to develop policies and protocols specific to rural maternity care that are broader and incorporate aspects that a fetus-only approach overlooks. Though there are specific protocols for dealing with emergency medical transportation, there is a need to develop policies that address the social, emotional, and economic aspects of relocation for childbirth. Political lobbying is probably required to achieve the needed changes.

An area of policy development that participants identified as particularly important and requiring attention was the need for assistance with the financial costs associated with relocation for birth. Participants highlighted the need for travel funds to be made available by the government to offset some of their relocation costs.

Another area requiring policy development is the creation of a formalized process for after care when women travel home with their babies after birth. Currently there are no such formalized processes. Protocols need to be

developed with receiving hospitals which deal with the issues of discharging a new mother and infant who are not in their home community. For example, a practitioner from the woman's home community could make telephone contact with her at least once prior to the arrival of the baby and once after the delivery to provide support to the woman and assess her situation. If it was deemed necessary, referrals could be made to assist the woman with accessing the appropriate support or care.

Development of policies and protocols specific to rural maternity care would acknowledge the diversities and complexities of rural health care. The new policies and protocols would move beyond a fetus-only model of care to incorporate the rural women's personal and social factors.

Formalized information sharing processes.

The current lack of formalized discussion about the issues associated with relocation contributes to dealing with the issues in an "underground" and incomplete manner. Consequently, rural women are not well prepared to deal with the outcomes of relocation, such as, for example, social isolation. Increased awareness by the rural women of the social, emotional, and economic conditions that result from relocation will assist in minimizing the negative impact of relocation for birth.

At a local community level the creation of support groups for rural pregnant women would provide a forum for women to discuss issues and concerns related to rural pregnancy and childbirth. This would provide an opportunity for women to share personal stories and experiences with other

women. Creation of such support groups would acknowledge women's experiences, provide an opportunity for women to learn from other women's experiences, and assist women with making informed choices.

Another way to share information would be to distribute information sheets. These information sheets would address issues around urban accommodations and their costs; list out-of-town childcare support, prenatal support groups, and resources; provide tips on how to cope with relocation for childbirth; and so on. These information sheets should be readily available to women and their families from practitioners and at medical clinics, hospitals, and health centres.

The current guidelines for prenatal classes should change to identify relocation for rural delivery as a topic that requires detailed discussion. At least one whole class should be devoted to this topic. The discussion should include issues arising from travel to and relocation in an urban environment; separation from family including other children; removal from the support system of the familiar local community; and the financial aspects of relocation.

Health policy makers should take into consideration the impact of the urbanization of maternity care on rural women and their families. This means health policy should be directed to integrate some of the distinguishing aspects of woman-centred care. At a minimum, rural mothers need to be part of the policy making process in a meaningful way. This would bring to the fore those health concerns that rural mothers consider to be important, ensuring that they are dealt with more adequately.

Nursing Practice Recommendations

The decrease in local childbirth services does not benefit the rural woman and has negative implications for the health of the woman and her unborn child. Nurses need to advocate the value of the availability of rural community birthing by getting actively involved in the policy making process. One such example is in the advocating of rural midwifery services, including First Nations midwifery services.

Nurses need to be sensitive to the impact of mother-blaming discourses and their devastating impact on pregnant women and, potentially, their fetuses. A more critical awareness of how nurses participate in reinforcing the dominant attitudes of society must be created. Consequently, nurses will begin to question their roles in sustaining inequities for rural mothers. Incorporating an ideology that does not blame mothers will help rural mothers to have their needs met and to trust the system. An example of making a shift in the dominant attitudes is to create opportunities for health care providers to talk with one another in an environment with some level of trust so assumptions can be questioned and examined. The examination and questioning of the current rural reproductive practice may result in a shift in attitudes amongst health care providers resulting in a health care system that supports and meets the needs of women.

It is not realistic to expect rapid changes in the current decision making process about where rural women have their babies. However, by opening up discussion on this topic more pregnant women will find their voice and current practices will not continue unchallenged. This is the first step to making changes

in the system. One suitable place to start is prenatal classes. Another is by raising awareness among nurses and other health care providers about the silence that surrounds the difficulties and inequalities associated with relocation.

The active use of risk discourse was evident in my own nursing practice. Before undertaking this project, I was unaware of my use of the dominant risk and safety discourses and how I contributed to sustaining the current rural birthing practices. For example, the focus of my prenatal discussions with women was on "where are you going to have your baby" and if a woman was unsure about leaving to have her baby, the discussion would shift to issues of safety and risk. The major area of change in my own nursing practice will be to create space for the rural pregnant woman's voice and to raise the importance of her role in making decisions about what she sees as best for herself and her unborn baby.

Further, my practice will support a woman's knowledge of what is best for herself and her fetus, and will not contribute to setting up competition between mother and fetus. Providing women with all the childbirth options available to them and creating a milieu which will support women in finding their voices, will go a long way towards moving to a place where women have real choice and reclaim their rightful role in childbirth.

Future Research

The unique perspectives of women from other rural parts of the province are also important and require further investigation to develop fuller understanding of the rural birthing practice of relocation for delivery. Suggestions for other research would be to explore:

- the impact on First Nations women of leaving their traditional territory to give birth
- the impact of out-of-community birthing on the bonding process between the infant and other family members including siblings
- the impact of out-of-community birthing on breastfeeding rates.

