

' LUCKILY WE HAD A TORCH '



CONTEMPORARY BIRTHING EXPERIENCES OF WOMEN LIVING IN RURAL AND REMOTE NSW

**Elaine Dietsch, Carmel Davies, Pamela Shackleton,
Margaret Alston and Margaret McLeod**

School of Nursing and Midwifery, Faculty of Science, Charles Sturt University

**'Luckily We Had a Torch': Contemporary Birthing
Experiences of Women Living in Rural and Remote
NSW**

**Elaine Dietsch, Carmel Davies, Pamela Shackleton,
Margaret Alston and Margaret McLeod**

**School of Nursing and Midwifery, Faculty of Science, Charles Sturt
University**

Midwifery Research Team

Elaine Dietsch^{1,2}

RN, RM, FPNP, WHNP, ANS(WH), DipSHC, MN(WH), PhD

Carmel Davies¹

RN, RM, BA, MTH

Pamela Shackleton¹

RN, RM, RN(Geri), BHSc(Nursing), MHED

Margaret Alston^{2,3}

PhD, MLitt, DipCompApplics(RMIHE), BSocStud

Margaret McLeod⁴

RN, RM, Cert(MidMan), BA(SocWel), GradDip(MH), MA(HSM), PhD

1. School of Nursing and Midwifery, Charles Sturt University
2. Institute of Land, Water and Society, Charles Sturt University
3. Faculty of Medicine, Nursing and Health Sciences, Monash University
4. Australian Rural Nurses and Midwives

Disclaimer

Charles Sturt University academics prepared the information in this report about the birthing experiences of women in rural and remote areas. It draws on stories provided by a number of women in rural and remote areas of NSW. The Nurses and Midwives Board of NSW accepts no responsibility for the accuracy or completeness of any material contained in this report. Additionally, the Board disclaims all liability to any person in respect of anything, and of the consequences of anything, done or omitted to be done by any such person in reliance, whether wholly or partially, upon any information presented in this publication.

Caution

Material in this publication is made available on the understanding that the Board is not providing professional advice. Before relying on any of the material in this publication, users should obtain appropriate professional advice. Views and recommendations which may also be included in this publication are those of the authors only, and do not necessarily reflect the views of the Nurses and Midwives Board or indicate a commitment to a particular course of action.

Published by

School of Nursing and Midwifery
Faculty of Science
Charles Sturt University

© Charles Sturt University 2008

ISBN: 978-1-86467-205-3

Table of Contents

	Page
Acknowledgments	v
Executive summary	vii
Chapter 1: Introduction and literature review	1
Synopsis of the study	1
Aims and objectives of the study	1
Specific research question	2
Literature review	2
Chapter 2: The methodology utilised in this study	5
Ethical considerations	5
Selection of participants	6
Gathering the data	7
Analysing the data	9
Maintaining rigour	10
Chapter 3: Themes gleaned from the participants' narratives	11
1. Primary health care: Acceptability, accessibility and affordability	11
2. Midwifery principles and philosophy: Choice, continuity of care and control	35
3. Human rights violations	43
4. Power differentials and abuse	58
5. Fear: Iatrogenic, community and women's	63
6. Emotional stressors	66
7. Inequities between rural and urban maternity services	70
8. Ripple effect on partners, extended family and community	73
9. Unnecessary obstetric interventions	76
10. Safety	80
Chapter 4: Recommendations	85
1. Practice recommendations	85
2. Policy recommendations	93
Chapter 5: Conclusion	96
Strengths of the study	96
Limitations of the study	96
Avenues for further research	97
Conclusion	98
References	99
Appendices	
Appendix 1: Closest town population, distance for antenatal care and birth and synopsis of birth outcomes	106
Appendix 2: Cover letter to potential participants	110
Appendix 3: Plain language statement	112
Appendix 4: Informed consent form	116
Appendix 5: Non-standard questionnaire	118

Acknowledgments

The Midwifery Research Team acknowledge with thanks the Category 5 Scholarship from the Nurses and Midwives Board of New South Wales which enabled this research project to be undertaken.

Sandra Forde, Registered Midwife from the Greater Southern Area Health Service played an integral role in providing the motivation to conduct the study, the preliminary literature review and some preliminary data analysis. Her support and encouragement was always very much appreciated. We acknowledge that it is midwives like Sandra, who have the experience and desire to provide the very best maternity services for women living in rural and remote NSW, who will be at the heart of improving rural women's experiences of pregnancy, labour, birth and beyond.

We are also grateful for the 'in principle' support and encouragement offered to us by the School, Faculty and University. Jennie Miecklejohn and Veronica McDowell from the Institute of Land, Water and Society provided invaluable advice and support. Fiona Shaw spent countless hours pouring over audiotapes of interviews accompanied by gurgling babies, happy and not so happy toddlers and transcribed them to perfection. Jill Harris from the Centre for Enhancing Learning and Teaching was tireless in her editing and her advice was so much appreciated. Wendye Edwards, from the Learning Materials Centre used her magic pen/computer and made the report so much friendlier. Thank you Jill, Wendye, Jennie, Veronica and Fiona.

The beautiful photograph on the cover of this report was taken by Tan Martin, a midwife and member of the Ngemba people. The photograph was taken at an ancient Aboriginal birthing site in Kurulkiyalia country. It is used with permission and our sincere appreciation to Tan and the Ngemba people.

Of course, our greatest appreciation goes to the 42 participants, living in rural and remote New South Wales who so generously shared their stories of having to move away from their communities, homes, families, children and sometimes even partners to birth their babies. As you will read, these babies were often born in large hospitals but inevitably there were also those born on the side of the road, in ambulances and at home (both planned and unplanned). Wherever they birthed, these women demonstrated strength and resilience and we appreciate their willingness to share their stories in the hope that this research project, their stories, will play a role in kerbing the closure of rural maternity units and reopen many that have closed in New South Wales.

Executive summary

Luckily we had a torch! This title emerged from our study of birthing experiences of women in rural and remote areas of NSW conducted in 2007, and from the story of one woman in particular who was grateful to have a torch in her car so that she and her husband could birth their baby by the side of the road with at least some glimmer of light. As was explained to us, the long distances to regional centres on lonely dark roads have resulted in women giving birth on the side of the road, despite extensive funding being invested by governments in creating centralised and technologically advanced birthing facilities in regional centres. Unfortunately the closure of smaller birthing facilities in smaller communities is placing women at significant risk.

This study was funded by the Nurses and Midwives Board of NSW, and it outlines the stories of 42 women who gave birth over the 12 month period prior to our entry into the field in early 2007. The stories describe the extraordinary circumstances in which many women living in rural and remote areas give birth. Expectations are that they will travel several hours to their nearest regional centre in order to give birth but in the process they face risks from unsafe road travel. They also face separation and isolation from partners, children, families and community support as well as financial hardship, and the negative impact on emotional wellbeing and family cohesion. These factors have been ignored. Often the experiences described by these women demonstrate that the human rights of rural and remote women are being violated, and that policies of centralisation and regionalisation are significantly flawed.

What our research reveals is that, in one generation, the closure of maternity services in rural areas has caused women, midwives, medical practitioners, enrolled nurses working in maternity units and rural communities to reframe healthy pregnancy and childbirth into a condition that necessitates specialist anaesthetic and obstetric services.

While childbirth is undeniably unpredictable in nature, the risks for healthy pregnant women and their newborns are small and potential rather than actual, and even labour and birth at a tertiary referral centre can never remove all risk and uncertainty or guarantee a healthy mother and baby.

The financial burden for maternity services has shifted from the public purse to individual women. At a time of incredible personal adjustment, women must leave home and family and travel long distances on dangerous roads for basic antenatal care and to give birth. Consequently obstetric interventions such as induction of labour and elective caesarean are offered in an endeavour to reduce the distress caused by enforced isolation from all that comforts them, despite the inherent risks of these procedures.

Some women shared their experiences of racial discrimination and even their intense fear that their babies would be taken from them at the larger maternity units where they birthed. The research concludes that it is time to stop maternity unit closures in rural NSW and to develop strategies and models of midwifery care that will enable the reopening of many that have been closed. As a matter of urgency, systems need to be introduced that will enable healthy pregnant women

choices as to whether or not they labour and birth in their own rural communities. The following recommendations emerge from this study.

Policy recommendations

We determined there is a need for policy recommendations in the following areas:

- the antenatal/birthing experience
- continuity of care in local communities
- financial support
- future developments in rural maternity services
- midwifery and general practitioner education.

These are discussed in detail in Chapter 4, Recommendations.

Proposed model of care

As a direct result of the research findings outlined in this report, we recognise the urgent need to develop a model of birthing care for women in rural and remote areas that provides women with a supportive environment, free of fear. The essential elements of our model is that it is woman-centred, community based and based on continuance of midwifery care throughout a woman's pregnancy. At the core of this model are the principles underpinning caseload midwifery care, and the adoption of this model will allow healthy (low-risk) women to give birth in a woman-centred environment, surrounded by family and community and confident of their own ability to direct their experience.

Under this model, women will have access to midwifery-led care in their own community. Antenatal care will be offered to healthy women in their homes if they wish, and they will also have the opportunity to attend groups run by the midwife during their pregnancy. Partners will be included in visits if they wish.

Once a woman is ready to give birth, her local midwife will be available to her throughout the birth which will take place in her home or in her community. She will be surrounded by her family but she will know that there is medical support available in an emergency. Following the birth, her midwife will visit her initially daily for the first 7–10 days and then weekly for 6 weeks or be referred to the Child and Family Nurse after the first week postpartum.

Midwives in community

It is proposed that in each community at least two midwives will be available to service women in their communities and to provide backup for each other. Drawing on the caseload model, we envisage the midwives will have a manageable workload and cost effectiveness will be assured. We anticipate that midwives will be paid by the public health system and a comprehensive cost analysis is presently being compiled by the research team. A manageable caseload

that factors in long distances to be travelled will allow midwives to invest significant energy to help ensure best possible outcomes for all the women they serve. The midwives will undertake home visits for antenatal care, provide groups for mothers where appropriate and be a support for women in their communities. They will receive supervision and support from the central professional body overseeing this model, and they will have an office in their local community with satellite technology linked to the management unit and to tertiary midwifery and medical support.

While the model is midwifery-led, midwives will work collegially with general practitioners in their community so a team approach will be available to women whose situations become complex. Both midwives and general practitioners will be enabled to develop professionally, access ongoing education for example, *Advanced Life Support in Obstetrics* courses and where experiences may not be sufficient to maintain clinical confidence in the local area, attend larger maternity units on an annual basis.

If a woman's situation becomes complex, or should she choose to access a larger unit for birth, partnerships will be developed to enable women to receive as much antenatal and/or postnatal care in their home communities as possible.

Management of this model

It is proposed that the federal Department of Health and Ageing allocate funds and call for tenders for the administration and management of this particular model, with the funding to be devolved to the state government which will create a management unit to oversee the midwives across the state. This unit, run along the lines of the Distance Education centres throughout remote Australia, will be staffed by experienced midwives who will provide supervision and support to midwives in the communities. They will have access to advanced technologies that will allow them to videoconference with individual midwives and to run group sessions with midwives. They will visit each community at least once a year to support/supervise the local midwives in their own communities.

Managers within this model will interact with the government and ensure that processes are smooth. Their role will be to supervise, support and evaluate the model, develop new ways of working in rural and remote areas, and generally ensure that this model empowers women to have safe and secure and healthy birthing experiences.

The government will fund the management unit and the midwives; provide funding for staffing, equipment, offices, and provide funding to undertake research and evaluation of the model.

Chapter 1: Introduction and literature review

Synopsis of the study

Although birthing in small, rural Australian maternity units is not associated with adverse outcomes for healthy women or their newborn babies (Tracy et al., 2006), the continuing closure of small maternity units in New South Wales leaves women living in rural and remote areas with no option but to travel. This often involves women in late pregnancy or early labour travelling long distances away from their home communities in order to birth in larger centres in New South Wales.

International studies, and Australian studies conducted in the Northern Territory and Queensland, alerted us to the possibility that the impact of this translocation is likely to be negative (Kildea, 2003; Hirst, 2005; Kornelsen & Grzybowski, 2005). It affects not only the birthing experience for the woman, but also her health and her newborn's future health as well as the relationship she has with that child and other children in the family (Kornelsen & Grzybowski, 2005; Lundgren, 2005; Kornelsen & Grzybowski, 2006).

The primary purpose of this exploratory qualitative study was to undertake indepth interviews with women in rural and remote areas in order to learn about their birthing experiences. The women were recruited from rural and remote areas in NSW where a maternity unit had closed permanently or temporarily when there was limited health professional support available.

Aims and objectives of the study

The aims of this study were:

- to learn from women of their experience of having to birth away from their home communities in rural and remote NSW;
- to provide women with the opportunity to speak about their experience;
- to provide a foundation for future research that will compare and contrast the experiences of women living and giving birth in rural and remote areas of Canada and New Zealand;
- to inform the development of innovative midwifery models of care in rural and remote NSW;
- to inform policy in relation to birthing in rural and remote NSW.

The objectives of the study were:

- to identify issues women experience when they are required to travel away from their rural and remote NSW communities to birth;

- to disseminate information about that experience to midwives and other relevant health professionals providing care to women in the referral hospitals;
- to alert child and family health nurses and other relevant health professionals in rural and remote towns to the impact that being transferred away from home communities has on the well-being of new mothers, their infants and family relationships;
- to provide information to policymakers about women's experiences of birthing in rural and remote areas and about service access and barriers;
- to provide detailed information on access to birthing facilities for rural and remote women, barriers to service delivery and access, appropriate service refinements and policy initiatives.

Specific research question

What is the experience of women who are required to travel away from their NSW rural/remote communities to birth?

Literature review

Approximately 130 rural maternity units have closed across Australia since 1995 (Australian College of Midwives, 2007). Thirty-six of the 84 maternity services in the public sector have closed in Queensland (Hirst, 2005). In New South Wales, the Australian Rural Nurses and Midwives (2007) reported that 32 of 67 rural maternity units have closed.

From the literature review undertaken prior to the research project being proposed, it was evident that women and their families in rural and remote Australia experience stress and are disadvantaged when they are forced to evacuate their communities to birth in larger centres. Themes identified in the literature included: partners and children being left behind; social disruption and isolation; financial hardship; poor access to care; and psychological stress (Chamberlain & Barclay, 2000; Tracy, Barclay & Brodie, 2000; Watson, Hodson & Johnson, 2002; Kildea, 2003; Parsons et al., 2003; Carver, 2004).

Maternity unit closures have taken place in the context of workforce shortages (Australian College of Midwives, 2007; Roxon, 2007) and the *a priori* assumption that safety for all labouring and birthing women is increased when a maternity unit is serviced by surgeons and anaesthetists (Department of Health, 1970). However, there has been no formal examination of either the safety or the cost effectiveness of rural maternity closures (Australian College of Midwives, 2007). Although the hypothesis has never been rigorously tested, studies from Australia (Cameron & Cameron, 2001; Tracy et al., 2006; Scherman, Smith & Davidson, 2008), Canada (Gryzybowski, Cadesky & Hogg, 1991; Rourke, 1998; van Wagner et al., 2007; Kornelsen & Grzybowski, 2008), New Zealand (Rosenblatt, Reinken & Shoemack, 1985), United Kingdom (Moster, Lie & Markestad, 2001), United States of America (Leeman & Leeman, 2002) and Scandinavia (Viisainen, Gissler & Hemminki, 1994) refute this assumption and argue that for healthy

women and their newborns born in small rural units without access to caesarean section and anaesthetic cover, health outcomes are at least equal to, if not better than, those birthing in larger, fully serviced units.

Furthermore, experience from the United States and Australia demonstrates that despite medicalisation, centralisation and technological advances, perinatal birth outcomes have not improved (AIHW, 2003; Braverman et al., 2003; Trewin & Madden, 2005; Hancock, 2007). In contrast, lessons from extremely isolated Canadian Inuit villages where childbirth for healthy women has returned to their own communities and has been supported by Inuit midwives, show perinatal outcomes are comparable with Canada as a whole (and sometimes more favourable) (van Wagner et al., 2007). This suggests that sustainable and culturally safe childbearing in remote communities is safe and improves outcomes when compared with models of evacuating women to larger centres to birth.

There is an assumption that midwives practising in large, tertiary units will be more competent than midwives working in rural areas. However, there is no evidence to support this (Hundley et al., 2007).

Carver (2004) suggested that the decrease in birthing services in rural areas leads to a reduction in people who want to raise families in rural areas. Transferring women away from their communities has also been identified as decreasing health care providers' satisfaction in their role (Kildea, 2003). The transfer of women increases the demands on the receiving hospitals where resources are stretched and this can have a negative impact on the quality of care provided by health professionals (Carver, 2004) and ironically worsen the staff shortages that lead to closure of maternity units.

When maternity services are unavailable in rural and remote areas women may have to leave their families for long periods of time. The outcome is that women are faced with separation from their families, local communities and other support networks. This form of isolation is known to contribute to postnatal depression (Carver, 2004) and the breakdown of community and family values (van Wagner et al., 2007). Many women regret not having their families close by and have difficulty focussing on their birth and early mothering experience (Chamberlain & Barclay, 2000; Kornelsen & Grzybowski, 2005). Women are also concerned for the children they have left at home and the type of care available (Kildea, 2003).

Kildea (2003) argued that the model of care currently available to rural and remote women is socially and culturally unacceptable. Watson, Hodson and Johnson (2002, p. 151) agree and discussed social and cultural issues with Indigenous women, stating that these women are '... absolutely terrified ... just knowing [and] hearing ... the stories from others'. The *NSW Aboriginal Perinatal Health Report* (NSW Health, 2003) recognised that many Aboriginal women do not access mainstream antenatal services due to their geographical and cultural isolation within the services offered.

Financial issues have been flagged by Watson, Hodson and Johnson (2002). Fiscal considerations, including the expense of travel may prevent families joining the women during this significant time (Tracy, Barclay & Brodie, 2000; Kildea, 2003). Women face economic stress when they have no choice but to travel long

distances to birth. Travelling significant distances is costly, involves time – and money for away-from-home accommodation – there is a lack of public transport to the birthing centres (Chamberlain & Barclay, 2000; Parsons et al., 2003).

The stress women living in rural and remote areas experience when they are given no choice but to leave their local communities to birth is likely to predispose them to postnatal depression, possible post traumatic stress disorder and may negatively impact their babies' health (Bell & McFarlin, 2006). Using animal models, prenatal maternal stress negatively impacts the fetus and its lifelong responses to stressors (Gunnar, 2000 cited in Bell & McFarlin, 2006). Research on human infants also indicates that fetal exposure to maternal stress hormones has a negative impact on their long-term health (Wadhwa, 2005).

Given the severity of the stresses experienced by the participants in this study, it is testament to their resilience and the support they receive from partners, family and community that postnatal depression is not pandemic in rural and remote areas. The 'resilience construct' framework (McMurray et al., 2008) explains how individuals are able to develop resourcefulness which attenuates negative social and cognitive experiences in spite of numerous psychosocial risk indicators.

This background information indicated the need for research to determine the experiences of women in NSW who are forced to move away from their communities to access maternity services.

Since this research project commenced, three significant documents have been produced which are entirely congruent with the findings of this study (Australian College of Midwives, 2007; Department of Health, 2007; *National Consensus Framework for Rural Maternity Services*, 2008). These documents will be articulated with the stories shared by the women to inform the recommendations made to improve maternity services for women living in rural and remote New South Wales.

Chapter 2: The methodology utilised in this study

Narratives of women's experiences of maternity services have been published for over 40 years (e.g. Kitzinger, 1962) and this type of qualitative research in midwifery is gaining credibility as an appropriate means of sharing knowledge about the experiences of women and midwives alike (Walsh & Downe, 2006).

This explorative qualitative study was informed by phenomenology, specifically the principles and philosophy espoused by Gadamer (1975). These principles have been selected primarily because they allow for feminist and critical application of findings. The principles call for understanding gained from the women's stories to be linked to midwifery practice and policy recommendations.

The members of the research team all work in a rural, inland NSW university. They are committed to improving health in rural communities and access to safe maternity services and primary midwifery health care. The researchers in this project have adopted an interpretative approach because, like Crotty (1998), they believe knowledge to be socially constructed. In this instance, it is constructed by the economic, political and medical powers that have seen rural maternity services diminished and women given no choice but to travel long distances for antenatal care and then to birth their babies.

The specific methods used in ensuring ethical integrity, selection of participants, data collection, data analysis, ensuring rigour and dissemination of findings are described below.

Ethical considerations

Principles of beneficence and respect for human dignity and justice (National Commission for the Protection of Human Subjects, 1978 cited in Roberts & Taylor, 1998) are considered essential components of this research project which builds on a phenomenological, women-centred framework. The focus of the study is the valuing and validation of women's subjective experience, with an accompanying need to eliminate or at least minimise any power differential between researcher and participant. In keeping with the principles described by Oakley (1993), participants in the study were encouraged to share, debrief and ask questions before, during and after the formal interview. Every effort was made to minimise or eliminate power differentials between researchers and all participants, although it is recognised that it is not possible to create a research process that completely erases all contradictions in power (Acker, Barry & Esseveld, 1991).

Potential harmful effects to the short and long-term physical, psychological, sexual and social wellbeing of informants from participating in this study were considered possible but very unlikely. It was considered more likely that participants would find the opportunity of sharing their stories therapeutic, especially as these stories would be used to inform midwifery practice and policy. Younger (1995) described three potential benefits for participants as they share their stories for research purposes. First, the process encourages the woman's emotionally and/or physically painful experience to be reconstructed by her in order to gain some distance from it, to put it in the past and gain mastery over it. Secondly, it gives the interviewer an opportunity to affirm the participant as they

create new meanings from their reconstructed stories. Finally, it can lead to liberation of the participant as they free themselves from at least some of the negative impact of their experience, allowing their suffering and themselves to be transformed by it rather than melded to it. These benefits were also reported by a number of participants in this study.

In a previous study conducted by the principal researcher, all the participants commented on the benefits of having the opportunity to share their experience at interview and believing that their participation in the research might be of value to other women (Dietsch, 2003). Other phenomenological researchers have noted a similar response from participants (Hutchinson, Wilson & Wilson, 1994; Imeson & McMurray, 1996). Eichblat (1996 cited in Koch, 1998) argued that the validation process and therapeutic value for informants participating in phenomenological research could be significant and needed to be more extensively explored.

All women gave their informed consent to participate and were advised of their rights as participants (see Appendices 2, 3 & 4).

No participant reported adverse effects from telling her story. Counselling services within local community health centres or from within the research team were not required.

Women who identified as Aboriginal or from a culturally and/or linguistically diverse background were not deliberately invited to participate, nor were they refused participation. Six participants identifying as Aboriginal gave their informed consent to participate in the study as did one woman with excellent English communication skills who identified as being a recent immigrant to Australia. To help ensure cultural safety and security for the Aboriginal participants, an Indigenous community advisory group was engaged. This advisory group consisted of one Aboriginal midwife with experience working in the area and four Aboriginal matriarchs.

A deliberate decision was made to avoid maternity units, antenatal and child and family health clinics or other health facilities (public and private) as a source of recruitment. The research project acted independently from any area health service, establishment or health professional working within each participant's home town. Charles Sturt University Institutional Ethics Committee Approval was granted for this project to proceed. The approval number allocated to the project was 2006/307.

Selection of participants

Women from rural and remote communities in NSW, where a maternity unit has closed or is working in a limited capacity, were invited to participate in the study. In keeping with a similar Canadian study (Kornelsen & Grzybowski, 2006), it was envisaged that approximately 30–50 women who had birthed in the last 24 months, would be interviewed and asked to share their experiences of being transferred away from their home communities to birth.

CSU Media alerted rural and remote radio stations, local television rural news broadcasts and newspapers to the study. Recruitment processes were described during these media releases and women who had given birth in the previous two years and who had to travel at least one hour/100 kilometres to the maternity unit were invited to participate. In addition, many branches of the Country Women's Association also invited women to participate and there was a snowballing effect as friends encouraged each other to participate.

A total of 45 participants responded to these invitations and gave their informed consent to participate in the study. Three participants withdrew prior to interview. The remaining 42 participants were from all over rural and remote NSW, and they shared their stories of seventy-three births. Six women identified as Aboriginal and one woman was a recent immigrant to Australia. No interpreters were required as all women and interviewers had excellent English communication skills.

As stated above, an Indigenous community advisory group was engaged to help ensure cultural safety and security for the Aboriginal participants. Members of this group were invited by the Aboriginal participants to be present for four of the six interviews attended. One of the matriarchs also shared her story of giving birth in the 1970s as a vehicle to demonstrate that in some aspects, contemporary Aboriginal women birthing within a medicalised system face similar racial discrimination and threats to those of their mothers and grandmothers.

As part of the commitment to confidentiality for the women, no town or maternity unit has been identified. Appendix 1 provides a summary of town populations, types of birthplace, times and distances travelled for antenatal appointments, labour and birth, and a synopsis of birth outcomes.

Gathering the data

Feminist principles guided the research project and the interview process. Each participant was recognised as more than a source of data – each is exquisitely a person. It is the participants' stories that are essential to this project and their experiences are accepted as both valid and valuable.

Data were collected during indepth interviews with either one or two of the research team members, depending on the desire of the woman and the experience of the researchers. Where two interviewers were present, one was in the role of observer and note-taker only. At the beginning of the data collection process, a novice interviewer was paired with a more experienced interviewer. As the study progressed, and once the interviewer was confident in her role, most interviews took place 'one-to-one'.

Interviews resembled a conversation rather than a survey, questionnaire or interview per se. A recursive model was utilised where the interview followed normal conversational flow and the participant led the pace and the direction of the interview. A modified 'funneling' technique was used to encourage the participant's conversation to flow from the broader aspects of her story/experience to the more precise details (Minichiello et al., 2004). Non-specific, open-ended

prompts that were designed to avoid influencing participants' responses in any way were utilised. Prior to each interview, participants were informed that they would be asked to share information related to two prompts. The first related to their pregnancy and birth experience. The second related to the impact of being transferred to a referral centre. These were the primary prompts and the only definitive 'questions' asked.

As anticipated, participants raised more specific issues and on doing so, the researcher involved in the interview utilised other prompts or probes to learn more from the woman. These prompts were modified but based on those used by Kornelsen and Grzybowski (2006). This list is not directive, exhaustive or complete but includes prompts to such concepts as the woman's perception/experience of the following:

Childbirth experiences

- What were the circumstances during which she left her home community to go to the referral centre?
- What was it like to leave?
- What was her greatest concern?
- Who went with her for personal support and were these the people she would have chosen?
- Did she need to leave extended family, other children, partner, and how was that for her?
- What arrangements had to be made in order for her to leave?
- How was the trip to the referral hospital/town?
- Did she feel safe on the journey and/or on her arrival?
- What did a good birth and/or a safe birth mean to her?

Services and care providers

- What maternity services were available in the local area?
- What satisfaction did she feel with services in both her home community and those at the referral unit?
- How well did those services meet her practical, emotional, physical and/or spiritual needs?
- What are the most important maternity services?
- In an ideal world, what services would be offered?
- How have maternity services changed over the past number of years?

- Did she or anyone close to her have experience of birthing in the home community and if so, how did that experience differ from the most recent birth?
- How might maternity services be improved for women in her town/area?
- How were her choices respected or disrespected by caregivers, the health system and/or her family?
- What was her assessment of professional support given to her during pregnancy, birth and after the baby was born?
- Were the caregivers present at the birth those people she would have chosen to be there?
- Was there anyone she would have liked to have been with her who wasn't?

Practical concerns

- related to finances, child care, own or partner's employment
- relationships with partner, children, family, friends
- possible future experiences.

Each interview lasted between thirty minutes and ninety minutes. Interviews were audiotaped and then transcribed verbatim with all identifying data changed on the transcript. Fieldnotes taken by the interviewer(s) were integrated and identified as such.

Analysing the data

Once collected during the interview process, data were transcribed verbatim from the audiotape as soon as possible following the interview. All data continue to be securely stored in a locked filing cabinet in the principal researcher's office and will remain there for five years following the completion of the study. After this time, all data will be destroyed by shredding or tape destruction.

Three interrelated processes were followed in the analysis of the transcribed interviews. Benner (1985) and Leonard (1994) refer to these as thematic analysis, analysis of exemplars and the search for highlighting stories. The three processes were not linear but occurred concomitantly and provided the basis for entering the practical worlds of the participants and their socially embedded knowledge. Thematic analysis, exemplars and where appropriate, identifying highlighting stories worked as both discovery and presentation strategies in this study. They enhanced rigour by allowing for the presentation of context and meanings (Benner, 1985).

For the purposes of this project, thematic analysis involved each researcher paying very careful attention to the data. Discriminate themes were identified by two individual research team members and these themes were then cross-checked. Only themes affirmed by paired consensus were identified. Comparative thematic analysis of this data was then carried out by the principal researcher. This analysis

was done individually on each transcript, and then across all transcripts to clarify similarities and differences between the participants' stories.

Theme identification and synthesis led to the eventual description of the contextualised experience shared by the informants, of having to birth away from their home communities.

Identification of exemplars involved the analysis of specific episodes or incidents described by the participants. Benner (1985, p. 10) defined an exemplar as 'a strong instance of a particularly meaningful transaction, intention or capacity'. Having identified a pattern of meaning, common situation or embodied experience, exemplars were extracted from the text to demonstrate similarities or contrasts in accordance with Benner's (1994) principles. The exemplars identified from the data in this project formed vignettes taken from the women's narratives. These are quoted verbatim. Where information is provided by the informant that is not relevant to the exemplar, the gaps in conversation are identified by the notation '...' in the vignettes.

Highlighting stories refer to strong instances of concerns or experiences which were augmented by exemplars and thematic analyses. Identifying individual highlighting stories allowed for themes and exemplars to be highlighted.

Between interviews, time was given to critique and review by the research team members. This helped uncover any missed opportunities or avoided issues. Interpretive dialogue began with the first interview so that data collection, inquiry and analysis occurred simultaneously, formatively and summatively.

Maintaining rigour

Prior to each interview, all equipment was checked and the participant's comfort assured.

Following each interview, the researcher(s) involved was encouraged to reflect on the process in order to bring the experience into clearer focus by allowing and even encouraging wonderment, confusion, conflict and/or uncertainty as each researcher endeavoured to more fully understand what the participant had shared. Time was given to critical self-reflection and evaluation of interview style. Steps in this process included being alert to the possibility of avoidance strategies or leading the participant's narrative, differentiation between appropriate and inappropriate silences, and/or the inability to follow-up or hear certain concerns and/or meanings.

The completed transcript was posted to the participant to read and discuss prior to the research team's interpretative analysis. This process of verifying the transcript with the participant is in keeping with the phenomenological process/feminist principles which advocate for the researcher to work in partnership with the participants.

Chapter 3: Themes gleaned from the participants' narratives

During the comparative thematic analysis phase of the study, major themes evident from the participants' narratives were grouped into ten major areas as follows:

1. Primary health care: Acceptability, accessibility and affordability
2. Midwifery principles and philosophy: Choice, continuity of care and control
3. Human rights violations
4. Power differentials and abuse
5. Fear: Iatrogenic, community and women's
6. Emotional stressors
7. Inequities between rural and urban maternity services
8. Ripple effect on partners, extended family and community
9. Unnecessary obstetric interventions
10. Safety.

Each of these major themes and their sub-themes are discussed. The women's narratives are dialogued with the literature surrounding that theme. Exemplars and highlighting stories are used to help readers follow the trail to the conclusions reached during the data analysis phase of the study.

1. Primary health care: Acceptability, accessibility and affordability

Primary health care is at the core of all Australian health services, and NSW Health (2007) cites 'strengthening primary health and continuing care in the community' as the third of seven strategic directions in the State Health Plan. In relation to maternity services, it aims to 'expand primary maternity services, including stand-alone primary birthing units, to give women more birthing options and provide extra support during and after pregnancy' (NSW Health, 2007, p. 21).

For the past thirty years primary health care has been defined by the World Health Organization as 'essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain ...' (*Declaration of Alma-Ata VI*, 1978).

Using this primary health care framework, the participants' narratives are interwoven with the literature to explore acceptability, accessibility and affordability of existing maternity services for women living in rural and remote NSW.

a. Acceptability

Like, this is Australia, it's the bush but ... (Participant 27, p. 10)

Under the theme of acceptability are two dichotomous concepts – acceptability and unacceptability. Participants would often speak of their appreciation of the limited health services that were available to them and many acceptable services were discussed, but many of the stories also highlighted unacceptable situations, as evidenced in the following:

Highlighting story

Karen (pseudonym for Participant 7) lives outside a small rural township with her husband. They have three children, two girls and a boy. The birth of their first child was uneventful, but the birth of their second daughter proved to be a frightening experience for Karen. Her labour progressed quickly and she presented to a small rural hospital for assessment. However, the inexperienced midwives were obviously frightened by the prospect of an unexpected birth and they arranged for an ambulance transfer. In the interim, a medical practitioner gave Karen an intravenous injection of Pethidine. During the journey Karen indicated she was ready to push, but the accompanying midwife repeatedly discouraged her from doing so. When they arrived at a larger hospital another midwife took over Karen's care and the baby was born without incident. While the outcome was satisfactory for both mother and child, these events led to a heightened sense of fear in Karen, her partner and her medical practitioner during her third pregnancy, particularly the prospect of travelling whilst in labour. To avoid this Karen was repeatedly advised to have an induction of labour at 32 weeks gestation by her medical practitioner. To avoid this coercion, Karen was forced to change medical practitioners and she then stayed alone in a caravan near the referral hospital for two weeks prior to the birth of her son.

Discussion

As indicated above, many of the women's stories demonstrated great appreciation of the limited health services that were available to them, and an acceptance of the realities of their situation. For example, women who had given birth in ambulances en route to the hospital spoke very favourably of the care they received:

But they were fabulous. The ambulance service were just ... they were great (Participant 13, pp. 3, 4)

Many participants also spoke very favourably of the services provided by the child and family health nurse in their area, especially when the women lived on remote properties:

The Community Family and Health nurse, is wonderful (Participant 3, p. 11)

I got home and had mastitis ... low milk supply ... and then I got mastitis ... so a lot of problems when I got home ... thank goodness we've got a

Community Health Nurse now, which we didn't have with [first child] ... if we had a problem we could ring [doctor in referral town] ... Now we've got [name of nurse], and she's just amazing. I rang her day and night and she'd come out to the house at the drop of a hat and she's rang [doctor] for me and organised scripts and that sort of thing, so I don't have to go to the [referral town] (Participant 12, p. 8)

Other women spoke of the excellent medical care they received:

The paediatrician I had down there was excellent. He'd actually finished for the day and he came to see me and explained to me that the first 48 hours were the crucial time (Participant 28, p. 5)

My pregnancy care was provided by my local GP/obstetrician ... it really is a beautiful model of care that we're able to experience in [name of town]. It's a very personal, all inclusive kind of package. It's beautiful (Participant 5, pp. 1, 2)

Many other participants described the acceptability of midwifery care to them:

[First child] was actually born in six and a half hours; didn't tear, everything remained calm. It was just a lovely experience ... Spent most of first stage labour in the shower and on the ball, and found myself needing to be upright for a good ... four and a half hours ... [I appreciated] the close affinity that I have with the midwife ... For my first experience giving birth was very important to me. I wanted to be surrounded by people I knew, or at least have a midwife who I knew well ... lovely birthing experience ... you realised how intimate the relationship between a midwife and a labouring mother should be (Participant 22, pp. 1, 2)

[Independent midwives] came together ... And they provided probably about weekly visits. ... so probably about four antenatal visits ... So they came, they drove all that way, they brought lunch, they turned around and drove back again. So it was amazing. And our family was intact, and to me, that was the real prize, and that I had, I enabled those twins to be born and to be healthy at 40 weeks, rather than to be that bit smaller, to feed that much more often, to be in a special care nursery (Participant 18, p. 4)

I have a lot of confidence in the midwives ... I would support midwives helping birthing women in town, without medical ... As long as I know that they are ... up to date with everything and regularly having training and all that kind of thing (Participant 2, p. 19)

The acceptability of midwifery-led models of care expressed by the participants is congruent with contemporary literature. Scherman, Smith and Davidson (2008) described the acceptability of a midwifery-led maternity unit established in far north Queensland, and Dahlen, Barclay and Homer (2008) compared midwifery services provided by homebirth and hospital midwives for first time mothers. They found that the homebirth services provided by midwives were the most acceptable of these services although the women in their study spoke very

favourably of all midwives who were prepared to ‘honour’ them and their birthing experience.

Unfortunately, many participants in *this* project also had stories of the totally **unacceptable maternity care**. Not all early childhood nurses were perceived as being as woman-centred as those described above, especially when circumstances made it very difficult for rural mothers to attend clinics.

I had to actually pay for someone to look after the other four kids, when they were very, very small ... I wasn't concerned about their weight, but I was wanting to get them weighed and, again, through this period of having huge issues with supply, I'd have to pay for someone to look after my kids and then to take them to the clinic. So, these services are not women friendly. These people sit here in their clinics. They have access to cars, they have car pools (Participant 18, p. 18)

Base Hospitals were also often spoken of very negatively as places in which to give birth. Women felt emotionally, spiritually and physically unsafe in them:

That feeling of loneliness and depression and isolation, it's really cold. The maternity ward's a bit nicer, but still, it's very ugly, very ugly. Like, even the beds downstairs don't have a sheet on it. ... And that's what I had to lay on until I asked the woman for a sheet. She wouldn't even offer me a sheet to put over me (Participant 35, p. 23)

Honest to God, when I walked in to the place where you give labour, where they inspected me. Straight, I walked out of there and it was like a depressing thing just come over me instantly. It is so, it's like you can feel it's haunted, man, because I walked in and, at the same time I said, 'Gee, this feels funny, hey?' And ... Mum's husband, turned around and said, 'Yeah, I reckon this place is haunted.' We all agreed. It's just that feeling (Participant 36, p. 3)

[Base Hospital] is just, scary. With my sister working in the Admin side of it and she's in Bookings and she's doing all that side of it ... the stories that you hear, it's just frightening (Participant 20, p. 8)

As was indicated in the highlighting story above, some participants went to district hospitals without maternity services, en route to the Base Hospital. And in other cases, further **delays** were experienced in transferring women out to larger hospitals with maternity units:

[I] said to [husband] 'Get me out of here. We've got to get out of here.' And they'd called the ambulance ... [it was] waiting at the door. The Director, the Manager ... [was] called ... in ... couldn't get any staff to cover the shift. Instead of the Manager saying, 'Just go. I'll deal with the shift. You just take her,' we had to wait for them to find someone to come on duty ... I was in labour ... it was a long time. They finally got me in the ambulance and the midwife came with me, who had ... been ... with me [at local hospital] and she just kept saying, 'I can't believe they gave you IV

pethidine. I can't believe they gave you IV pethidine.' And I was calming her down, I said, 'Well, they've given it to me now.' (Participant 7, p. 9)

Yep, they called the plane in. You have to wait, see I came in at eight o'clock and the plane came in at 11am and ... So you better hold on ... You get to the airport and then they have to take you in an ambulance to transfer you to the hospital (Participant 27, p. 3)

I was laying there feeling like I was still bleeding, and not knowing and they weren't checking. Yeah, it was just a real concern. It was very lacksadaisy about my transfer, it seemed to take forever, and I laid in there in the bed in [small town] for ages before they got me transferred. And I was just thinking, you know, 'I could be having this baby.' ... Yeah, it was not ideal. There was just nothing, nothing really. Nothing intermediate there, locally, just to do simple checks ... I don't know if an internal like that is something that anyone does anywhere, if there's like a reason to warrant it. But it just really didn't seem ... like the right course of action at all ... and I don't know why. I'm not sure why that took so long. Everyone was just wandering in and saying hello ... patting your head and doing all this and I don't know why it took so long, I really don't. In fact, [Base Hospital] was ringing and saying, 'Where is she? Where is she?' (Participant 20, p. 11)

Criticism of maternity units was not limited to the public system, as many participants also spoke of the unacceptability of the care they received in the **private system**:

I was getting ready to leave the next day. I was very stressed with the fact that he wasn't feeding properly. I was very stressed that my milk hadn't come in, because I kept on thinking to myself, 'This is it. You've got 12 hours, you've got 8 hours, you've got four hours, you know? To get it right.' ... the nurses in [private hospital] actually were, they were so pro breastfeeding that I think they did damage. They just put the baby straight onto me with no help, no assistance, and they split my nipples straight away and they never really recovered from that (Participant 13, pp. 11, 12)

The nursing, as support, was absolutely horrid ... They had to send me away after being induced once, they didn't have enough staff to continue my labour – it was absolutely disgusting that they had to send me away, but it just shouldn't have happened ... It was the after care, when we went back up on the own room and the own ward ... especially the care after, when I haemorrhaged as well ... I think they thought that since I was second time round, that, you know, she knew everything, she'd be right sort of thing, but it was nine years difference in between [first] and [second] so everything sort of went out the window and I didn't have a clue ... and the breastfeeding wasn't working and things like ... for a private hospital ... the care was not up to scratch (Participant 14, pp. 6, 7)

A number of participants spoke of their distress at **hospital protocols** that required them to have to locate their own medical records from local medical centres and/or gather equipment in early labour before being able to start driving:

You've got to take all your own things into the hospital – which, I can understand, in, you know, budgets and all that sort of thing, but when a woman lives two to three hours away and you start contractions, the last thing you think of – like, you might have a bag packed, but you might not be prepared for five days away from home, and getting, you know? ... you're just not thinking clearly (Participant 7, p. 6)

Participants often spoke of **medical practitioners** whose care was not evidence-based; for example, treating asymptomatic Group B strep with penicillin at thirty-four weeks gestation, or attending routine urinalysis and weighing at every antenatal visit. Others shared stories about **dangerous practices**:

I developed a urinary tract infection that the doctor didn't want to touch because I was pregnant, so it just got worse and worse. And then, in the end, when I started vomiting because I was, you know, it wasn't very healthy, he'd say, 'Oh okay, I'll put you on something.' And so I was in hospital here for a week ... Someone specialised, that knows. You know? Because, if you end up in hospital and you're not treated for something as trivial as a urinary tract infection, and you've got to get really bad before they do something, that's not good. Especially when you're pregnant (Participant 27, pp. 4, 7)