Conclusion

In all parts of British Columbia, medical authorities govern reproductive care. The medical system, its focus, as well as its practitioners have been instrumental in shaping pregnancy both within society and in the relationship between the pregnant women and their health care providers. In summary, analysis of this study's findings suggests that even though medical practitioners sought to provide good quality reproductive care, they did so by justifying, legitimizing, and sustaining control over the pregnant women. The study found that reducing the importance of women's subjective observations, devaluing their interpretations, and moving pregnancy from the domain of the women into the medical system and by default into the public sphere, standardized the fragmentation of reproductive care. The general rural public was skilled at supporting the current system of out-of-town birthing. Medical professionals as well as family and community members navigated women through the perceived labyrinth of risky pregnancy.

In the current health care system of turf disputes and fear-based protocols, it is a challenge to provide woman-centred reproductive care in British Columbia. The current fetus-centred approach to reproductive care places the

needs of the fetus over the mother's and obscures the health and well-being of the woman and her family. The increase in the medicalization of women's bodies and the basic process of reproduction, as well as the health care providers' fears of litigation contribute to the erosion of woman-centred reproductive care. Furthermore, with the erosion of maternity care in BC becoming the trend, Canada's standing of having the lowest maternal mortality rate in the world could be lost. Reproductive care must better meet the needs of pregnant women by shifting the focus to the women, and recognizing the importance of their hopes and dreams for the birth of their children. My hope is that this research will inspire further examination of the impacts of rural birthing practices.

Epilogue

A Case Study of Change

In an attempt to create an opportunity for change in the delivery of perinatal care at the health centre where I work, I implemented a pilot project to deal with some of the issues surrounding the birthing practices as they relate to relocation. Birthing practices in this rural community are consistent with the provincial trend of rural women relocating to an urban community for childbirth. Pregnant women in this community express issues similar to those expressed by the women participating in my study. Given this, I thought I would try to implement some of the practice recommendations I suggested in the final chapter of this thesis.

In my role as the health centre administrator, I have worked to create a perinatal outreach position primarily responsible to provide information, support, and education - that strongly focuses on relocation for birth and the impacts of these practices on the birthing experience - to pregnant women and their families. A mother who resides in the community was hired who personally experienced relocating for the births of her children and who has an interest in childbirth. The woman works as a perinatal outreach worker for 15 hours per week with a flexible work schedule allowing her to work evenings, weekends, and from home. She is responsible to initiate a formal information sharing process to increase the awareness of rural women and other health care providers about the social, emotional, and economic hardships resulting from relocation. The topic of relocation for childbirth is discussed in detail during prenatal classes and during one-on-one home visits with pregnant women.

An example of change that occurred from the openness of discussing relocation for childbirth is the creating of a postnatal ‘supply bag’ that will be available on the BC Ferry serving this community, as well as the mother having access to a private area. The majority of the women have their babies in a community that requires travel by ferry for about 8 hours. In the fall and winter months it is common for the ferry to be stranded due to poor weather; this means the normal 8 hour ferry ride could be as long as 48 hours. To assist with the inconveniences of an extended ferry ride, the supply bag will provide the mother, at no cost, basic supplies such as diapers, wipes, receiving blankets, nursing pads, information sheets, etc. In addition, the mother can access the first aid room if she requires a private place to nurse her baby or rest on a bed.

Creating an opportunity for people to talk with one another about the current rural reproductive practices of temporarily relocating for childbirth creates a space to question and examine these practices. From this openness, it is hoped that further change will occur as it relates to changes in attitude that improve service and promote equality in health care.

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Appendix A

List of Documents Used in Data Collection

Document Title	Author
Professional Documents	
Clinical Practice Guidelines for Obstetrics Policy Statement: Number of Deliveries to Maintain Competence	Society of Obstetricians & Gynaecologists of Canada (SOGC)
Health Canada Pacific Region Community Health Nursing Program Guidelines	Health Canada Medical Services Branch-Pacific Region
Rural Obstetrics: Joint Position Paper on Rural Maternity Care	Society of Rural Physicians of Canada, College of Family Physicians of Canada, and SOGC
The BC Reproductive Care Program (BCRCP) Guidelines for Perinatal Care Manual	BCRCP
Newspapers	
The North Island Gazette from 1999 - 2001 and 2003	
The Campbell River Mirror from 1999 - 2001	

Appendix A

Document Title	Author
Resource Documents	
Today's Parent Prenatal Class Guide, 1999	
Local Policy Documents	
Mount Waddington Community Health Council Medical Staff Bylaws	Mt. Waddington CHC
Mount Waddington Community Health Council Mission Statement	Mt. Waddington CHC
Mount Waddington Perinatal Advisory Committee Rules of Operation	
Mount Waddington Perinatal Advisory Committee Meeting Minutes from 1999 – 2000	

Appendix B

Interview Questions

As you know I am interested in learning more about what it is currently like for women in this area when they are pregnant and delivering a baby. As you may be aware many women who live in this area deliver their babies in another community. I am especially interested in how leaving the community to deliver a baby affects the women. To do this I want to hear what women have to say about it.

I want to remind you again that all the information you share with me will be kept confidential and your name will not be used.

Can you tell me about your experience with this pregnancy?

Probing Questions:

How did you know you were pregnant?

How did you first get health care in relation to this pregnancy?

What was your prenatal care like?

What was your delivery experience like? Or What are your plans for your delivery?

What influenced where you had your baby? Or What influenced where you are going to have your baby?

Do you recall the conversation you had with the doctor about having to go elsewhere to deliver your baby? Tell me about this conversation?

Do you recall any other time when the topic of having to deliver elsewhere was discussed (i.e., prenatal classes, with friends, etc.)? Tell me about this?

How has having to leave here to deliver elsewhere affected you?

How has this affected other people that are important to you?

What do you think is behind the idea of having women deliver elsewhere?

What advice would you offer other women who are pregnant?