32 weeks, he wanted to induce. And I said, 'Whatever I do, I really don't want induction' ... And he said, 'Oh well, because you're so far away and because of the quick labour with [previous baby], I think you should think about it.' So that I said, 'Well, I'll think about it, but I really don't think so.' Then he pushed it onto me again the third time I went to see him (Participant 7, p. 1)

And the fact that the doctor who cannulated me and gave me IV pethidine, should have known better. When a girl is in end stage of labour and they're not going to be able to deliver, to give them IV pethidine ... So, a doctor came in who I didn't know before ... and she cannulated me and then, the next thing, she gave me pethidine, she gave it to me IV. Whack! Like, I've never heard of anyone giving a woman in labour IV pethidine [the unit where the woman was given intravenous pethidine does not have a maternity service, so she then had to travel in an ambulance for over an hour to the closest birthing unit] (Participant 7, pp. 13, 9)

I was complaining about having like a little period pain down the bottom of my stomach. And [GP] said, 'Oh, that could be preeclampsia. Just in case, you better go and get a ultrasound. And here we are ... Here we are on the phone to [80 year old friend], 'Can you please pick up the kids from school? We've got to go' (Participant 29, p. 3)

The GP here wanted to give me an internal and I'm saying, 'No.' And he's saying, 'No, no, I must.' And he's got the gloves on and I'm crying and, you know? I'm saying, 'I can't. I've got a low lying placenta.' And I'm saying, 'Please ring my doctor in [regional city], please ring my doctor.' ... And it was kind of like it was as if I was insulting them to say that ... I

couldn't get through to him at first, he was determined to do this internal examination (Participant 20, p. 7)

Others spoke of **medical practitioners** whose practices left the women feeling **culturally and emotionally unsafe**:

Because of how caustic the GP service was, and that they would not be supportive of me (Participant 18, p. 4)

The doctor checked me out and they really weren't very professional about even just examining me internally, because the woman who did it, the door was wide open. I had to tell her, I said, 'Can you please shut the door?' And the curtain, she didn't even pull the curtain across. I said, 'Oh, can you pull the curtain across please?' And I asked for a sheet to be put over me, and she's just looking at me like, 'Are you serious?' And I'm like, 'Yeah.' Because she just left the door wide open, people walking past, and there I am just laying there. And so she was really blunt like that ... and they were looking at me with disgrace because I wanted a bit of privacy. Like, I wanted a sheet over me, because I'm a bit touchy with people. You know? And she's going, 'What do you want a sheet for? You're about to give birth soon.' And I'm like, 'Because I'm a bit shy about it.' Yeah, so that was really, really rude, man (Participant 35, p. 3)

I was scared ... It sort of hurt because they were real rough. Yeah ... it hurt because they were just going real fast and hard (Participant 36, p. 7)

And [obstetrician] was odd. He was really odd. He sort of put his head around the corner and went, 'Oh,' he said something, and went, 'Oh no, that's not the right one.' And went, 'Oh yes,' Oh, he was just bizarre ... He was so bizarre. Anyway, I didn't see any more of him (Participant 20, pp. 2–3)

There were many stories of how the participants **lacked confidence** in the care they received from the **medical practitioners**. On occasions, the women themselves had to find out the correct treatment or recommended prenatal screening and advise their medical practitioners accordingly. Many participants found this to be quite frightening for them:

Having confidence in the ability of medical services? You know? That's not, not a good thing to say but ... I personally don't have a lot of confidence in the doctors that are here now (Participant 26, p. 13)

Then I was seeing a doctor. I got postnatal depression. I didn't work it out until nine months. I was going to the doctor – we have a lot of different doctors here, especially at that time. We had one doctor that was here that it was really hard to get into. I was going to this guy, 'I'm losing, I don't have my sex drive. I have no energy.' You know? All the signs for depression, and the doctor would say – because I had some lumps on my legs – 'Oh, we don't know what it is.' You know? And it took me nine months to work it out, that I had postnatal depression (Participant 24, p. 3)

[Note: this participant was later diagnosed and treated for postnatal depression]

I think more scary than empowering, because ... you've just got to go with it and hope that, you know, your intuition and instincts are right ... Yes, definitely self-monitoring ... we're lucky that we have internet and we have books on pregnancies and that, so you can read up and know that, 'Oh well ... I should be having ... gestational diabetes tests, so, you know, if they don't mention it next time I go, I'll mention it.' (Participant 2, p. 7)

Interestingly, this compares with what Groft and Robinson Vollman (2007) found when discussing the experiences of HIV positive patients living in rural Canada. The residents felt that although the physicians were quick to refer, they lacked knowledge of HIV/AIDS and relied on their patients to inform them about the latest treatments. This led the residents to feel uneasy and apprehensive.

Complaints were not limited to unsafe medical practitioners. Many participants shared instances of how **insensitive**, even **cruel** or **dangerous** some **midwifery practices** had been:

You expect midwives to be caring, nurturing sort of people, not aggressive and vicious and rude and cruel. Absolutely cruel (Participant 37, p. 20)

I pushed the buzzer and I said, 'I'm in labour.' And she said, 'No, you're not.' And then ... I said, 'Well, I am, and, you know, check me.' ... I don't know whether she'd had a bad experience or she just wasn't in the mood for it that night or, but, I mean, [husband] was running and getting pans and things (Participant 7, p. 13)

I was getting contractions so close together again and when the nurses came to see me, I said that the cramps were enough to, you know, stop me from sleeping and they were getting quite painful. They put a monitor on me and they thought that it wasn't, they couldn't understand why it was stopping me from sleeping. It wasn't enough to ... think anything was happening. ... and then my waters broke. So I ... used the buzzer. But even though my waters had broken, she still didn't seem convinced. She was saying, 'Oh, it's okay, she's had leaks before.' And I was saying, 'No, I've been bleeding, I haven't had leaks.' (Participant 28, p. 4)

They don't discuss things with you, like, it's like a gaol. Like, they tell you how it is, and if you do it any different, then, obviously, you're not listening to them and doing the right thing. It makes you feel inadequate (Participant 29, p. 7)

I find a lot of the ones in [Base Hospital], not all of them, but mainly a lot of them, were really snappy. Yeah. Like they don't want to answer your buzzer and if you buzz them, they get wild and, you know what I mean? They'd just be, yeah, you're in their way (Participant 35, p. 5)

Although staff shortages of **medical practitioners and midwives** were mentioned by the participants, on many occasions these staff shortages were exacerbated by medical officers and midwives being either **unable or unwilling to work to their full scope** of practice:

GP at [nearby town] ... put his hands up and said, 'I don't have any obstetrics insurance or indemnity ... I will refer you to an obstetrician.' ... Straight up. No blood pressure, no nothing taken ... [Closest town with maternity services, 4 hours' drive away] (Participant 2, p. 3)

They finally got me in the ambulance and the midwife came with me ... and she just kept saying, 'I can't believe they gave you IV pethidine.' And I was calming her down, I said, 'Well, they've given it to me now.' ... We got oh, 20 kms out on the [town] road, and I said, 'I want to push.' ... And she said, 'You're not pushing. You're not having this baby.' I said, 'Just pull over. I really feel like I want to push.' And she's going, 'You're not having this baby on the side of the road, you know? Blah, blah, blah.' So, she said, 'You just hold on.' So we got to [hamlet], and I said, 'I can't hold on any longer.' And, anyway, no, she made me hold on, hold on, hold on. And we got to [district hospital] and they raced me into the labour ward and there was a midwife waiting there, and [she said to the midwife who had travelled with me] 'You want to deliver it?' And [that midwife] said, 'No, I don't want anything to do with it.' ... I had like ambos in there, I had this midwife I'd never seen, I had the midwife who'd freaked out on me ever since [local hospital], and I sort of lost it with them a bit, and said, 'Look, can someone just tell me when I can push?' Because she crowned as they lifted me and the midwife at [district hospital] was really good, she said, 'Okay, you can push now.' And [baby] came out and everything was fine, but it was really stressful and just not necessary ... but to me, it's the babies that don't want to come that you worry about. The ones that are coming ... let's at least have a look and see. But she felt so obviously out of control ... she just wasn't coping at all, and I thought, 'You don't even know what you're doing.' (Participant 7, pp. 9, 10)

Other participants spoke of how **medical infighting or hospital bureaucracies** worsened an already critical shortage of health professionals:

They [doctors] had a huge fight and he ended up winning the hospital service and everybody's going. I think he lasted about [a month], I can't remember. And, the other doctors got kicked out of the hospital ... they just fly them in. So, you've got your local doctors, but it's really hard to get in and see them, and you can't see them at the hospital (Participant 24, p. 9)

Yeah, he was criticised out of town ... He was there for about six weeks and then he went. He'd been there for a good 15 years, Dr ..., but they had fights with the hospital and he was trying to get doctors established there, like, a fulltime doctor at the hospital. Because there's no doctor at the hospital either – we have to get a locum in. Any doctor that's in town is not allowed to go to the hospital, they're not allowed to go there (Participant 29, p. 8)

... and they're [Drs] all fighting and so, you know, they had to vote for the hospital. And then the one doctor got it, but he couldn't handle it because he's really depressed himself, but he knew this, he lasted three days (Participant 27, p. 6)

Observations that the health system is seen to serve itself and the needs of its staff above the needs of those it is meant to be serving have been previously published (Dietsch & Davies, 2007). This effect was evident in the narratives of the women who shared how **health professionals gave no consideration of their geographical isolation** or their needs. In one instance quoted below, staff at the nearest Base Hospital made no effort to find the forms needed by the participant to claim for her travel, and in another instance, nobody told the patient that the travel scheme existed. Further examples cited here show a disregard for the inconvenience that distances to services cause to these rural patients.

And the other thing which annoyed me with IPTAS [Isolated Patients Travel Assistance Scheme] that was more a local thing, was when I went to find out, to get the forms and whatnot to go down for my nuchal translucency scan to [Base Hospital, 4 hours' drive away], the people at the hospital said, 'Oh, I can't find any. You'll have to ring someone.' ... I was a bit annoyed by that ... I thought well, you know, it's hard enough to get hold of stuff up here ... without having, you know, other boundaries or things to stop or hinder your progress (Participant 25, p. 4)

I didn't know about until after the event – was the IPTAS ... That's the only thing we can claim, and that's only if you don't have the service available to you. ... I could have claimed the 15 cents a kilometre, or whatever it is, but I didn't know anything about that at the time. ... With the IPTAS, they'll pay up to \$45 a night, but then I think it's only, it's limited as to how many nights they'll pay you. So I never even, I didn't know about that at that time. Didn't even look at that as a way of being compensated (Participant 2, p. 4)

Because he was going to send me to [town, 4 hours' drive away] that day to have blood tests done ... 'Well, I can't.' I said, 'I was there last week. I'm not going again today, at one o'clock in the afternoon, to drive four hours, to only get there for them to say, no, we've closed (Participant 2, p. 14)

I went to [Base Hospital, 4 hours' drive away] for checkups when I did the bleeding. They said, 'You'll most probably lose it.' You know, 'There's a good chance you'll lose it, go home.' (Participant 24, p. 4)

On many occasions there were **no services**:

And after talking about it later, [partner] was really quite worried at that stage he said, because, you know, there were no midwives, there were no doctors (Participant 22, p. 10)

There was no actual antenatal unit or midwives or anything like that (Participant 29, p. 12)

None [no local services] (Participant 39, p. 4)

b. Accessibility

It was a big day ... seven hours of driving just to go to the obstetrician for five minutes and be out again (Participant 16, p. 1)

Maternity services are becoming less accessible to women in rural and remote NSW. Many areas once had thriving, safe maternity units with excellent perinatal health outcomes but these services are contracting until there are fewer and fewer basic services and women have to travel longer and longer distances to access basic maternity care. The two stories outlined below highlight some of the issues associated with lack of accessibility to local maternity services for birthing.

Highlighting stories

Emily (pseudonym for Participant 9) and Felicity (pseudonym for Participant 31) live on properties approximately three hours from the private hospital in the regional city or the base hospital where most women in the area travel to birth.

Emily was extremely keen to have a vaginal birth after having a caesarean with her first pregnancy. She gave birth vaginally to her second child at a small district hospital [unplanned] en route to the larger regional city hospital. Emily was thrilled with the birth outcome and wonders if her birthing en route to the private hospital was subconsciously due to her strong desire to have a vaginal birth which would have been less likely if she had arrived at the private hospital in early labour.

Felicity had an unplanned homebirth following a quick labour which she experienced as traumatic in some ways as she felt unprepared to birth at home in front of her young child. However, in other ways Felicity describes her unplanned homebirth experience positively as it meant that no unwanted medical interventions such as drug administration were possible:

The births have both been really good ... I didn't have any drugs with either of them. [Second birth] was a lot quicker. [Second birth] was about an hour from start to finish. Had him at home, in the lounge room (Felicity)

Discussion

Many participants regretted the **closing of maternity units** that had once served their rural communities.

Yeah, my mother-in-law had her first three here, and my husband was her fourth one, and they went to [referral town]. So it must have just cut off then (Participant 17, p. 8)

No. You can't have your babies at [closest town, 1 hour away] anymore. You have to go to [3 towns, all at least 1.5 hours away] ... [maternity services stopped at local hospital] 12 years ago (Participant 7, p. 2)

But I don't necessarily think the answer is to make big maternity units in the major towns either. Like, there's quite a fair hospital at [town 20 minutes drive from home] ... They used to have babies there. Years ago, I don't know when, but they did. And they would have had a lot less equipment and resources available to them than what they do now (Participant 6, pp. 11, 15)

I thing it's appalling for the size of the town ... the town is meant to be around 5000 ... We did have an ultrasound up until last year (Participant 2, p. 14)

While some areas have no local service, others have very limited services. Many participants were confused by the fact that many times there was a beautiful new **hospital in the town which provided no maternity services.**

Brand new maternity unit built ... four years ago, and the frustrating thing is it's not being used ... because of no operating GP obstetrician ... the case remains that you have adequate facilities but no services (Participant 22, p. 1)

We're trying to work out what the hell the hospital is there for? I mean, what's it do? ... it's for basically, accident and emergency and old people ... So the hospital is sort of there but ... we just don't know what it does (Participant 24, pp. 8, 10)

I was very concerned about delivering on the side of the road, and so I asked at the [hospital without maternity services] if it would be okay if I felt I was close to delivery, if I stopped at the hospital. They said 'No, we'll put you in an ambulance' (Participant 39, pp. 4-5)

Like, they built a new hospital with, there's no ultrasound machine ... it's ridiculous if you ask me ... There should be a delivery suite, at least the basics. You know? The heaters when they're born. ... and there should be just the basics ... and they need a doctor ... no, there's no midwives ... a brand new hospital ... if I could have just gone straight to hospital it would have been fine ...

Absolutely ridiculous. I just can't believe it. I don't know why. Why would you bother building something? Like, I wouldn't build a shed if I wasn't going to use it ... If you're not going to put tools in it, what's the point in building it? (Participant 29, pp. 12, 14, 18, 19)

Women report travelling for many hours and **long distances to access basic antenatal** care. It was not unusual for women to report seven hours of driving (round trip) for a five minute obstetrician appointment:

It'd be seven hours we'd drive ... just to go to the obstetrician for five minutes and be out again ... that's what you do when you have children (Participant 16, p. 1)

During my antenatal care I was going down and visiting the doctor, so that was, for me, a 500+kms round trip, just for one appointment ... towards the end, where you're actually ... two weeks apart, doing 270km down and 270km back, so yeah, just over 500km. It really started to take its toll, because I did have swelling (Participant 22, p. 3)

We had to go to [regional town] for our antenatal appointments and once they got closer, it was a bit hard to get to [regional town] because it's three hours from where we are ... as it gets closer, you know, you're going there every week, over to [regional town] (Participant 14, p. 1)

And then I fell pregnant with [second baby] and all my antenatal was done through a doctor. There was ... no midwife ... We were going to go down to [town 770 kms, 9 hours' drive] and have [baby] there because that's where [partner's] family came from (Participant 24, p. 2)

For some women **antenatal care is not feasible** and they do not access any care during pregnancy.

So, it doesn't happen. They just don't do [antenatal care], and why would you? ... And that's what I've noticed in [rural town], a community that has no birthing service and hasn't had it for 15 years (Participant 18, pp. 16-18)

A lot of them just don't [have any antenatal care] (Participant 25, p. 8)

Other participants discussed the **fatigue, discomfort and time costs** involved in travelling for a basic antenatal appointment.

In the car for that amount of time [7 hours], I'd suffer for the next two days (Participant 22, p. 3)

I had troubles, my tailbone was really sore for several weeks and ... when I got there ... And he turned, on the way back, had been head down ready to go. By the time we arrived he was breech, and I started to feel like there was something wrong when we left [city where I had had an antenatal appointment that day] to head home and, about halfway home I thought he was getting a bit heavy ... when I got there and the baby had turned ... I ended up having a natural delivery in the early hours of Sunday morning ... 30 weeks (Participant 28, p. 1)

And the travelling was probably the hardest part of that. ... and that got very tiring, particularly after 26 weeks ... Well, I mean, travelling anywhere is usually a long trip ... It was a whole day and usually I'd try, if I had to go by myself, which was quite often the case — I'd like to stay overnight with my parents so I wasn't ... in the car for six hours in one day ... I had to go to [town 3 hours' drive away where baby was to be born] to each appointment. I signed up with an obstetrician there ... and even though I was share caring with a few appointments ... once it got to that

latter stage, we had to go to [birth town, 3 hours' drive] all the time (Participant 3, p. 2)

So you'd be out of pocket each time anyway, plus the amount of time and energy to travel (Participant 2, p. 5)

If a woman has children, she needs to either arrange **child care** or take those children with her in the car:

It took me longer than bloody eight hours ... I left here, yeah I left here about eight or nine o'clock in the morning, and I got to [city] at nine thirty that night. And I was knackered. I was buggered. The kids were berko, I was berko, yep (Participant 25, p. 14)

I would go and see him [obstetrician for antenatal visit, 8 hour round trip], I'd have all the kids, I'd have the other two boys (Participant 24, p. 4)

And to do that [travel to appointments] I would, most of the time, have to put my daughter into day care, because it would be too big a day, to go over there ... I could take her, but, I took her a few times, but you just have to sit around and wait ... it was just too hard ... I had a lot of ligament pain and that sort of thing, so a lot of movement issues (Participant 12, pp. 1, 2)

And having that second child to look after. Sometimes we took her [to city 3.5 hrs away] ... sometimes we'd leave her in day care (Participant 16, p. 1)

But, of course, with the twins, most of the care would be [regional city] based, so that would be a 500 kms round trip, which I did, but I could not fathom that I would be birthing in [regional city], when I had four other children and they were all under school age (Participant 18, p. 1)

Table 1 outlines the distances and hours travelled by women for antenatal appointments. On average, women travelled for more than 5 hours and 422 kilometres (round trip) for each antenatal appointment.

Table 1: Distances and times travelled by participants for antenatal care (ANC)

ANC attended locally	ANC 95–199 kms	ANC 200–299 kms	ANC 300–399 kms	ANC 400–499 kms	ANC 500 kms +
10	20	18	21	3	1
Average distance travelled for antenatal care 211 kms (422 kms round trip)					
ANC < 1hr	ANC 1 < 2hrs	ANC 2 < 3hrs	ANC 3 < 4hrs	ANC 4 < 5hrs	ANC > 5hrs
11	13	18	13	17	1
Average hours travelled for antenatal care 2.52 hrs (5 hour+ round trip)					

To avoid the possibility of birthing en route, many women spent **long periods away from home** and staying in the town where they intended to birth. Having just driven four hours for an unnecessary ultrasound scan, this participant describes her distress when having to prepare for long periods away from home:

I was fine and there was nothing wrong with him and it was a pointless trip, and a very costly trip ... I ended up walking out of the doctors in tears ... I think it just overwhelmed me too much. Because the only thing we found out when we were there was they put an extra two weeks on his due date ... I don't care if I'm sitting at home when I go into labour and I go up to the hospital and I have him. But when I've got to plan to go away and get my children looked after and have to pay for accommodation and leave money for them, I've got to save for them, I need to know how much to put aside. With two weeks and four weeks, there's a big difference (Participant 29, pp. 3–4)

For some participants, birthing in the **closest maternity unit** was **not the most appropriate option**, especially if family support was available in a more distant locale:

Because you had to go somewhere. For me to go to [Base Hospital, 4 hours away] was almost more hassle than for me to go to [city 8 hours, 750 kms away] and have to stay, you know, stay with my sister (Participant 25, p. 1)

It was safer for me to be in [birth town, 3 hours' drive away, rather than closest unit 1.5 hours' drive away] with my parents (Participant 3, p. 3)

[Mother lived in a town 760kms or 9 hours' drive from their home] Mum, we're coming down to have the baby, is that okay? ... Because we stayed with family, we didn't pay rent or anything, so that was really good (Participant 27, pp. 4, 11)

The following table demonstrates the distance participants travelled to birth.

Table 2: Distances and times travelled for labour and birth (intended)

Birth at home/locally	Birth < 199 kms	Birth 200–399 kms	Birth 400–599 kms	Birth 600–999 kms	Birth > 1000 kms
2	18	36	5	11	1
Average distance travelled for birth 330 kms (660 kms round trip)					
Birth < 1hr	Birth 1 < 2hrs	Birth 2 < 3hrs	Birth 3 < 4hrs	Birth 4 < 5hrs	Birth > 5hrs
2	14	14	12	18	13
Average hours travelled for birth 3hrs and 51 mins (7hrs + round trip)					

On average, women travelled 330 kms (660 kms round trip) to birth. The average time spent driving to their birthplace took 3 hours and 51 minutes each way.

When women need to be evacuated from their own communities to labour and birth, many have the option of choosing between **undesirable alternatives**. That is, travelling in labour with its undeniable discomfort and the accompanying risk of birthing en route, or spending many weeks in the town where they will labour and birth. Describing her birth experience en route to the maternity unit, this participant said:

We got to [two other rural communities on way to city] and they were still five minutes apart, but they were fairly intense ... Because I hadn't been through that last stage of giving birth [with first child] I thought I would be right. So I kept going ... we wanted to make it to [city 3.5hrs away]. And I wasn't right. ... We got to the other side of [next little rural hamlet] and I got out of the car and I just could not get back in. [Husband] said, 'Come on, let's get back in. Come on, we're nearly there, we're nearly there.' And I couldn't ... I was pushing ... ready ... for [baby] to come out ... I thought ... we'll make it there, but we didn't. ... [Husband] was on the phone to 000 and they were talking ... what to do ... I was standing outside of the car, it was nine degrees ... about half past five in the morning ... we all coped ... the ambulance was coming out ... [Husband] had the sleeves rolled up and ready to deliver this baby ... they were telling him ... 'You're going to deliver this baby.' But he didn't tell me. So I was thinking ... 'I'm not going to give birth on the side of the road.' ... And then the ambos turned up and eight minutes later [baby] was born ... we got into the ambulance. They were just about to say, '[Husband], you drive the car and we'll meet you at [private hospital in city],' and they were just about to shut the door and the ambo said to [Husband], 'Oh, no, just stay here.' (Participant 16, pp. 3–4)

Of particular interest in this scenario are two concepts. First, is the risk of hypothermia for mother and baby with the temperature being only nine degrees. Second, is the fact that in retrospect this woman found birthing en route to be a much more empowering experience than giving birth in a well-equipped hospital:

It was that easy ... I was on all fours ... that was the most comfortable position ... Because I had an epidural with [first child], I didn't think I'd give birth ... as natural as that. I didn't think I could do it. But I had no choice, I had no drugs whatsoever. And after I'd done it, I just felt so proud that I could do it. And you don't need drugs ... I didn't even feel like I had given birth ... it just seemed like a natural, the natural thing (Participant 16, pp. 3–4)

Rural women's resilience is legendary and as the above experience illustrates, this participant was no exception. Her ability to successfully adapt to what many would perceive as a high-risk, stress-prone situation increased her sense of self-confidence and justifiable pride. Prior to interviewing this participant, many other women in the community urged us to interview her. She is seen as a cause for celebration and the community continued to draw strength from her experience long after the birthing experience. Sonn and Fisher (1998) argue that competent communities as well as resilient individuals have the capacity and resourcefulness to cope positively with negative or highly stressful situations.

However, **resilience and resourcefulness should never be seen as a reason to allow a situation to remain unchallenged.** This includes the situation of healthy pregnant women being forced to leave their home communities to labour and birth. Many participants travelled for hours in labour and they describe their experiences:

So I'm all fours in the car, yelling at [partner] to rub my back ... And he's driving through town and rubbing my back with the other one, in peak hour traffic, going through [large town 1 ½ hours' drive from home] on the highway ... The pain was just excruciating, so all I was thinking about was ... 'Rub my back, rub my back.' Because we've got a manual car, he's having to change gears as well ... as rub my back and, I don't know how [partner] was feeling with driving and having to do everything (Participant 6, pp. 4, 11)

So we're 17 kms from town [without a maternity service], so all the way along I'm saying, every time I'd have a contraction, I'd say, 'Stop, stop the car ... And then he'd stop the car and I'd say, 'What are you doing? Don't stop the car. Keep going, keep going' ... I just kept on thinking, 'I'm going to give birth to this baby in the car.' ... I was in the front passenger seat ... It was awful. That was the worst part of it. ... The pain was so bad and it was just so out of control, you know? I just kept on thinking, 'I'm going to give birth to this baby in the car (Participant 13, pp. 2, 5)

I remember lying on the back seat with [toddler] and holding my hand through to [husband] and just squeezing every time a contraction was coming, so he could time it still ... we had lots of pillows. We tried to make it comfortable ... you feel all the bumps (Participant 17, pp. 5, 6)

My waters broke with [name of first child]. My husband rang the hospital and said, 'What do we do?' They said, 'Oh, you've got plenty of time. Take your time coming over.' My contractions were eight minutes apart. By the time I got to [referral centre, 1hr 40 mins away], they were four minutes apart and we virtually got in the car and left. It was eight hours from when my water broke to when I had her. With [name of second child], my water didn't break but I woke up with a contraction and they started off five and a half minutes apart and they said to my husband, 'Put your foot down and make sure you get over here.' ... Yeah, so I had [name of child] five hours from my first contraction (Participant 12, p. 4)

We basically planned to just travel over when everything started happening. So, I started getting ... I wasn't sure whether they were contractions or not, I started getting back pain, and I started timing it, and it was becoming regular, and I thought, 'Mmm, this could be it.' So, I spent the whole day before she was born just keeping an eye on the timing of the contractions ... We started driving at about six-thirty in the evening and as we were driving over, they were getting closer together. I think they were down to about two minutes apart in the car (Participant 15, p. 2)

About 2.30 am I felt my first contraction ... I just waited for three, and then I said, 'Right, we're going.' And we didn't muck around. We got up,

straight in the car ... I had my contractions, but I was still right to sit there. I was sick halfway on the way in between here and [large town 1.5hrs away] ... Luckily, I had a spew bag in the car so we didn't have to stop (Participant 16, p. 2)

I was in the front seat. Yeah, just hanging onto the hand bar, and that just gave me a bit of stability, I suppose, during each contraction, and I'd just breathe through each contraction ... had the urge to want to be upright, so that was probably the hardest thing with being stuck in the car and not being able to move around ... We were travelling, yeah, 80 kmph I suppose, 80/90 kmph. And it was just the longest trip in history. I was, 'Are we there yet? Are we there yet?' (Participant 22, p. 6)

Not surprisingly, many women reported how **travelling had a physiological impact** on their labours:

I found, by the time I got into the maternity unit, my contractions had become quite irregular. Still, they'd probably gone up to a two or a three, but I was managing without the gas, didn't have any pain, just breathing through them. And, I think I knew then that, I remember saying to [partner] distinctly, twice during those early morning hours, 'Something's not right. I just know that something's not right.' And I actually burst into tears and the midwife walked in and said, 'Oh, what's wrong? What's happening, what's going on?' And [partner's] standing there going, 'I don't know. This didn't happen with the first one. I don't know what's going on.' And it was just because ... I just knew that things weren't travelling along as they should be (Participant 22, pp. 7–8)

I think they were down to about two minutes apart in the car. We got to [Base Hospital] at about ten-thirty at night and all of a sudden, the contractions went back out to about 12 minutes apart (Participant 15, pp. 2, 3)

Having given birth in a larger town, women are then faced with the **long trip home**, usually with a newborn baby. Most women had a private car to drive home in but on occasions women travelled back in the bus, which would make a four hour drive, a seven hour trip.

And then you've got that huge trip home ... And I think the worst thing was that trip home from [hospital] the first time with a brand new baby. It was such a long way, like seven hours to get home. People just have no comprehension of what that's like (Participant 13, pp. 11, 17)

Drove back [4 hours] with a little two day old baby in the car (Participant 36, p. 8)

We fed [newborn] before we left, put him in the car ... By the time we got home he was screaming in pain ... so the poor little bugger was screaming his head off for hours. We had no-one here to call, we had no idea what was going on. My husband rang a girlfriend who came around. Anyway, we didn't have any bottle, any formula, anything, because I just thought I

was just going to breastfeed, as any first time mother thinks they're going to do. So, I'd actually had a bottle here from my niece, it had been in the cupboard for I don't know how long, found it. So we sterilised that and she put some water in it to give to him to try and flush him through (Participant 19, p. 8)

The **drive home** could be excruciatingly **painful** following abdominal surgery or suffering from conditions such as severe urinary tract infection (UTI):

It was still uncomfortable coming home, but I just had to get here. Life doesn't kind of stop because you have a baby (Participant 26, p. 1)

In the car ... I felt terrible ... screaming in pain ... I said, 'Pull up here. Pull up on the road.' Keep going, pull off the road, keep going, pull off the road ... Yeah, every single time. ... terrible pain, terrible pain [Note: On arrival at her home town, this woman was admitted to hospital and placed on IV antibiotics for 3 days for UTI which had been ignored at the Base Hospital] (Participant 38, p. 19)

Access to breastfeeding support may be non-existent. Some participants in this study found this experience devastating and their biggest regret:

We only had the nurses from [large town, 1.5 hours away] visiting every fortnight, and I was having real problems breastfeeding, and I ended up stopping the breastfeeding after about two weeks. I was trying to combine breastfeeding and bottle feeding, because she wasn't getting enough out of me, and, yeah, that was my biggest regret ... I think if I had had more support it would have been a lot better ... and it took me quite a long time to get over the disappointment of not breastfeeding. I think it took me about six to eight weeks before I started coming to terms with it properly. So, yeah, I went through a few tears in that time (Participant 15, pp. 3, 4)

[Baby] wasn't latching on correctly. I ended up with the cracks in my nipples that were just so painful and you'd pull him away and he'd have blood all over his face. Then I ended up with mastitis, so ... he went onto the bottle. So, I think I fed him for a week, and that was it. And I'd be sitting here ... Oh, I was devastated. I'd be sitting here at whatever time in the morning, crying my little eyes out because it would just be killing, like trying to feed, and yet we didn't have a midwife here. ... So we had no-one (Participant 19, p. 6)

But it's the breastfeeding side of it that I seem to have trouble with. And like, both times I've stopped breastfeeding at six weeks, after having mastitis five times with both of them. ... There's nobody at [town] or [closest other town, 80 kms away]. The nearest lactation consultant is in [city, 4 hours' drive away]. It's a bit far to go for a feed ..., and there is a group [of the Breast Feeding Association] at [town, 200 kms away] ... That's where I was actually on my way to when I had the car accident (Participant 2, pp. 3, 4)

Exacerbating the inaccessibility of maternity services for women is the **inability or unwillingness for midwives to work to their full scope of practice**.

But if you did have any sort of technical questions, [midwives] sort of couldn't help you. They would just, would measure how low you were and check your pulse and heart rate and that sort of thing. So it was only very basic care ... You get over there, you see them, you've got a question for the midwife, or for the doctor, they say, 'Oh yeah, can you come back tomorrow?' (Participant 12, p. 1)

I'd take [child] in for his needles ... she's a trained midwife, so she'd always know the right questions to ask, and she is in a way, was my midwife during pregnancy ... she [early childhood nurse and midwife] ... didn't carry out all the checkups and things like that but she certainly provided the emotional support which was such an important part ... and it is very sad to walk into that hospital and to see all those midwives and none of them practising ... Because we have quite a healthy growth rate in [town closest to home, 70 kms away] I mean, I know of at least 12 women currently who are pregnant, and are all travelling out of town because there's no antenatal care provided in town by a trained, well, anyone (Participant 22, p. 17)

Midwife, and she called the doctor when the baby was coming, so ... So, yeah, midwives don't normally deliver up there (Participant 23, p. 4)

... one of the ladies, I think, who runs the A&E is a midwife, but there's no services offered (Participant 24, pp. 8, 1, 2)

I basically sought midwives. And I had a few midwifery consults, but not with midwives that were going to care for me because there was that huge issue of ... twins. Although, when I had ... my fourth baby, and I'd had him in the same location, it was very difficult and, in fact, my midwife travelled 11 hours from [interstate] to come to care for me (Participant 18, p. 1)

Equally of concern is how more **unqualified health professionals** are taking the role of midwives and medical practitioners:

The only doctor available at that time didn't have his obstetrics licence – he had experience with pregnant and labouring women, but wasn't actually licensed to practise as such ... ended up having antenatal care with the GP here [in town 70 kms from home] who is not obstetrically trained (Participant 22, pp. 3, 4)

So for all my checks, I just went down to the doctor's surgery and I think ... the nurse that they had there, she used to take the blood and do that sort of stuff. It was only if you really needed to see, or if there was something abnormal with any of your tests that ... you'd actually see the doctor (Participant 26, p. 2)

[Closest town] was not an option to give birth. There was no-one skilled enough to do it (Participant 18, p. 1)

I saw two different doctors ... No, the health care in [home town] is terrible if you ask me. We've got this hospital, um, which is great and wonderful, but ... (Participant 24, p. 10)

c. Affordability

A lot of people live ... on the poverty line out here ... a lot of people live on the poverty line or just over (Participant 26, p. 14)

As a result of the closure of many birthing services in rural and remote areas the costs of accessing birthing facilities have shifted significantly from the public health system to the individual family. These costs are substantial and include both financial costs and social costs to the families and communities already disadvantaged through separation and isolation. For all women interviewed this had had at least some impact, and the following highlighting story exemplifies these problems.

Highlighting story

Nadine (pseudonym for Participant 29) is a mother in her mid-thirties. She has just given birth to her seventh child. The family lives on a basic wage in a small town four hours from the regional centre. They have a very unreliable car and the stress of accessing care at a distance from home is financially and emotionally overwhelming. They are new to the community and do not have family support.

Nadine attended some of her antenatal care visits. Because she has nowhere to leave her children, she chose not to travel away prior to the birth of her seventh child. When she went into labour she was lucky to be able to call on her neighbours, a couple in their seventies, to look after the other six children. On the way to the regional centre while in labour, their car broke down and she was left on the roadside for several hours while her husband went for help. She made it to the hospital eventually and had a healthy boy. She was very anxious about her other children back home and was concerned about the strain on her elderly neighbours. While she was in hospital, her husband was sleeping in the car to cut down on costs and they were highly anxious to leave hospital as soon as possible after the birth. Nadine had been unable to source IPTAS funding because she had trouble accessing the forms, deciphering them and having the doctor complete the relevant sections. The baby bonus, once received, would be used to pay costs associated with her husband's time off work, travel costs, paying something for child care and covering the costs of car repairs.

Discussion

The financial costs of birthing to families include costs associated with accessing antenatal and birthing facilities at a significant distance from home. Accommodation costs when waiting for the birth and for partners and family during the post-birth period, plus the costs of child care for other children, lost work time for partners and for the mothers, and associated medical costs all added to the financial distress experienced by the participants in this study.

The social costs of birthing include stress on women accessing regular antenatal and birthing services at a considerable distance from home. Many experience separation from family in the month before the scheduled birth and become anxious knowing there is the likelihood that partners will miss the actual birth because of distance. The inability of friends and neighbours to visit during the immediate postpartum period further adds to feelings of isolation and loneliness.

Financial costs

Many women report the **financial costs** as well as the **inconvenience** associated with travelling for **antenatal visits**.

It'd be three and a half hours, so it made it a little bit tricky to go to the city ... it'd be seven hours we'd drive ... I was working and [husband] was working, and if you stayed there, you would have to pay for accommodation ... we would usually do it all in one day ... it was a big day ... seven hours of driving just to go to the obstetrician for five minutes and out again (Participant 16, p. 1)

Well in the end I was going every two weeks before I finished work and then I was going every week once I finished work ... petrol was \$1.30 or something at the time. It was very expensive and we were going constant (Participant 3, p. 15)

For many women these antenatal visits required them to take **time off work** – so the financial costs also included lost pay and sometimes additional costs to their employer to replace them.

That was hard to take days off. My work at school has to be really, really good to me ... you've got lessons that others can take. [Our town] has a shortage of casual teachers, so sometimes if you can't get a casual, your classes will be taken by other teachers, so that's a burden on the school (Participant 3, pp. 2, 15)

Because of the significant distances, many women were accompanied by **partners who also had to take time off work**.

[Husband] had to take a day off work to drive me [4.5 hours' drive each way] (Participant 13, p. 8)

Others reported significant costs associated with **travel for prenatal tests** and their frustration that the medical fraternity did not understand the costs involved for the family.

I was fine and there was nothing wrong with him and it was a pointless trip, and a very costly trip ... I ended up walking out of the doctor's in tears. It had nothing to do with him, I was just more upset with the whole trip (Participant 29, pp. 3–4)

Others noted that they were **not able to afford the costs** associated with these trips.

I was supposed to have a scan at 30 weeks to see how the placenta was and I rang him and said 'I just can't drive all the way to [city 8 hours' drive away] to have a one hour scan. I just can't do it.' Financially because of the drought and what not and also just time wise and ... my husband not being able to mind the kids for me ... it was \$140 to have the scan ... I had to pay for my fuel to get to [town 3 hours away] and get back as well (Participant 25, pp. 2, 13)

The **medical costs** associated with the **visit** were rarely bulk billed.

There is no choice. It's a GP-led service. Women have no real continuity because GPs work on a roster-like basis. There is no free antenatal care so again all women pay, even on a health card, there really isn't any – they do not bulk bill (Participant 18, p. 15)

The financial **costs** associated with the **birthing process** were also noted by many women.

\$4,740 plus – I can tell you my doctor's [bills] and all that kind of stuff because I paid the bills yesterday ... (Participant 25, p. 4)

A significant part of the financial costs relate to **the need for women to leave home up to six weeks before the birth**. Women report that their doctors are insistent that they be close to the regional hospital for several weeks prior to the birth. Women report that they have to cover the costs of accommodation for this period. They may be separated from family for several weeks. Women having their second or subsequent children report that this sometimes leads them to make a judgment call as to how long they might stay at home.

It's a really expensive exercise. \$600–\$700 a week (Participant 13, p. 8)

Four weeks [away from home] it set us back a little bit ... I suppose we knew from about 34 weeks that we were going to have to do that, but still you weren't anticipating it I suppose (Participant 20, pp. 2–3)

I went because the GP said you have to be gone by four weeks before your due date. And the obstetrician was basically saying the same thing. ... I rang around, motels, caravan parks, cabins, everywhere. Basically we were looking at \$2,000 easy (Participant 2, p. 4)

Some women reported choosing to have a **caesarean or induction to limit the time** away from home.

But what choice did I have? The choice I had was to be induced at 38 weeks, to have a caesarean section at a similar time or to travel. My view was that I simply, I could not physically afford it and neither could I afford the time ... when I was going to have six children aged six and under. I couldn't simply sit around and wait for babies to be born hundreds of kilometres away and have my husband take what I saw as wasted time off work (Participant 18, p. 3)

Accommodation costs do not stop once the mother goes to hospital. Partners like to be close to their wives and new babies after the birth and this additional cost causes further financial stress for families. Some women noted that their husbands slept in their cars to cut down costs. If there are other children in the family the **additional costs** include child care.

[My mother, husband and first child] *stayed at a motel for the five days that I was over there ...* (Participant 13, p. 6)

When the birth is difficult or there are problems with the baby, the time away from home can be long and expensive. One woman who had a multiple birth reported that she had been away from home for 12 months.

There are many who simply cannot afford the associated costs of birthing away from their community. These women often miss out on antenatal care and their birthing experience is fraught.

I'm lucky I've got a car, I've got that mobility. There's a lot of people in the [town] that don't have that mobility. As tough as finances are I can whack it on the Mastercard and work out how I'm going to pay for it. But some people don't even have that option and I think that's really tough. We've got too many young girls in town having babies [without proper care] (Participant 25, p. 7)

Huge issues around affordability and travel. There are a great number, not the odd one or two, but there are huge pockets of women that are having none or very little antenatal care ... there is no acknowledgment of the cost, as in financial and emotional cost of actually accessing appropriate care (Participant 18, p. 17)

Emotional costs

All women reported on the social/emotional costs associated with birthing away from their community. Many spoke of their fear, isolation, lack of support and the sadness that their husbands had missed the birth of their child. These are described more fully in the section on emotional stressors.

Financial recompense

The two sources of financial support are the **IPTAS** scheme (Isolated Patients Travel Assistance Scheme) that funds travel away from home for essential medical treatment, and the **Baby Bonus**. Both of these are inadequate for the women interviewed for this study. Women reported that the IPTAS scheme guidelines necessitate applying each time a trip is made. For women and their families attending regular antenatal care, birthing and postnatal care, this requires significant paperwork at a time when the family is stressed. Invariably women reported that they had not been able to do this. Several reported that they were unsure how the scheme worked or that they were not eligible. Lack of information and support with this scheme is a real problem for women in this study, as was the lack of consideration given by health professionals to the problems caused by geographical isolation (discussed under 'Acceptability' issues).

IPTAS – that was really hard ... it's really hard financially and I haven't looked into it really well, but I understand I'm not entitled to any IPTAS funding (Participant 25, p. 4)

Others reported that the **Baby Bonus** is used to pay costs associated with the birth rather than to support the baby and family as it is intended to do. Further, because it is received sometime after the birth, it does not relieve the immediate financial stress.

I think probably the biggest issue is the financial burden for anyone having children. ... some people can't afford to pay for it up front. So the Baby Bonus comes, although it's fantastic, It's actually not at the right time (Participant 25, p. 13)

2. Midwifery principles and philosophy: Choice, continuity of care and control

The participants in this research all believed that living in a rural/remote area of NSW placed extreme limitations on their choices of where and with whom they could birth, especially when they desired to have continuity of lead maternity carers. Many women sought to take control but they did this in different ways, from being 'hyper-organised' in their families and home to electing to birth at home. The woman who had control, and chose and planned for a homebirth with continuity of care from known midwives, had a very positive experience. In comparison, the participant who had no choice and had an unplanned homebirth with no known carer experienced as distressing the lack of control in her given situation but still described her unplanned homebirth as 'brilliant'.

Highlighting story

To illustrate the principles of choice, continuity of care and control from the participants' narratives, Felicity's experience is described. Felicity (pseudonym for Participant 31) had an unplanned homebirth. She had private health insurance and felt robbed of her choices in terms of not having a private obstetrician present and her choice of where she wanted to birth:

I felt really – and I still do – feel really robbed. And like, yeah, as I said, you pay all your money into your health insurance and all that sort of stuff, and think you'll have the baby at [regional city] ... I actually never got a choice to where I wanted to go.

She had opted and paid for private obstetric care in an effort to ensure continuity of care. However, her first baby was born while the obstetrician was away and the second baby was born at home. Continuity of care, a longed for principle, was not realised in either of Felicity's birth experiences.

The most traumatic aspect of Felicity's unplanned homebirth was having her daughter present, and this fact highlighted her lack of control over events surrounding the birth.

We rang the neighbour across the road and asked her to come over and get [older child], because we'd sort of half lined her up anyway. She strolled over thinking, you know, heaps of time, they've got to pack their bags, head off, and I was in the bathroom at that stage. And she started coming up the hallway and I'm yelling out, 'Don't come up here. Don't come.' And she panicked then, and my husband panicked. They were both a bit teary, and I just kept saying, 'Get [other child] out of the house. She doesn't need to hear this.' But she kept saying to my husband, you know, 'What's wrong with Mum? I'll go and ring the doctor, she's sick.' ... just little things that she still remembers ...

On reflecting on her birth experience overall, Felicity was grateful that she and her husband had not attempted to drive the two and a half hour drive to town as she would have had her baby en route. Despite the lack of continuity of care, or the fact that the person she had chosen to deliver her baby was not present at the birth, or the fact that she didn't have as much control of events as she may have liked, she expressed her surprise that it was not an entirely negative experience; instead she described it as 'brilliant'.

Everyone said, 'Oh, you must have been so scared and really nervous' but I really didn't have time to be ... But, as far as the labour and everything went, it was brilliant ... The births have both been really good. ... I didn't have any drugs with either of them. [Second birth] was a lot quicker ... about an hour from start to finish. Had him at home, in the lounge room (unplanned) ... So that was a two hour trip, but never got made, thank goodness, because I would have been in the car.

a. Choice

Women still should have the right to choose and the more that's taken away from them, the less autonomous that they feel. And the less positive experiences they'll have (Participant 22, p. 16)

They just do it. Because, you have to do it. You know? You've got no choice (Participant 6, p. 10)

Discussion

Many participants indicated they felt they had no choice in issues relating to most aspects of maternity care. This feeling of powerlessness impacted on many aspects of their lives. Women were usually **realistic about** what **choices** should be available but questioned why at least the basic maternity services were not accessible to them.

I know we'll never get an obstetrician ... in town, and I am happy with that. But I would really like to see [regional city] get the services they deserve ... because the area they resource is just enormous. It would be so much easier to ... have a birthing centre. Some people like to have water babies, some people like to have birthing stools (Participant 19, p. 12)

So if you go to the A & E, they don't know your situation and with an experience I've had with mastitis recently ... I've ended up having to go to [town one hour drive from home] once and [town 350 kms or 3 hours' drive away] last month (Participant 28, p. 6)

Pregnant women who live in towns where there are maternity services expect they can quickly manage their lives and be at the hospital as early as necessary. On the other hand women who live in towns where there are no maternity services have a whole variety of issues that must be addressed before they seek maternity services. These women voiced their concerns about the expectations by medical and other staff that they **leave their homes** and await the birth of their babies in unfamiliar, lonely towns, often without transport. This was stressful, unnecessary and led to feelings of powerlessness. Their **other children need caring for** and the women would have to take them to larger towns if no local care was available.

I'm not going ... I didn't have a car in the city, I was there for three weeks [previous pregnancy] I had to go to the hospital ... for a regular check up and then they wanted me back in two days time for a day visit ... I was relying on [other family members] to take time off work to take [other child] because I couldn't have him at the hospital. So, I just found that really stressful (Participant 2, p. 20)

And it's really expensive to stay somewhere for three weeks ... you can't lob in on friends when you've got two children and having another one (Participant 13, p. 6)

Women were forced to **make choices between their families' emotional and social needs and their own perceived physical safety** when there was no maternity unit in their town. They would be expected to leave children for long periods of time to birth in the maternity units which were located long distances from home:

And my doctor ... doesn't know that I left it so late to go up there because I didn't tell him ... 'If your placenta is a big issue you might have to come up at 26, 28 weeks' ... I just said to him 'I can't do that'. And had I started haemorrhaging it would have been a really big problem for me as far as trying to deal with my family (Participant 25, pp. 10, 11)

... and you start bleeding through the night ... You've put your own baby and self in jeopardy, [or] ... you've gone all that way for nothing (Participant 29, p. 3)

'Shall we risk or shall we go over early?' and we ended up deciding we'll just wait about (Participant 15, pp. 5, 11)

So my option was to go and sit, if I wanted to birth at the time that they were ready to be born, rather than to schedule at 38 weeks. And to sit hundreds of kilometres away in the middle of summer with four other kids around me, that was not safety (Participant 18, p. 4)

There's no way I could go and look after two boys ... I was advised to go three weeks before by our GP but I've chosen to leave it until now (Participant 2, p. 2)

Some towns provide only very basic maternity services and women are not given choices about midwifery models of care. Where a midwife only sees the woman during birthing, the midwife does not work within their full scope of practice, with the result that there is a risk of deskilling the midwife. If the 'system' allows medical practitioners to deny the midwife the right to work with women at other times, for example during the antenatal period, pregnant women are only exposed to the medical model of care, thus supporting the women's perceptions that they have **no choice of maternity care**:

I mean there are no choices ... No continuity of midwifery in any way, shape or form. In fact, no midwifery care outside of the labour ward so no midwifery antenatal care, no real postnatal care other than the Child and Family Health universal visit ... the midwives that are working locally are ... working in an amazingly fragmented way (Participant 18, p. 3)

[Obstetrician] *wasn't that keen on [midwife] doing it [antenatal]* (Participant 13, p. 8)

The impact of not having access to a local maternity unit to birth had some parents **questioning whether they wanted to have another baby**. The thought of finding child care for their other children and then driving for hours for maternity care caused them to question their life plans and desires:

It will really make me think about whether I have ... another baby ... to have a third one means that there's two children that you need to have looked after for the day. It's a very long way to [birth hospital 4.5 hours' drive from] with two kids (Participant 13, p. 14)

That was why ... I got my tubes tied ... I just can't go through this again (Participant 24, p. 5)

I would like to be able to have another child, but you know, not being able to have scans here or anything ... Knowing that you'd have to travel so much while you're pregnant (Participant 28, p. 7)

Besides the child care issues and enormous distances to be travelled already discussed, women would like the option of birthing in their home towns so they can **access the support of family and friends**:

First and foremost I wanted to birth in my community with my family, and not have to drive hundreds of kilometres, which was the only option (Participant 18, p. 1)

b. Continuity of care (and lack thereof)

I just think it's so important to build up a rapport with your midwife and if that midwife can be guaranteed to be your midwife during labour and follow on through postnatally, I think you have such better outcomes for the mother (Participant 22, p. 11)

The concern is that you don't have continuity of care (Participant 28, p. 6)

Discussion

Participants desired continuity of care and carer during their pregnancy, and wanted to see the **same health professional** all the way through. Contrary to the World Health Organization recommendations for Appropriate Use of Technology for Birth, commonly referred to as the *Fortaleza Declaration* (Parliament of Australia, 1999), almost all women in Australia have a medical practitioner rather than a midwife as their lead carer during pregnancy and birth. Few women have had access to midwifery-led services and expressed their desire to have the same doctor providing their care. They were keen to develop a rapport and trust with the doctor. This was so important to them that they were prepared to travel very long distances to get it.

I'd rather have a doctor that I know and that I've built up a rapport with and that I trust and I'd rather travel that distance to get that ... I'd prefer to know my doctor before giving birth and them delivering the baby (Participant 40, p. 5)

It's really hard to get a rapport with someone that you don't know anyway (Participant 23, p. 10)

I started with the GP in [referral town] that's just as annoying ... just going over for ten minute appointments ... They were sending them in say two week blocks ... They were always there, but they were just different ... you wouldn't know who you were going to get (Participant 17, p. 2)

Midwives also benefit from **continuity of midwifery care models** through which they are able to build on and sustain their midwifery knowledge and skills. With continuity of care, midwives see women through the antenatal, birthing and postnatal periods so they can promote wellness for that woman and her baby. The midwife is thus being permitted to practise her craft and is more likely to stay in the rural area and not be forced to move to the city to practise midwifery:

From a midwife's perspective, [there's] professional satisfaction that you do receive from building that rapport with mothers and to actually have that sense of closure after each pregnancy (Participant 22, p. 11)

If midwives are not given the opportunity to provide the sole care for women, there may be **shared care models between midwives and GPs** but this is still overseen by the GPs who retain control. However this shared care model of maternity care further reduces continuity of care:

I used to [see GP/obstetrician] ... when I had [daughter], but it had changed because you would see [Doctor] sort of once every second or third visit and the other visits you'd just have check ups with your midwife. They call it Antenatal Clinic, don't they? Yeah. So, didn't have as much one on one (Participant 12, p. 1)

The need for rapport with the primary carer is not possible when different doctors are involved in the woman's care. If the **doctors keep changing**, the women and midwives have limited exposure to them and this prevents a sense of teamwork which would reduce the amount of conflicting information women are given.

Ideally it would be lovely if he [Dr] had a rapport with the nurses around and with me, but he can't have it with me because I don't know who he is (Participant 17, p. 7)

The doctor that I had been to ... she knew everything from ... the word go, what was going on, and then I got this other doctor who, he wasn't really sure what was going on and sort of ... in a panic and then tried to panic me (Participant 26, p. 4)

I didn't have the connection or the rapport with the midwife in [hospital where second baby was born] that I did in [hospital where first baby was born] ... because you just don't have the relationship with the midwives (Participant 22, p. 11)

Women are forced to forego the notion of continuity of care when they have to accept different doctors because of the distance they have to travel for their preferred doctor.

So we'd drive over there (4.5 hours' drive from home] for the prenatal appointments ... and then I also went and saw my GP in [town 1.5 hours' drive from home] to do every kind of second appointment ... to cut down on travelling (Participant 13, p. 1)

On the other hand, in their quest for continuity of care, some women are prepared to **travel very long distances** so they can see the same carer.

I just wanted to have somebody, the same person dealing with my pregnancy the whole way over. So I went to [town, 250 kms or 3 hours' drive from home] (Participant 25, p. 1)

In towns where there are no maternity services it would be helpful to have a **midwife who can conduct an assessment** on women who present with pregnancy related issues. This would allay the fears of women when everything is normal, or an assessment might provide evidence that the woman needs to proceed to a maternity unit, thus reducing the risks for women seeking maternity care.

I still wasn't sure if it was waters or ... because you have leakages and that all the time. So the next day I went to see my doctor at [town, 30 minutes drive from home] and she was away. And I got some old bloke

that said ... 'I want you to go into town [1.5 hours away] and have this, this and this just checked' ... but he didn't examine me or anything like that (Participant 6, p. 2)

If the doctor's worried about a woman – she might have high blood pressure or whatever – why can't he put her in, just to keep an eye on her? Why should she have to leave to then go to another doctor in [town 1 ½ hours' drive from home] (Participant 6, pp. 13, 16)

Besides no continuity of care, some women see the only care available as **fragmented, medicalised care**:

No continuity of midwifery care in any way, shape or form. In fact, no midwifery care outside of the labour ward (Participant 18, p. 3)

There is no choice. It is a GP-led service. Women have no real continuity because the GPs work on a roster-like basis (Participant 18, p. 15)

c. Control

'Would you be happy for me to do an internal? See where you're up to and perhaps rupture your membranes' ... I said 'Well yeah by all means, do a PV and I would like to know how dilated I am and I'll go from there, I suppose, see if there's any bulging membranes or ...' (Participant 22, p. 7)

Discussion

Women have a sense of control when they are involved in making decisions about their midwifery care. Informed choice (and refusal) is an important aspect of decision making and women have a right to expect to make their own decisions, especially considering they usually have to be so organised in preparation to relocate to a town away from their home to give birth. Women have to **organise** every facet of **their lives** before they can then think about travelling to the town where their baby will be born:

You'd have to pack for a month ... Have I got nappies? ... Enough nappies to get me to [city, 8 hours' drive away] ... Have I got food to get my kids from here to there? Is my car serviced? (Participant 25, p. 15)

I'd organised everything ... accommodation for [husband] and my sister and the kids ... I'd contacted all the spots where it was ... possible to stay and ... And they just rang when we got there (Participant 16, p. 5)

Then had to organise petrol ... you wouldn't want to be caught on a night when you were low on fuel (Participant 17, p. 8)

Just the fact that it was more of an ordeal to organise everyone around the birth (Participant 23, p. 4)

All women want the best health outcomes for themselves and their baby. Many feel responsible for acquiring their own **knowledge about pregnancy** in order to have control of knowledge.

I did an amazing amount of research ... But I knew I had to get to term and yet, and to everyone's amazement except my own because of how much work, I did, I gave birth at 40 weeks (Participant 18, p. 3)

The participants had to be **super-organised** in readiness for the birth of the baby in towns away from home. This could lead to women taking risks with their own health, especially when an illness or complication had been identified:

I can't believe I am just ignoring this [placenta praevia] I think the reason I left it so late to go with [third baby], I just couldn't stand the thought of getting organised and planning, because it wasn't just a matter of jumping in your car and in half an hour you'd be at the hospital ... So I should have gone possibly a week earlier or something and it was all just too hard (Participant 25, p. 15)

Contingency plans are prepared by women who try to have control of their pregnancy and life. They are a safety mechanism that will decrease the risk taking. Such plans can assist with a woman's safe arrival to a birthing unit because they have prepared for the unexpected:

I had a contingency plan that if I went into labour early, that I would be cared for at [regional hospital] which was about, nearly two and a half to two and three quarter hours to [drive]. ... Any extreme emergency that facilitated that I present at [closest hospital] which was 45 minutes away, that I had a midwife I knew would make that transition there, because of how caustic the GP service was, and that they would not be supportive of me (Participant 18, pp. 4, 5)

That's what safety and risk is about ... If you don't have a plan for a 'what if' then I don't think that is safe (Participant 18, p. 13)

Regardless of where a woman lives (city or bush) she has **no control** over some aspects of her pregnancy such as her baby's presentation or the length of her labour. Women voiced concerns about birthing in their home towns where no maternity services were available to deal with unexpected pregnancy events.

[Baby] actually came breech, and thankfully ... you just think 'what if'? Imagine if I was at home in [home town] I had an hour labour, first baby, didn't know what was going on. I would have been at [town 2 hours' drive away] ... I had a breech baby that ... if you didn't have the expertise and the care necessary in the time ... it certainly could have endangered him and me (Participant 3, p. 7)

These stories highlight the desire of the women interviewed to have some choices about where they have their babies and who their carers will be; they want continuity of care, both at the antenatal stage and during birthing, and they want to have a degree of control over these and other factors.

3. Human rights violations

Violations to a woman's human rights can be sub-grouped into three discrete concepts. First is the woman's right to basic health services. Second is the enforced separation many women experience at the time they leave their rural and remote NSW communities. This separation often involves their partner and the father of their child, and may also include separation from their children, family and communities. Third is the racial abuse experienced by many of the Aboriginal participants when they leave their country and communities to travel to larger Base Hospitals to birth. The following story illustrates the concepts of lack of basic health services and the difficulties caused by separation.

Highlighting story

Louise (pseudonym for Participant 27) and her partner lived in abject poverty, suffering severe financial hardship and terrible living conditions. She had her first baby in the Base Hospital 4 hours' drive from her home.

But we were living on the camp with nothing ... a generator and no water tank ... No walls. There's a concrete platform in the middle, and then you've got the kitchen which is just corrugated iron with open, big open windows. So, if there's a storm, you know, you're stuck in it. The only place that actually was indoors, sort of – this was built in 1967 – was the bedroom. The master bedroom, but then that was that old, there were that many cockroaches, it wasn't really nice ... last year was nearly 50 degrees hot. With a little baby, you have to be careful. You know? And if there's no water, what do you do? So we had to go into showers every day in town, at the Bowling Club.

After the birth, floods marooned them in town for a prolonged time before they could eventually travel home. Their stay added even more to their financial distress.

In spite of economic disadvantage, Louise argued that community support is good:

We've got it pretty good, because everybody talks to everybody.

With her last pregnancy, two weeks before their baby was due and on their way to stay in the town with the Base Hospital, Louise and her partner realised that they could not afford to stay there due to the costs of the motel that would be required and so they opted to drive 9 hours to where they had family support:

This was two weeks before she was supposed to be born – we had put away that much money we could stay in motels only for two weeks, but not much longer than that. So we were really worried if she was going to be late, and then, on the way down ... I said, 'Why don't we go and see your Mum?' And he goes, 'That's a great idea.' So he went to the nearest phone box and rang up and said, 'Mum, we're coming down to have the baby, is that okay?' And she was stoked.

During this pregnancy Louise had to travel backwards and forwards to the Base Hospital by bus. The bus trip involved travelling down one day, staying overnight and then travelling back by bus the next day. She did this to receive treatment for basic health problems such as a urinary tract infection.

I was back and forth ... I developed a urinary tract infection that the doctor didn't want to touch because I was pregnant, so it just got worse and worse ... in the end when I started vomiting ... they had to send me back and forth to [Base Hospital] a few times ... by bus.

Louise believes she could have received this treatment without having to travel. She is originally from a country where midwives worked to their full scope of practice and she compared pregnancy care in her homeland with the technologised care she received in Australia:

At the hospital, I think, [there are] midwives ... so you can go for regular checkups with someone that knows what's going on, not just an ordinary GP that's got to go out of his way and think, you know, 'What is the story here?' You know? 'How do we do this again?' ... And, 'What medications can we give to someone ... ?' Someone specialised, that knows. Because, if you end up in hospital and you're not treated for something as trivial as a urinary tract infection, and you've got to get really bad before they do something, that's not good. Especially when you're pregnant. But they don't know. They've put it in on the computer ... 'Beep beep', 'What do we do? Oh, can't do it.'

When considering her human right to basic antenatal care, Louise concludes:

Like this is Australia, it's the bush but ...

a. Right to basic health services

Where you live is where you want to be to have your baby and I believe that it has a fairly major impact on people (Participant 3, p. 13)

Discussion

Participants often spoke of their strong desire to **birth in their community** in close proximity to family, friends and their social supports. They saw this as a basic health service to which they had a right.

First and foremost I wanted to birth in my community with my family, and not have to drive hundreds of kilometres, which was the only option (Participant 18, p. 1)

Something as simple as establishing a rapport with at least one health professional, shouldn't be all that much to ask, I don't think. It doesn't matter where you live (Participant 22, p. 15)

Some places without maternity services also **lack other basic primary health care** strategies such as childhood immunisations, or facilities such as water.

I was quite surprised when I moved up here, and, like, the early childhood clinic has only started up last year again. They had nobody running the clinic here for two years ... so they're trying to catch up on all the immunisations and everything ... I mean, the population of the town is meant to be around 5,000 (Participant 2, p. 13)

And the women who live out on the camps ... lack of services, lack of water and, you know, all the basic things ... I was in a camp ... I had a really, really terrible marriage. When I left him I spent two and a half months in women's refuges (Participant 24, p. 11)

Access to maternity services and basic health services can be seen as a social justice issue. In one town involved in this study, **social injustice** was being perpetrated by those with commercial interests maintaining a status quo whereby all routine antenatal screening was provided by general practitioners and these same GPs refused to 'bulk bill' or 'allow' midwives to provide free antenatal screening to women in the outlying villages. Private commercial interests dictated what antenatal services could be offered to women (antenatal education only) and what services could not be offered (antenatal health assessments), even when that antenatal care was being publicly funded through the *Families First* program. This is discussed fully in Section 4. on power differentials and abuse.

When services were offered at the Base Hospitals, participants described situations in which their basic **right to privacy and dignity was ignored** by health professionals:

The doctor checked me out and they really weren't very professional about examining me internally, because the woman who did it, the door was wide open, I had to tell her, I said, 'Can you please shut the door?' And the curtain, she didn't even pull the curtain across. I said, 'Oh, can you pull the curtain across please?' And I asked for a sheet to be put over me, and she's just looking at me like, 'Are you serious?' (Participant 35, p. 3)

b. Separation from partner, children, family and community

Once I got there I just cried, because I got really depressed, because as soon as I walked in like I had no one with me ... And I was crying, because I just really wanted my Mum or someone there (Participant 35, p. 2)

As has already been indicated in previous sections, separation from family and community for birthing is one of the hardest aspects facing women in rural and remote communities. The following story highlights the pain experienced by women at this time.

Highlighting story

Rachel (pseudonym for Participant 3) was expecting her first baby and had experienced a very healthy pregnancy. She lived with her partner in a town of 3,000 people. There was a brand new hospital which not long ago had a busy maternity unit. The town where Rachel was to give birth was 3 hours' drive away. On the advice of her obstetrician she travelled to the regional city a couple of weeks before her baby was due to minimise the risks of having to drive in labour. Rachel was lonely and missed the contact with her partner:

It was very, very hard, because ... we'd talk on the phone a lot ... You don't get to see each other. Being the time of year it was ... he was flat out. You know? The conversations you have with your partner about how you're feeling and ... it was tough because he was all by himself over here ... he loves to feel the baby move and all these sorts of things that you can't do if you've living three hours apart ... I said to him this morning, 'What would be his comment about what I was going to say to you?' And I'm sure he was jesting but he said, 'Oh I was heartbroken when you left.

Rachel was to be induced at term. She received Prostin gel to ripen her cervix and at the time of her induction, her baby was an undiagnosed breech presentation. Rachel and her partner desperately wanted to be together for the birth of their first baby. Sadly, the closest he came to being with Rachel was listening to her over the telephone while she laboured and then gave birth:

And I didn't want to call [partner] over if it was going to be two days because he had 15,000 sheep ... I had my sister there, but obviously, I wanted [partner] to be there, but ... timewise we thought, 'Oh well, if it's going to be a slow labour, then he's got three hours to get there ... Nine-thirty my waters broke and ten-thirty [baby] was here. So [partner] didn't even get in the car ... It was tough ... [sister] was on the phone to him constantly through that, the hour after my waters broke. And he actually heard the last contraction on the phone. He was talking to one of the midwives and she said, 'Oh, the baby will be here any minute in fact ...' and he heard this big screech, which was me. And the midwife then said to him, 'I think it was just born.' [laughter] And then I think he said, 'Oh, I think I've got to go.' I think it was all a bit overwhelming for him to be listening on the phone as his wife was in the throes of the last contraction ... it's not ideal to be away from your partner and away from where you want to be (Participant 3, pp. 6, 7, 9)

Both Rachel and her partner regret the fact that geographical distance made it impossible for them to be together at the time of their first baby's birth:

[Partner] didn't get to share the birth, and that's a major thing. His little baby boy was, well, nearly 12 hours old, I suppose, before he got there, and, you know, to miss that, ... and [partner] will never, never see that. ... (Partner) would have been a support and I think he would have been there for me. Sadly, he wasn't and he didn't get to see his baby born (Participant 3, pp. 13, 14)

Discussion

The sense of **profound loneliness** was evident for many participants, but particularly for those who were transferred from their home communities by Air Ambulance. Many spoke about how the size of the plane, and the rules and regulations and other factors meant that it was not possible for them to have a known support person with them. This is exacerbated when the women are from close knit communities that have little outside contact.

It's very isolating for them, it's distressing for the family. Generally, the Mums are usually flown to a larger facility for the delivery, due to short staffage in our remote areas. Once they get down there, they have no one ... a support person doesn't even travel with them because ... of the small plane that flies them down. So, when they get down there, they're just thrown into mainstream. Most of our women don't have the basic terminology, like, they don't ask questions. They are thrown in the deep end ... it's totally different down there. In the remote areas it's one on one, but once they get to a larger facility there's a dozen people that they may come in contact with in a very short time, and this impacts on our young girls, because they're shy girls in the first place. They don't openly communicate. If it's not a familiar place, they will, they'll clam up ... the girls are just isolated from the word go once they've been transferred from their own community (Participant 34, pp. 1, 3)

I was a bit scared to go by myself ... They don't let you. No ... there weren't no room [on the plane] (Participant 36, p. 7)

None of my immediate family is here (Participant 17, p. 2)

Alone ... And I pressed and pressed the button, they never come and then I was lonely (Participant 38, p. 13)

To be labouring and birthing without known and chosen support is to invite physiological sabotage. The release of oxytocin which coordinates and strengthens uterine action during labour is intrinsically relational (Uvnas Moberg, 2003). This means that to enhance optimum oxytocin release the woman needs to feel safe in her environment and particularly with those around her, which is definitely not the case for many of these participants:

As soon as I walked in like I had no one with me, really, and I was really out of my comfort zone (Participant 35, p. 2)

The participants sometimes expressed their distress in terms of being in a foreign or an **alien environment**. In keeping with the findings of Uvnas Moberg (2003), their settings far from home were certainly not perceived as the safest place for them to labour and birth, especially when staff increase such feelings of alienation by the way they treat the women.

I don't believe that people that have no family or little family and social support and are in a totally alien environment are in the safest possible place (Participant 18, p. 14)

I suppose the thing I'd say is that I don't think people understand how foreign it feels to go to a completely different place where you have no home, not your own things, to give birth (Participant 13, p. 17)

In the hospital, they're in a totally different environment. It ... disempowers them. ... they don't have rights. They're spoken down to, they're not addressed in a formal manner. It's actually degrading to actually see some of the midwives speak to our girls (Participant 34, p. 4)

I was going to [Base Hospital, 4 hours' drive away], and once I got there I just cried, because I got really depressed ... Then they induced me, but then, I told them I was getting contractions and I was in labour, and they wouldn't believe me. They said, 'No you're not, you're smiling. You don't look like a woman in labour.' Because I was walking around and, when I'm in labour, until the very end, you can't really tell because I'm very quiet and if I'm in pain I'll just stand there and I won't really make much racket about it. And they wouldn't believe me (Participant 35, p. 2)

The literature cites many advantages to **partners being present** and supporting women during labour and birth. These include family bonding, greater closeness to partner and baby and improved attitudes to parenting (Hollins Martin, 2008). In contemporary Australia, it is an expectation and it is considered the woman's right to have her partner with her during labour if this is desired by them both. However many of these participants did not have the option of having their partner or any other support person with them.

I went back into my room and I was just crying, and they wouldn't let my husband come up. ... And then someone rung out the hospital, once I'd rung him crying, and complained and then they finally did something about it. And they took me down to the labour ward and I was like four centimetres dilated (Participant 35, p. 2)

For many participants, the **separation** started many weeks before their baby was born. Partners often had to return home for work and financial reasons. This was particularly hard for farming families who were affected by drought.

So we actually stayed in [city] for about a week, 10 days, after I came out of hospital, so I suppose we had, well, I had five weeks, I suppose, all up (Participant 2, p. 12)

Towards the end of it, he [partner] was coming back [home] for a week to ten days, to do a bit of work (Participant 26, p. 9)

I had a fortnight wait in [regional town] while [partner] stayed home here with the other two girls (Participant 7, p. 2)

My husband couldn't come with me to [Base Hospital, 4 hours' drive away] for a month before the baby was due. He just couldn't do that ... Your sheep need feeding and your cattle need feeding irrespective and ... even for [husband] to be away for the week that we were away with her, he found that really kind of tough because he felt an obligation to be with me

and the kids, but also, he was concerned about the welfare of his livestock and stuff like that ... [a real stress] Absolutely, and quite stressful for him, too, not having, I guess, support for him (Participant 25, pp. 11–12)

While the partners of some participants stayed at home due to work and farming commitments, some women were **alone with their children in a regional centre** waiting for the imminent labour and birth:

It was hard. It's hard leaving, leaving your own home and your own space and everything. Your kids are out of routine, you know? With [partner] being on the land, you know, you'd like to be able to say, well, just come whenever (Participant 25, p. 3)

For other participants, **forced separation from their other children** caused them and their children distress and anxiety. Often times the young children did not cope well with travelling for many hours at a time to visit their mother and new sibling, and in other instances, young children did not understand where their parents were:

[After the birth] Mum brought her [child] over the first morning ... She rang me and said ... 'Can I bring her over?' ... to meet the new sibling, because I wanted her there as much as I could, and she was just tired and horrible and yucky and cranky ... so she went home that night and then Mum brought her back the next day and she was like that. And then I said to Mum, 'Don't bring her back again.' It was just the travelling ... I didn't take into consideration the travelling and how it would affect her ... she couldn't handle it. So, she came over the first two days and then sort of that was it until we got home (Participant 12, p. 6)

But, I didn't get to see her until the Monday, and he was born on the Friday. I had all that time ... It was the first time that I'd ever been away from her overnight and then it was Thursday, Friday, Saturday, Sunday – Monday before I got to see her. So, four nights away from her (Participant 15, p. 7)

That was hard ... [child] was only 16 months old and I cared for him the whole, like, I didn't go back to work, so it was hard to leave him and not see him for two or three days at a time (Participant 17, p. 15)

[So what was it like to leave, how did you feel?] Very upset actually. I had to do it very quickly ... But I couldn't be upset, because then they would have got upset. I had to go, 'Hey, I'll see you in a couple of days. ... Everything will be okay' ... So, especially the little ones, because they don't understand. You can't tell a two year old and a fifteen month old that Mummy and Daddy don't want to see them for a couple of days. ... I've always promised every single one when they're born, I'd never leave them. And, to a certain extent, I already have. I know I'm coming back, but do they know that? The older ones do, but the little ones are probably sitting there thinking, 'Gees, where's my Mum? Where's my Dad?' And when we speak to them on the phone ... he heard our voice and he put the phone down and ran down the front ... looking for us. And I said to her, 'I

don't know if I can speak ... because I think I'm going to just upset him ... He started crying, and he's only fifteen months old. ... Apparently he was pulling the phone down, trying to look into the earpiece thing (Participant 19, pp. 15, 16)

Very, very sad. And I think I cried myself to sleep the last three nights I was in hospital, because I'd missed him so much. Like [first child], I'd never spent that much time away from him. I'd been away for like a weekend from him, but not over a week. It was awful. It was just awful. And I actually came home a bit earlier than they wanted, they wanted me to stay a few more days, but I said, 'Look, no, I'm fine. I'm happy to go home,' because I just missed him so much (Participant 19, p. 8)

To move away from home was hard, extremely hard, because I had to leave my mother in an isolated area with two small children. And she's not used to that. It was hard just to be away from them full stop. And take their Daddy away as well. So it was really traumatic on them (Participant 23, p. 11)

Hadn't seen the boys for 6 weeks ... we drove to [town, 4 hours' drive] to see them. Because I thought, Oh, I can't not see him on his birthday (Participant 26, p. 5)

Left six children at home ... we ring them ... Yeah, ten bucks, twelve bucks or something ... Yes, just to make a three, four minute phone call. You're putting coins in because it's an STD call ... Six kids, you know? You get to make a sentence or more ... It's enough to start ... Just to say, 'hello, I love you, be good.' ... 'Quickly, put your brother on.' ... And they want to know what the baby looks like and how long is, and like, 'We'll show you the details when we get back.' Oh, it's awful ... And being so far from home and just being in an unfamiliar place (Participant 29, pp. 6, 12)

Oh, I tried not to talk to them on the phone and that, you know? Because when I talk to them, you just cry, and so I actually ended up running away from the hospital. They wouldn't let me go but I just took him and went. But I knew he was safe (Participant 35, p. 4)

For participants with **older children**, the choice was to leave them in child care if it was available or to have them miss school:

[Older child] missed out on a lot of school ... you'd have to stay overnight sometimes because it was too far to travel [for antenatal care] ... so that's two days of school that [older child] misses out on ... missed out on three weeks of school (Participant 14, pp. 1, 8)

There were **sad occasions** when women needed their partners', family and community support desperately, for example when a baby was not expected to live. It was at these times that they felt most alone:

And then, as it turned out ... [partner] came back here [to home town] with the boys – so I was up there ... And so they gave her not even a very

positive 10% chance of survival, and then said that if she did, that she would more than likely have a disability (Participant 26, p. 3)

On rare occasions, the **mother and the baby were separated after the birth**. When transfer to a larger centre was necessary due to complications, the mother and baby were transferred in separate ambulances and to separate hospitals:

My placenta didn't deliver and so they then took me to [hospital, one hour's drive away] and I had a curette ... and [newborn] in another ambulance over to [hospital, three hours' drive from home] (Participant 13, p. 3)

As the time for the birth became closer, participants and their partners often became increasingly anxious that they would **miss the birth** and many times this is what happened:

I'm hoping that my husband will be there ... I wouldn't like him to miss out on it, but it just depends on what's happening at the farm (Participant 14, p. 9)

See everything happened at night. There was no chance to get him to come down. And in the morning I had to ring him and tell him he had a son, which was quite a surprise (Participant 28, p. 5)

I was worried about my husband because he had to come back to the farm and what if I was in labour for over two days or something? I would have liked for him to have been there, but it's a bit hard for him to come and visit every day when he's got other commitments back here (Participant 42, p. 4)

So I rang him and said, 'I think you need to come over. It looks like it's going to be tonight.' And so it would have been about seven-thirty or something like that ... He got held up in a meeting and the next thing, the doctor's there, ready to do it and he didn't even make it ... So I'm on the phone crying and saying, 'You're not going to make it.' (Participant 20, pp. 3-4)

My husband being on the land, I was up there [city, 8 hours away] on my own and he was back here, but I wanted him to be there and so we set a date and the doctor was going to induce me (Participant 25, p. 1)

After the baby was born, many **participants mourned** the fact that they were separated from their partner and other children at a time when the family should have been bonding and precious lifetime memories being made:

I had [baby] during sowing ... my husband would have had to find accommodation over there ... [husband] could stay overnight. Maybe he stayed for two days but then, you know, there was a time when he had to come back home ... so it's a whole day that he didn't even see him ... you do feel the need to have your husband there but they can't continue farming, like work, and drop in even (Participant 17, pp. 2, 5)

You feel sad because you're being separated and it's a time where, ideally, you'd all like to be together and have those bonds develop as early as they can (Participant 22, p. 14)

[Partner] stayed at his brother's place. With [first child] he was there the whole time. He stayed at a friend's place the first time. With [second baby] he was coming and going. Because of work commitments, he had to come home. He didn't get as much time off as he needed because there were other people away and they'd just planted these new trees and he had to be home for watering and plus my son (Participant 19, p. 7)

My husband had to leave us all after the children were born, to come back home, because of the time we've been in drought, feeding sheep. So he had to come home and do that (Participant 39, p. 3)

One participant's partner shared his **distress at being unable to support his wife** postnatally due to the geographical distance between them:

It was terrible. I didn't have any money. ... So it was very difficult ... there were other reasons. We were worried about the house being burgled ... We'd been threatened a few times. Which was a shame ... If I'd known it was going to be that bad, I would have gone down. We've got a bloke living behind us that's threatened to break in as soon as we left, so we didn't dare leave the house unattended. But I didn't think it was going to be anything like that, or else I wouldn't have cared about the house. I thought it was going to be ... in, out. She'd be back in a couple of days. Didn't know it would be anything like the nightmare that occurred (Participant 37, p. 17)

Community support at the time of family formation and birthing in the community has been identified as a time of healing and capacity building in isolated Canadian Inuit communities (van Wagner et al., 2007). Alcohol abuse and intimate family violence in communities were reduced in these communities when women laboured and birthed locally with Indigenous midwifery-led models of care (Birth Rites, 2002). The participants in this study also spoke of the loss of community support:

And I think that if that woman could still have that strong community – I guess that when women have to travel, they seem to lose anything locally ... And that's what I've noticed in [small town], a community that has no birthing service and hasn't had it for 15 years, where ... I had our fourth baby and lived for most of the pregnancy with the twins ... trying to then establish a Mothers' Group and all those sorts of supports because everything happens outside of the community (Participant 18, p. 18)

[Home town] is a very, very good town ... We know most of the town. It's such a supportive, lovely place, and you want to be where you've got your social networks and your friends ... But no-one got to see [bub] until we got home, which was a week later. And, you know? We've got lots of friends with little ones and they were really excited about the baby and

things, and you don't get to share that with the community ... If we had have been able to have the baby in [home town] ... we would have had lots of visitors that could have just popped in to see him and to see how we were going ... But it didn't happen. It couldn't happen (Participant 3, p. 10)

I had [partner's] sister pop in and see me once but that was all that I had there ... no friends, no nothing that come over (Participant 14, p. 6)

c. Racial abuse

Violence ... begins long before fists fly or lethal weapons extinguish lives. Where resentment and aggression routinely displace cooperation and communication, violence has occurred (Namie, 2003, cited in Felblinger, 2008)

Like, one of the midwives said ... 'Oh, we have a lot of trouble with black girls from [town].' That was out of her own lips. That was to my face. She said, 'Oh, we have a lot of trouble with black girls' ... I don't believe they treat whites the same. I can't believe they would (Participant 37, pp. 18, 20)

Perinatal mortality rates are up to five times higher in the Indigenous compared with the non-Indigenous population (Trewin & Madden, 2005) with double the percentage of low birth weight babies (Laws & Sullivan, 2005). There is evidence equating stress and anxiety with both prematurity and low birth weight babies (Arias et al., 2003; Orr et al., 2007 as examples) so stressors experienced by Aboriginal women during pregnancy, labour and birthing need urgent consideration. The highlighting story that follows provides many examples of stressors that affected the birthing experience of this participant.

Highlighting story

Jemma (pseudonym for Participant 38) was a young Aboriginal woman from a small town who was transferred by Air Ambulance to a Base Hospital with a severe urinary tract infection at term. She travelled alone and was extremely frightened. Her partner (who identifies as Aboriginal but who is Caucasian in appearance) was unable to be with her due to there being no room in the aeroplane and then extenuating circumstances stopped him from being with Jemma and their baby until the 8th day following her caesarean section. The caesarean was attended at midnight on the night she was admitted to the Base Hospital. Jemma's baby was well.

Less than eight hours after her caesarian section and with a severe urinary tract infection, Jemma was informed that she would need to go to the nursery, estimated to be over 100 metres away, to feed her baby. Although she was desperate to see her baby, Jemma was given no assistance by the midwives to get out of bed:

And they were just cold and callous. They refused to help ... They absolutely refused. They said, 'Pull yourself up by that handle.' And, I

mean, if you've got a stomach wound, there's no way that you can pull yourself up (p. 10)

Jemma is less than five foot tall and the foot stool that could assist her was out of sight and under the bed:

All they'd do is come up and say, 'Your baby's crying. Get out of bed and go down and feed her.' Right from the start. This is the morning after a major operation (p. 18)

Following this incident and in the days to follow, the midwives reported to Jemma that they were concerned that she was not 'bonding' with her well baby who remained in the nursery. Jemma's partner says:

[My wife] was so scared and so frightened because they were threatening her with DoCS [Department of Community Services] all the time (p. 10)

This was not a one-off threat but such threats continued throughout her hospital stay. For the last three days of her admission in the Base Hospital, Jemma was so frightened of the midwives and their threat to report her to DoCS that she slept in a chair beside the baby's cot in the nursery.

Jemma remained in the hospital and her only support was the Aboriginal health worker who occasionally came to see her. Jemma's husband described the scene:

It was obvious that she cared, otherwise she'd be lying in bed and telling everyone to go away. She was making every effort. She was sitting up at night in a chair next to the ... baby in the nursery ... sitting up in the chair ... nights and nights ... She didn't dare go to bed because she couldn't get there, because if she was late, if the baby was crying, and that [midwife] would come up and say, 'Oh, I had to feed your baby. You don't care, do you?' That's the sort of thing she was saying. 'I had to feed your baby' (p. 18)

Exhausted from sleep deprivation, in terror that her baby would be taken from her and in agony from an untreated severe urinary tract infection, Jemma pleaded with the midwives to be allowed to go home. She reported their response:

All the time they're saying, 'You go. Go on, you go.' ... 'You can drop dead in the car park, but the baby stays here. We won't come and help you.' ... You can drop dead and your baby can stay here.' And I said, 'Baby not staying neither, baby coming with me.' ... it's just a nightmare. It's just something you couldn't imagine doing to someone (p. 26)

Jemma's husband was contacted by the Aboriginal health worker who advised him to come to the Base Hospital immediately as she was concerned that Jemma's baby would be taken by DoCS and she was powerless to stop them:

[Aboriginal health worker] she was very concerned. She was the one that rung me up and said, 'You better come down' ... They just pretty well brushed her aside (p. 14)

On arrival at the Base Hospital, Jemma's husband went looking for her and eventually found her being verbally abused in a public place by one of the midwives:

And then that woman [midwife] walked over, and they were sort of half behind that pillar and I was walking down the corridor and this woman was in her face, screaming at her. She was saying 'Did you feed, did you bath the baby? I don't believe you. You're lying to me. Did you bath the baby?' And she was screaming at her. And I got closer, and I couldn't believe that it was [my wife] and this woman was just over her, just yelling, literally yelling at her. ... in front of everyone ... She was absolutely shocking. She was the worst, but they were all terrible (pp. 12-13)

And all the abuse was terrible. Terrible, [my wife] was like a broken woman when she came [home]. She left here bright and happy and looking forward to the future, and came back like an old woman, like a broken woman. That's what she was like. I really think it scarred her. I think it's really brutal, it's shocking. It's disgusting, the way they were treating her. I don't know what she was like the day after the baby, but after eight days she was, she couldn't walk, she couldn't do anything, so, I don't know, I can't imagine what she went through for the first couple of days ... Oh that was shocking. It was like they were, it was designed to break [my wife] and take the baby (pp. 14, 19)

During the eight days Jemma spent at the Base Hospital, she received no treatment for the urinary tract infection. It was not until she returned home to the small town hospital on Day 8 postpartum that she was admitted for three days of intravenous antibiotic treatment and her pain and urinary tract infection eventually resolved.

Discussion

The Aboriginal participants spoke frequently of **being judged, stereotyped and degraded** by the midwives. Their stories were confirmed by the Aboriginal midwife:

I have seen and spoken to Aboriginal young girls, especially, [they] said that they feel judged ... stereotyped ... They're not doing it the right way ... In the hospital, they're in a totally different environment. It ... disempowers them. ... They don't have rights. They're spoken down to, they're not addressed in a formal manner. It's actually degrading to actually see some of the midwives speak to our girls ... They're given direction ... authoritative direction, without consulting with the young girls. The girls are not openly involved in a conversation. They're actually given directions ... These girls do have rights, but they get in the system, that's all taken away from them ... It's like the authority figures, the nurses, the midwives, have to have this control (Participant 34, pp. 2, 3, 4)

The Aboriginal midwife cited above believes that these ‘standover’ tactics play a role in **discouraging Aboriginal women from breastfeeding** their babies:

[Midwives] they stand over the girl ... Physically, yes. They actually invade the girl's private space. The tone and manner is always aggressive. Rarely have I seen compassion shown ... Aboriginal girls, if they're going to be reprimanded that they're not doing it right by a non-Aboriginal white fella, they immediately get their back up. So they'll go for an easier alternative while they're in hospital, they'll go to artificial feeding. They'll go out and get a couple of bottles. They don't want to be judged (Participant 34, p. 4)

Some Aboriginal participants described how Aboriginal and non-Aboriginal women were **treated differently** in this Base Hospital:

I personally noticed it. Just the general way that they went about things with white women. I had a white woman next to me in my room, and she was ... would come and check up on her, just check up on her for no reason. 'Are you okay? Do you need help, assistance, rah, rah?' And I mean, I saw other young black girls there that were being treated worse than me (Participant 36, p. 20)

The participants described how they were **not listened to nor were they believed**. One participant pleaded with the midwives to allow her partner to be with her in the labour ward, but this was refused because they did not believe she was in labour:

But then they induced me ... I told them I was getting contractions and I was in labour, and they wouldn't believe me. They said, 'No you're not, you're smiling. You don't look like a woman in labour.' Because I was walking around and, when I'm in labour, until the very end, you can't really tell because I'm very quiet and if I'm in pain I'll just stand there and I won't really make much racket about it. And they wouldn't believe me, and I was just, I went back into my room and I was just crying, and they wouldn't let my husband come up. But I just ended up ringing him and I said, 'No, just come up. Don't worry about them. You know? I know I'm in labour, don't worry about what they say.' And then someone rung out the hospital, once I'd rung him crying, and complained and then they finally did something about it. And they took me down to the labour ward and I was like four centimetres dilated ... yeah, I found that really distressing, because the fact that they just wouldn't believe me (Participant 35, p. 2)

The Aboriginal midwife reiterated other occasions when Aboriginal women were treated differently and were **not believed** that they were labouring:

Aboriginal lady ... birthing ... and non-Aboriginal lady birthing ... bet your life, the midwife is actually in with the non-Aboriginal girl. I've experienced that recently, quite recently, on a number of occasions, where a doctor and a midwife has been with a non-Aboriginal girl while the Aboriginal girl has been left in a labouring ward on her own waiting for

someone to come in ... I've also had women, Aboriginal women, on the ward labouring [?] and they haven't been believed, that these girls have been ... in labour. They've just been left on the ward. Given a handover in the morning shift, it's been stated that these girls have kept other members in a four bedroom ward awake all night ... [a vaginal examination is done and] eight centimetres and bulging forewaters ... And she told me, 'They haven't believed me all night' (Participant 34, pp. 4, 5)

Having discussed how they weren't listened to or believed by the midwives, some went on to describe how their **wishes to breastfeed** their baby were **negated**:

They didn't ask me until I got back to [local hospital], they asked me if I wanted to breastfeed and I said, 'Yeah, I'll try it.' ... At [Base Hospital] they were just giving me the bottles, so I had to give him bottles because they wouldn't show me. And when I got back to [local hospital] the doctor asked me, 'Do you want to try breastfeeding?' I said, 'Yeah.' And because my Mum used to be a nurse, she helped me put him on (Participant 36, p. 26)

I was pushing them. I wanted to breastfeed. They were trying to bottle all the time. I said, 'No, I'm breastfeeding' (Participant 25, p. 25)

Several participants described their **fear when they 'escaped'** from the Base Hospital:

And so I just grabbed him and I said '... pack the car, we're going to head off.' So we just, I just ran down the steps and went. I was so scared though, it was like I was stealing someone's baby ... Yeah. I was really scared (Participant 35, p. 4)

Loss of freedom: I actually ended up running away from the hospital. They wouldn't let me go but I just took him and went ... I suppose because it was like my freedom was taken away, in a sense, in the hospital, over my own child. Do you know what I mean? They wouldn't even let me stinking bath him, and he'd been in there for four days and every day I'm there going, 'Can I bath him?' And other midwives are going, 'How come you haven't bathed him?' ... And I'd say, 'Because other ones wouldn't let me.' And they're like, you know? I just, my freedom was taken away over my child, and I hated it (Participant 36, p. 5)

It is not surprising that a recurring theme related to the Aboriginal women's **fear of the midwives** as also described by the Aboriginal midwife:

Fear of the nurses, yeah. I mean ... so many times that the nurses have their own attitudes and, you know, their beliefs. They're not welcoming, by any means ... midwives actually (Participant 34, p. 10)

Beddoe and Lee (2008) discuss women's fear of obstetrician demeanour and strategies women can use to reduce that fear. However, there is a paucity of information about women's fear of midwives in the literature. This is surprising given the significant attention to midwifery bullying in the workplace over the last

decade (Leap, 1997; Kirkham, 2007 as examples). It would seem that a culture that causes some midwives to fear each other would be a culture conducive to building fear of those same midwives in women patients. This is an area that demands urgent exploration to develop strategies to ensure women's emotional safety.

4. Power differentials and abuse

Clearly [Medical Practitioners] are business, they are financial and they are a vested interest. I don't believe we have anywhere else a system that enables those that have absolute self-interest to make the decisions, because that's what happens in maternity services. The first people that are asked if they agree that we should have a new model of care or a midwifery model of care, would be the local obstetric service, whether that be procedural GPs or, in fact, specialist service. So the very people who are benefiting totally from the status quo are asked if they'd like to change that. Well, we know the answer is largely going to be 'no' (Participant 18, p. 19)

And all the abuse was terrible. Terrible, [my wife] was like a broken woman when she came [home]. She left here bright and happy and looking forward to the future, and came back like an old woman, like a broken woman. That's what she was like. I really think it scarred her. I think it's really brutal, it's shocking. It's disgusting, the way [midwives] were treating her (Participant 37, pp. 14, 19)

Power is exerted and abused in multiple ways throughout maternity service provision in NSW. This section will look at two distinct areas of power abuse. The first relates to medical dominance and explores how commercial and vested interests negatively impact on woman-centred care in rural areas. The second looks at how women have been emotionally abused by a powerful health professional, in this instance the midwives' power over women.

Highlighting story

In this instance, the highlighting story does not relate to an individual woman's story but rather to a geographical area in rural New South Wales where maternity service provision is controlled by a group of private medical, general practitioners.

There is no choice. It is a GP-led service. Women have no real continuity because the GPs work on a roster-like basis. There is no free antenatal care so again, all women pay, even on a healthcare card ... they do not bulk bill to my mind at all (Participant from this area)

In this area, there is a significant incidence of adolescent pregnancy and a high proportion of women who are socio-economically disadvantaged, do not attend for antenatal care and are living in socially dysfunctional environs. The only antenatal care provided in this town is through general practitioners who refuse to bulk bill. *Families First* funding was sought and approved from the public purse to enable a community midwife to visit outlying areas. However, that community midwife is limited by commercial interests of the medicos within the town to the

extent that she is permitted to provide antenatal education only. She has been refused permission to provide antenatal care in any form outside of education. The general practitioners who provide maternity services in the local town successfully blackmailed the local community and public health system by threatening to withdraw their services:

The GPs said that if that program provided antenatal health care, they would pull their services from the local unit ... And that same person that provided the education is registered and trained to provide health care, and actually could be providing an amazing continuity model and some huge support. Just think of that support for those young mums, particularly. In [small town with Families First funding] there is a huge teen pregnancy problem that has been highlighted at kind of state government level. It's quite a pocket. Huge disadvantage in [town]. We have women that are regularly, not the one off, regularly attending in labour with one or less antenatal visits, often none. Huge issues around social dysfunction (Participant from this area)

This community midwife travels to outlying regions where she serves women who have sometimes travelled large distances:

So some women can travel the 240 kms to [town] or to [other town], because they're about equidistant. So where I travelled the 150 kms round trip, they're travelling 240 kms round trip. Some of them come in from properties down roads as well, so the time is huge. It could take them around three hours round trip, obviously without having a break in the middle. But that service exists to provide them with care, but the local GP service actually prevents them from providing antenatal health care (Participant from this area)

Women are then forced to travel for many hours to have an expensive and brief antenatal appointment with a general practitioner who has vested financial interests, when that service could have been provided by the publicly funded midwife:

So this service still exists so far, and what happens, in essence, is the midwife, again, required by the position statement to be a midwife, she travels out with a doll and a pelvis and a video and a book, maybe, and she provides education, and yet she is prevented, by the local GPs, to provide health care. She doesn't have a Doppler, she doesn't have a blood pressure machine, and that very same woman that's been provided education then turns around, possibly the next day or the next week, and drives 240 kms for an antenatal health visit (Participant from this area)

Some participants in this study had expressed their belief that general practitioners were not prepared to practise obstetrics in rural areas due to the high cost of insurance. However, this was in direct contrast to a participant from this area who argued:

In Australia currently, we are now seeing a gigantic industry around birth, and around rural birth, which I think people need to know, because we are

now seeing GPs getting a huge amount of support, incentives to actually practise obstetrics. Huge \$17,000–20,000 handouts from the federal government. Their indemnity is being paid. In NSW their indemnity is paid in its entirety by the state government for private obstetric work, but then they also have the federal government indemnity system ... despite the continual propaganda that this is about insurance. It's an absolute lie, because 100% rural obstetric indemnity insurance is covered by the public purse ... So you get your insurance paid, you get considerable incentive, you have no competition, you are an absolute monopoly, and so then you're going to say, 'Well, look, I know I don't bulk bill and I know there are women that are travelling hundreds of kilometres to me and there could be a very safe midwifery clinic in town X. Not on your nelly!' Does not happen. So, it is purely self-interest and business that is getting in the way of safety (Participant from this area)

Confusion was often expressed as to how this highly publicised arrangement could be maintained. Private general practitioners' desire for financial reward and professional dominance is perceived to take precedence over women in need of maternity care:

So women have actually been calling for it quite clearly, and where it comes down to is, it would act in competition with a total monopoly of GP services where there's no public care and no free care. Even though we know these women aren't receiving the care, therefore they're not paying money anyway ... they're seen as a threat to the business of the local GP service. That is categorically what is happening now (Participant from the area)

Discussion

Birth is powerful. From the beginning of time women working with the *sage-femme* (literally 'wise woman' and the term used for a midwife in France) have known it to be so. With the medicalisation of pregnancy and birth, the power is shifting more and more towards the system that governs how a woman should birth, and away from the birthing woman herself (Wagner, 2007).

a. Medical dominance

As discussed in the literature review, there is no evidence proving that healthy women and their newborns are safer giving birth in a maternity unit with anaesthetic and surgical facilities. Yet such is the **power of the medical paradigm** that this notion has become embedded in rural consciousness with many women assuming that it is illegal to birth in a maternity unit that does not have an anaesthetist:

They've got the setup in there [local hospital] but because they've got no anaesthetist or the legalities ... they can't deliver babies (Participant 7, p. 2)

Participants commonly expressed frustration, but accepted that obstetricians and **general practitioners would do what suited them best** rather than trying to

accommodate the physical and emotional support needs of the women. As previously reported (Dietsch & Davies, 2007), the system is seen to be there primarily to serve itself.

It's just like, 'This one's come in, have the baby, shove her out, bring the next one in' (Participant 35, p. 23)

All they want you to do is come in and get out, get out of the way ... so they can go and have their cup of tea. It's not a caring environment at all (Participant 37, p. 23)

Another participant shared how she was to have a **caesarean section**, even though it was not a medical emergency and her partner was travelling to be with her:

I mean it was, you go with it and obviously ... I couldn't put it off for [my husband to arrive] ... He missed it by about half an hour, 20 minutes in the end. ... I guess you can't put off theatre staff and that sort of thing. ... it was just ... not a very nice experience altogether ... The caesar was horrible (Participant 20, p. 4)

Medical dominance and the exertion of power for commercial and vested interests by some rural practitioners is described in detail in the Highlighting story above.

b. Emotional abuse by midwives

However, medical practitioners are not the only health professionals to exert power over women. In many instances, participants shared stories where **midwives had also abused their power**. Sadly, this abuse of power was not perceived as unusual but as an endemic culture of negativity:

And it wasn't just one nurse ... They come down and they was swearing in my face (Participant 38, pp. 12, 21)

I was disgusted. I thought my treatment was bad ... just being rude and stuff, and not wanting to help you and things like that, but not to ... Oh that was shocking. It was like they were, it was designed to break [friend] and take the baby (Participant 35, p. 19)

This **lack of midwifery care** and compassion surprised some participants:

I honestly thought a hospital, a maternity ward, I thought it would be full of caring, wonderful people (Participant 37, p. 22)

This same participant described an encounter he witnessed between his wife and a midwife (see Jemma's highlighting story in Section 3, under 'Racial abuse'). Already feeling alone and in a foreign environment, some participants, especially those who identified as being Aboriginal, felt further alienated and disempowered by the midwives and the Aboriginal midwife argues:

In the hospital, they're in a totally different environment. It ... disempowers them. ... It's actually degrading to actually see some of the midwives speak to our girls ... It's like the authority figures, the nurses, the midwives, have to have this control (Participant 34, p. 4)

Like [midwives] were looking at me like I'm dumb and stuff, and I'm asking for painkillers and they just wouldn't, because they didn't believe I was in labour ... and they kind of put it over you and stuff. That's what I felt (Participant 35, p. 2)

As discussed in Section 3, midwives exerting power over women in the form of reprimands and judgmental attitudes are thought to **discourage women from breastfeeding** and providing their babies with the healthiest start in life. The mother's right to respect and the baby's right to their mother's milk have been denied:

Some participants described **feeling intimidated** at a time when they were most vulnerable.

Yeah, there was aggression towards me, especially when I first went in, in labour ... So I was very timid. ... I'm not one to let someone run over me, but ... I just went into a shell ... she got stroppier (Participant 35, p. 5)

Midwives were seen to use their judgment of whether or not a woman had bonded with her baby, as an intimidation and a weapon to exert power over the woman. **Threats of authority** caused one participant to fear that her baby would be taken from her and as a consequence felt she had no choice but to sleep, sitting up in a chair, beside their baby's cot in the nursery (see Jemma's highlighting story, Section 3):

Another participant felt she had no choice but to **'escape'** from the maternity unit with her baby. She describes feeling how her freedom and also the sense that she was the mother of her own child were under threat.

And so I just grabbed him and I said, '[Name of husband], pack the car, we're going to head off.' So we just, I just ran down the steps and went. I was so scared though, it was like I was stealing someone's baby ... (Participant 35, pp. 4-5)

One participant described an encounter with the midwives as being in a **war**:

If they really wanted to help, they could have brought the bottles up, had the baby next to [my] bed ... but it was just a war (Participant 27, p. 20)

Sonn and Fisher (1998) have argued that oppressive social systems (such as the maternity service described above) and enforced interaction with a dominant culture lead to the loss of individual and community cultural identity. This in turn disrupts healthy development of self and community, the results of which are seen in increasing family and community dysfunction, poverty, and violence as well as an increased maternal and neonatal morbidity and mortality rate (Birth Rites, 2002).

5. Fear: Iatrogenic, community and women's

Fahy, Foureur and Hastie (2008) argue that maternity services that are informed by an obstetric paradigm based on risk identification and early intervention are operating within a fear-based paradigm. Birth has been redefined during the medicalisation process from a normal, healthy life experience to a pathological or potentially pathological problem that can only be considered normal in retrospect (Wagner, 2007). This perception is not based on evidence nor does it improve outcomes for healthy pregnant women and their newborns. Nevertheless, it has been widely promoted and accepted by health professionals (including many midwives), communities (remote, rural and urban) and women themselves.

Fear was often tangible when the women in this study spoke of their experiences. The midwives and medical practitioners feared childbirth and any role they played in actively assisting women to birth. Communities had accepted the *a priori* notion that birth in a larger unit must be safer for women and their babies. Women feared most of all. They feared birth itself, and they feared giving birth on the side of the road. They feared being separated from their children, partners, families and support. They feared that their local health professionals would not be skilled to assist them but they also feared the attitudes and behaviours of midwives and medical practitioners from Base Hospitals with a reputation for intimidation. Fear is not conducive to healthy birth and Foureur (2008) hypothesises that the fear cascade is at the root of both uterine inertia and fetal asphyxia in labour.

This section will explore three fear groupings: fear of labour and birth demonstrated by health professionals, especially medical practitioners and midwives (iatrogenic fear); community fear of birth; and the women's own fear of labour and birth.

a. Iatrogenic fear

So I started to see [GP, 1.5 hours away], and I went to see him three times, and every time I left there nearly in tears because he was very cautious about things, but he made me worry about things in pregnancy I'd never worried about with my previous two. And he had me pretty stressed out (Participant 7, p. 1)

Discussion

With the closure of rural and remote maternity units, many **midwives and medical practitioners are becoming deskilled** and losing confidence to function to their full scope of practice:

And we walked in and the midwife who was on said, 'Oh, you're not in labour.' And I said, 'Yes, I am.' And, anyway, she put me on ... and she just freaked out. I don't know why she panicked. Whether she panicked because I was so heavy in labour or, I don't know, but she just panicked (Participant 7, p. 8)

But [the midwife] felt so obviously out of control ... she just wasn't coping at all, and I thought, 'You don't even know what you're doing.' ... so that was [delivery of second child] (Participant 7, p. 10)

On an individual and professional level this is disappointing but the **impact on a labouring woman** may be catastrophic:

But the amount of girls that have had a baby on the side of the road because they do present to [local hospital] and they say, 'Get in the car with your husband and keep driving.' So the husband gets in the car, they drive ... and the woman has the baby on the side of the road (Participant 7, p. 11)

Giving birth on the side of the road is not the only concern. As quoted earlier, one participant spoke of a medical practitioner who wanted to induce her at 32 weeks gestation so as to eliminate the risk of her birthing en route. The interviewer, thinking there may have been some confusion, asked both the woman and her partner, who was present at the interview, to repeat the information:

Another participant, whose baby was presenting by the vertex, described her **doctor's fear** in case the fetus became breech:

But he actually told me not to .. if this baby starts coming, he sees a foot, he says, 'I won't be able to help. I'll have to stand back.' ... Because then he's liable if anything happens ... And they don't have the equipment to deal with stuff (Participant 29, p. 8)

Healthy pregnancy, labour and birth have come under the jurisdiction of obstetrics, a surgical discipline. As a consequence, medical practitioners and midwives have lost confidence in a woman's ability to birth and in their own skills in working with women without recourse to surgical solutions (Klein, 2005).

b. Community fear

Women have clearly been led to believe that with a doctor present it is, in fact, safer (Participant 18, p. 21)

Discussion

The perception that labour and birth have evolved from a life experience to a pathological event that is to be feared is reflected in many but not all of the participant interviews. The general belief that for best outcomes, women must be cared for by specialist medical practitioners with technological resources is not one supported by evidence nor by all of the participants in this study:

A perception ... based on absolute propaganda. No clinical evidence to say that specialist care is safer, for a start. We've seen medicalised childbirth being seen as the absolute pinnacle, and anything else is inferior, and often, which I find so very distressing, is that women in rural areas and, of course, we know that Caroline Anderson paid with her life

when she lived in Warren in rural NSW, but she felt that the best birth that she could possibly have would be an elective caesarean section. ... She flew to Sydney to give birth on a scheduled time when her husband could be present, and on her third caesarean section, she paid for it with her life. ... But that did not come out. It didn't come out that, in fact, a perfectly healthy woman was led to believe that because she had private health insurance and because she lived in a rural area where there was no services, that that was the best way to do it for time, convenience, for you know? A whole range of things (Participant 18, pp. 21-22)

Maternal death is fortunately a very rare occurrence in NSW. Caroline Anderson, aged 37 and from Warren in Central NSW, did not die in a small rural maternity unit, nor by the side of the road in labour. Caroline Anderson was a healthy woman who believed her safest option was to have an elective caesarean section under epidural anaesthesia at a large private hospital in Sydney. She developed an epidural abscess and died in 2004 (Stott, 2005).

It is paradoxical that as women become healthier, more socially powerful and enjoy better living conditions there is a cultural decline in confidence in women's birthing capacity (Reiger & Dempsey, 2006; Fenwick, Gamble & Hauck, 2006). Western **cultural attitudes** not only reflect but also serve to **construct increased fear** and anxiety surrounding birth.

When a woman decides to take control of her own birthing experience and remain locally to birth, she may be labelled **negligent by her community** and accused of putting her baby at risk:

I was speaking to someone ... in town, and it was her second child, and she had stayed at home until she knew she could not stay at home any longer. That she was ready to push. ... So she had obviously made no other attempt to find, to go anywhere else. And that's just negligent, I think, on her part ... The poor baby, well, I wouldn't give it the best chance (Participant 23, p. 9)

c. Women's fear

And to have a baby without one single complication is just, yeah, lucky (Participant 23, p. 9)

Discussion

Increased anxiety and loss of confidence in a woman's capacity to birth normally have become normalised, internalised and enacted by individual women (Reiger & Dempsey, 2006). The implications of these internalised beliefs mean that everyday, healthy women living in rural and remote NSW put themselves at risk through driving long distances for a short antenatal check. At the time of birth they believe the only safe option is to separate themselves from family and community support and to give birth in a large institution with recourse to epidurals, electronic fetal monitors and specialist obstetric surveillance. Without evidence, and contrary to clinical guidelines (National Institute for Clinical

Excellence, 2005), electronic fetal monitors are now seen as essential equipment for healthy, low-risk women when they are labouring:

I don't think they've got a CTG (Participant 23, p. 6)

Women living in rural and remote areas pay the heaviest price when they give birth in a large hospital with specialist care:

So, yeah, I feel very sad but I don't think that is confined, that only rural women think that being in the largest hospital is safe. I think that nine out of ten women in Australia, if you ask them where they think would be safest to have their babies when they were perfectly normal and healthy, they would tell you that the largest hospital would be the best. So that's just part of the myth of medicalisation of childbirth. But yes, it is, I guess, it's just exacerbated in rural communities when there's so much extra emotional and financial cost that goes with actually achieving that (Participant 18, p. 22)

6. Emotional stressors

I don't think I've ever been so scared as I was that night ... (Participant 7, p. 13)

Emotional stressors were identified by a number of participants or their partners, in the course of the interview process. The women's stories highlighted extraordinary levels of stress, anxiety and fear which stayed with them until their babies were born, with some experiencing ongoing depression when they returned to their homes and families. According to Cohen (2000), stress is a physiological response to any stressor or demand and most people experience it in the course of their daily lives (in Elder, Evans & Nizette, 2005, p. 7). The highlighting story below (Jemma's story) has also been told in Section 3, as it related to racial abuse and violation of human rights. However, other aspects of her case are drawn on here to highlight the additional emotional stressors faced by Aboriginal women giving birth in rural NSW.

Highlighting story

Stress, anxiety, fear and depression were manifest in many of the non-Aboriginal women who were involved in the study. However, the suffering of Aboriginal women was far more severe, exacerbated by separation from their immediate families and extended kinship groups. Jemma's story is particularly disturbing. Jemma (pseudonym for Participant 38) was a young Aboriginal woman who was transferred to a Base Hospital for the birth of her baby. She was separated from her partner during most of her hospital stay and her fear of the midwives escalated during this time. The Aboriginal midwife had previously commented:

How many times do we see young Aboriginal girls be shipped out at the last minute because they're presented right on delivery, because they have this fear of being transferred away from their own town, their own communities, where they've got their support (Participant 34, p. 1)

This fear is well founded, for in Australia's recent past many Aboriginal children were forcibly removed from their families. As a consequence Aboriginal women continue to fear, with good reason, enforced separation from their children. Jemma, who was unwell and exhausted, faced this fear alone until her partner arrived at the hospital. Later the family took their baby home. Jemma's partner commented:

[My wife] was like a broken woman when she came [home]. She left here bright and happy and looking forward to the future, and came back like an old woman, like a broken woman ... I really think it scarred her (Participant 37, p. 14)

Jemma experienced psychological trauma during her hospitalisation, with the effects being obvious to her partner. Given Jemma's lowered mood, monitoring for severe postnatal depression was clearly indicated. If left undetected, untreated and unmanaged, this psychological morbidity had the potential to affect Jemma, her partner and their baby well into the future. When Jemma was interviewed 20 weeks after her discharge from hospital her mood had lifted, but she expressed feelings of anger when she talked about the care she had received in the maternity unit. The interviewer believed that Jemma's feelings of anger and disappointment were appropriate responses to a highly unpleasant and demeaning experience. It could be argued that Jemma's resilience and strength of character, coupled with the support she received from her home community, partner and family, were factors that increased her capacity to cope. However, it should also be noted that prolonged and severe episodes of anger, sadness or mood swings are depression indicators.

Discussion

Many of the women stated that **geographical isolation** throughout their pregnancies significantly increased their levels of stress. While they made every attempt to adapt and remain stoic, 'isolation' was a constant stressor, particularly when exacerbated by a previous negative experience:

But if [it] floods. We couldn't get out, we couldn't do anything ... we had to wait until the last minute ... if something happens again, you're stuck. Because it takes, you know, 45 minutes to get to [bigger town], but then they've got to fly the aeroplane in first and then it's got to be decided to do it and it takes hours before ... you get on the plane (Participant 27, p. 2)

Others were very worried about **not being able to recognise the first signs of labour**, which limited their chance of getting to a hospital in time for the birth:

Distance was my scariest thing ... I was worried that I'd be in [home town] and I wouldn't know that it was going to happen and I'd be stuck and I'd have the baby on the highway ... probably my biggest concern ... I had a little bit of a panic attack (Participant 3, pp. 2, 3)

According to Elder, Evans and Nizette (2005) ‘prolonged stress can be harmful and have a negative effect on physical and mental health’ (p. 7). A number of the women stated that they experienced various degrees of anxiety, or unease, during their pregnancies. In some instances it was provoked by **concern for their toddlers** or young children:

Everything’s gone so smoothly so far, but if I have to spend two weeks in hospital, like, what would happen? ... Who’d look after the kids for those two weeks ...? (Participant 23, p. 13)

In other instances high levels of anxiety were directly linked to **travelling whilst in labour**:

First time around I was very anxious. Just wanted to get there and get it done (Participant 12, p. 4)

I’ve got a friend ... she was really calm with her first two, but the third one, she was just really anxious towards the end ... she said, ‘What if [husband’s] not around? How am I going to get in the car? What am I going to do with the kids? Is he going to be with me?’ You know? That trip. I think the trip just worries you so much.’ ... You know, in labour (Participant 7, p. 12)

Many of the women indicated that they managed their high levels of anxiety by being **highly organised**. They planned for every contingency, including preterm labour, absence of partner, mechanical breakdowns, floods, and by pre-arranging meals, accommodation and childminding well in advance of the anticipated arrival of the new baby. A number of women were of the view that health service staff failed to recognise or acknowledge their heightened levels of stress and anxiety, brought about by geographical isolation. As indicated in stories above, some women who were already compromised by these overwhelming feelings were subjected to further emotional stressors by **unskilled or uncaring clinicians**.

While feelings of stress and anxiety are generally related to a vague and non-specific threat, fear, in contrast, is a response to a known threat (Eby & Brown, 2005). Labouring women, escorted by their equally fearful partners, were well aware of the known threats, including increased levels of discomfort and pain during their isolated travels along country roads.

We’ve got an old four wheel drive that’s very bouncy, so ... yeah, the bumps ... [its] not a good place to be (Participant 29, p. 9)

They also feared motor vehicle breakdowns, animals of the night crossing into their paths and causing accidents, and their inability to summons help on mobile telephones. However, their greatest fear was that their journey would end in an unexpected roadside birth, resulting in a catastrophic haemorrhage, or a ‘flat’ or dead baby:

[Labouring on the road] ... was my biggest stress, which is why ... I wanted to be induced early (Participant 23, p. 10)

Unlike my neighbour, I don't want to have a baby in an ambulance ... If I was to have another child and it was a fast labour, there's always that possibility of going early again and being unprepared and not making it to [hospital for birth] (Participant 39, pp. 4, 7)

Even when the women were able to access assistance from health service staff the **journey to hospital remained a frightening** affair:

I had placenta praevia ... which was scary. Scary when you're this far away ... I woke up one morning and got out of bed and had a huge rush of blood and a couple of clots ... So I basically had to ring an ambulance, and they came and got me and eventually got me to [town, 1.5 hours away] ... [and] went on to [regional city]. The whole process of getting from here to [regional hospital] was horrendous ... (Participant 20, p. 1)

Partners of labouring woman also experienced high levels of anxiety, as they were responsible for driving them safely to hospital, supporting them along the way, and dealing with the eventualities:

Emotionally I don't think I've ever been so scared as I was that night, because I didn't know what was going to happen. Like, if I'd had to deliver on the road, I don't think she, she wasn't going to cope with that (Participant 7, p. 13)

When many of the women reached hospital destinations their levels of anxiety and fear did not always abate. In some instances they felt the need to remain hyper-vigilant and in control, to preserve their own safety and that of their unborn child. Others wanting to avoid this type of scenario made conscious decisions to leave their partners, their young children and community support networks and waited in **lonely motel rooms** close to medical and hospital care:

We'll make sure I'm there and setup (Participant 3, p. 4)

While wanting the perceived safety of birthing in a large referral hospital, the experience could be both **daunting and depressing**:

That feeling of loneliness and depression and isolation, it's really cold (Participant 36, p. 23)

When they get to a bigger facility, the whole situation is just taken out of their hands. It's frightening ... (Participant 34, p. 3)

Giving birth in large referral hospitals or private hospitals, under the care of obstetricians, did **not always have the outcomes** women were anticipating:

Rural women think that being in the largest hospital is safe ... that's just part of the myth of medicalisation of childbirth (Participant 18, p. 22)

I had this huge haemorrhage afterwards, huge, and that was really devastating ... I thought I was doing to die though. I really should have had a blood transfusion ... I suffered from postnatal depression at six weeks (Participant 14, p. 3)

Most of the women thought their unease would disappear following the safe birth of their babies, but some women experienced protracted symptoms of anxiety, irritability and tearfulness, signs of **postnatal depression** (Keltner, Schwecke & Bostrom, 2003). Campbell, Hayes and Buckby (2008) state that ‘most estimates put the rate of postnatal depression at around 10% to 15% in the normal population [but] in Australia, it has been found to be around 14% (p. 124). Despite the evidence, some of the rural women involved in the study were left undiagnosed and untreated for many months:

I suffered from postnatal depression at six weeks. I didn't feel right for at least 12 months. It took 6 months to finally get back to sort of half normal and then it took a good 12 months – I ended up on medication and everything for the postnatal depression ... I wasn't too bad in the hospital ... [at] my six week check up with [specialist obstetrician], I just burst into tears, and he put me on some medication (Participant 14, pp. 3, 10)

I had anxiety, depression. I had panic attacks ... calling [husband] to come from work to come and get me because I was just hysterical ... I didn't see any psychologists or psychiatrists or anything like that. I just got through it (Participant 14, p. 10)

7. Inequities between rural and urban maternity services

My sister, who is in Melbourne ... could live in her own home and have her babies at a very good hospital with, ... and all that kind of stuff, at no extra cost to her. But, for me, I had to pack up and leave home a month, basically, before my due date, and I had to ... find accommodation and do all that kind of stuff, which ... is fairly prohibitive as far as making the process easy. I mean, if you have to do it, you have to do it, but it doesn't make for an easy time of going away to have a baby (Participant 25, p. 10)

Highlighting story

Amanda (pseudonym for Participant 6) lives in a mountainous area on the border of NSW and Victoria. She believes that equity of access to services is a basic tenet of primary health care. She also believes that there are political motives for closing maternity services in rural and remote areas. Whether the closure of maternity units is politically driven or not, the *National Consensus Framework for Rural Maternity Services* (2008) makes a strong argument for transparency and local community consultation in relation to maternity service provision, development, sustainability or downgrading. This did not happen in Amanda's area and has led to deep suspicions and resentment.

I think it's just the bureaucrats and government are more in the cities and ... If you want to live out here well, you know? You've got to travel. But, I

think that they forget that we're entitled to have the same services and health available to us as all other Australians (Participant 6, p. 15)

Discussion

In few areas of life is the **urban/rural divide** as deep a chasm as it is in maternity services, and women living in rural and remote areas of NSW are acutely aware of the inequities:

I was only ... four or five blocks from my private obstetrician. And only two blocks from the private hospital where I had [first child in the city] (Participant 2, p. 2)

It's easy, because you've got all the midwives and lactation consultants and all that sort of stuff [in the city]. ... It's certainly not our choice to live away from medical care that means you can't ... do all the things that people in the city can do (Participant 3, p. 10)

I don't think people, like my sisters who live in Sydney, have no idea that it costs us to just go to the doctor, it's like \$150 in just expenses before you have to pay the doctor's fees. It would be great if you could, if people knew that [midwife] could do shared care, or even the GP could do shared care. I think that would make a big difference (Participant 13, p. 13)

So coming up here has been just a huge change and like, I've got girlfriends who have had babies down there and that's the thing, they travel like 10 minutes to get to a hospital and have the facilities at their fingertips and that sort of thing and just go, 'Oh, how do you do it?' But, to me, I mean, you know, for me to say to them, 'Oh yeah, I've got to travel an hour and 40 minutes to get to the hospital.' And they go, 'Oh, my goodness.' But, at the end of the day, it's just like walking down the street ... Oh, we're going to go to [referral town] tomorrow,' and that's just like we're going down the street to get the milk ... And, you know, country women are just as deserving as the metropolitan ... Like, my girlfriends travel 5 kms and have everything at their fingertips, and they're still going, you know? La, la, la ... Like, I'd love to see some Melbourne or Sydney-ite come out here and have a baby (Participant 19, pp. 12–13)

And I think about my sister, I went down to help her in Melbourne with her kids ... She was ten minutes from her hospital. It was just easy. Everything about that was easy (Participant 25, p. 15)

Comparisons were also made between the local hospital that had limited maternity services and the Base Hospital where women had no choice but to attend in labour:

Oh [local hospital] is excellent ... I really loved [local hospital]. ... The staff here are so nice. ... And their personality is nice. I find a lot of the ones in [Base Hospital], not all of them, but mainly a lot of them, were really snappy. Yeah. Like they don't want to answer your buzzer and if you buzz them, they get wild and, you know what I mean? ... You're in their

way ... I was dying to come home. I was saying, 'Can't you just do this in [local hospital]?' You know? And they couldn't (Participant 35, pp. 5, 23)

One participant expressed her **frustration** that there is a well-equipped hospital maternity unit close by but they offer no maternity services. Even when she was concerned that she was in early labour, no health professional was prepared to assess her before she drove three hours to the hospital where she was to birth:

If I was in a town where you could go to the hospital just up the road, they could listen to the baby's heart beat, they could tell me, 'Look, everything's fine. Your body's getting ready. Nothing to worry about (Participant 3, p. 3)

Another woman was refused advice over the phone and forced to travel a long distance over mountainous roads with her children at night. Having been assessed at the distant maternity hospital she was then advised that everything she was experiencing was normal and she could return home over the same dangerous, mountainous roads. **No consideration** was apparently given to the **safety** of her and her children.

When you're right out here and ring and they say, 'Come in and we'll check you.' Well, you've got to get other kids up and then they say, 'Oh, it's just such and such, go home' (Participant 6, p. 2)

Inequity is not limited to antenatal services and birthing. One participant who suffered from severe postnatal depression believed that because she lived in a rural area, her condition was negated:

It was really very stressful, and I only saw a doctor after that. And nobody ever checked on my postnatal depression and that, because I know that ... they really worried about it if you're in the city. They, you know, they keep on monitoring you and everything when you have your next baby ... nobody ever checked me (Participant 24, pp. 6–7)

Some participants explained that they had no choice but to **stop paid employment** earlier than they would have liked so that they could access antenatal care and organise their family:

Whereas, if I'd been working in [city] or something, you know, I could have just stopped work when I needed to, prior to having the baby, rather than having to get organised as well (Participant 25, p. 5)

It is difficult for some participants to understand how a community can have many pregnant women but still **no access to maternity services**:

There was 28 pregnant while I was pregnant with him ... and all due in April (Participant 29, p. 14)

8. Ripple effect on partners, extended family and community

... my husband drove me. And he stayed with me for that two weeks. And he stayed with his sister. Yeah. We were there all up for about a month because I had, ended up having an emergency caesar ... (Participant 26, p. 1)

While the following is not a particularly outstanding story, it demonstrates the ripple effect that extends well beyond the 'rural couple'. It is reflective of the circumstances that many child bearing couples face in isolated areas of Australia and their heavy reliance on family, friends and neighbours in a time of great need.

Highlighting story

Catherine (pseudonym for Participant 23) lives on a farm with her husband and children. They were expecting their fourth child. The family farm is on an isolated dirt road some forty minutes drive from the town. Catherine's partner and children often accompanied her when she travelled into town to access antenatal care. Towards the end of the pregnancy Catherine and her partner were worried and anxious about a number of issues:

Everything's gone so smoothly so far, but if I have to spend two weeks in hospital, like, what would happen? ... Who'd look after the kids for those two weeks ... And who'd look after the farm in that, like, your income then? ... There is actually no one that we pass, friends' wives, that we could leave the children with, so if I did spontaneously go into labour, it would have meant I would have had to drop them off somewhere and then actually turn around and go ...

Catherine also worried about her mother, who had made a commitment to come to her home to look after the children:

I had to book in with [name of Dr] to deliver, to induce me a week early, because I just wouldn't have made it the 120 kms ... I wouldn't have made it that far in labour. So he induced me a week early, so I didn't have that problem, and that also meant that I could organise my mother to come and stay with the children ... To move away from home was hard, extremely hard, because I had to leave my mother in an isolated area with two small children. And she's not used to that.

When Catherine and her partner travelled the long distance to have their child they only had each other for support. After the baby was born Catherine was keen to return home as soon as possible, for she didn't like sharing a room with four other mothers and babies. She was also adamant that when she left the hospital the whole family should be involved in the collection of the new baby, even though it was a long round trip for her older children:

The family will definitely come over and pick Mum up and bring the baby home.

While the birth of Catherine's fourth child ended well, the forward planning brought with it a great deal of worry and anxiety for both Catherine and her partner. It also involved coordination of others outside the nuclear family, particularly the organisation of safe and reliable care for older children, and in a number of cases the daily responsibilities of farm maintenance.

Discussion

The closure of maternity units in a number of rural townships resulted in women being forced to leave their local communities and support networks. As many of the women lived on farms their partners found it extremely difficult to leave their livestock and crops for long periods of time. Still, the men made every attempt to balance farming and family commitments:

[Partner] just did everything. He still went to work and organised [child] to go to school and was checking the stock and ... so he was ringing every day. He came in, as well (Participant 6, p. 6)

He was stressed [husband] ... he was stressed, because he really would have preferred to be back here [farm]. So he was stressed and he was wanting to be out on the farm and doing things and all that, but he couldn't ... (Participant 14, p. 9)

... we were in the middle of sowing, so [partner] ... was going to come back that night. I delivered [new baby] at eight-thirty in the morning and ... 'Well, all's well, you might as well head back and keep doing what you're doing' (Participant 22, p. 14)

[Partner] came home to get all their gear [children] to organise them to go to school ... [he] came home on that Friday, because we had animals and stuff to feed and what have you. And we were lambing and calving, at the same time (Participant 6, p. 5)

If the men could not cope with their farming responsibilities, other family members, friends, neighbours and acquaintances would come to their aid:

He's [husband] in partnership with his brother, farming ... but it's just depending on how busy it is on the farm, leaving all that work to his brother (Participant 17, pp. 2, 3, 5)

We got the neighbours to do the water runs and that sort of stuff (Participant 13, p. 4)

Due to the fact that we've got dogs and sheep and animals to feed, that was not so feasible [staying in referral town prior to the arrival of the baby] ... there's a gentleman that works here on the farm, he was on standby ... (Participant 42, pp. 3, 4)

In addition to looking after the farm the women and their partners required other forms of assistance. One essential area of need was **childminding** and some couples found they had limited support:

We knew absolutely no one, really. We were going to put [six children] into foster care for two or three weeks ... That's we thought our only option because ... we couldn't find a placement where all the kids could be together ... they were going to split them up ... you don't want your kids to split up because they depend on each other (Participant 29, p. 1)

Other couples were fortunate because their **families came to their assistance**:

I was relying on either my mum or my mother-in-law to take time off their work to take [son] because I couldn't have him at the hospital [city] (Participant 2, p. 20)

I had my grandmother from [one town], she came down and looked after [older child] for me ... my mother from [another town] came ... (Participant 14, p. 2)

Mum had taken the week off work so she, she was here to do, you know? To be my right hand, or to be my Mum basically. [laugh] And the benefit of that was that [in laws] were able to bring [first child] here (Participant 22, p. 14)

I stayed in [local town] until I was ready to go ... I had my sister [organised for child care] ... (Participant 16, p. 2)

Well, I'm lucky, his Mum and Dad live on the place as well. They're about eight kms away, so between them and my Mum, you know, the girls are sort of looked after (Participant 7, p. 4)

We actually had the boys in care five days a week, which was a big help (Participant 26, p. 8)

Despite their willingness to look after grandchildren some of the **grandparents were not accustomed to the geographical isolation**:

My parents came and stayed with us during that time, so it was actually quite hard on them, being in their late 60s, to drive into [referral centre] each day ... it was probably tougher on them having to drive in and back every day, both financially and just tiring ... to drive over 200 kms every day (Participant 42, p. 16)

Some of the women felt that they were placing **unrealistic burdens on their families**, friends and neighbours:

She [mother-in-law] came up from Sydney. She drove up from Sydney so that she could assist us with just travelling to and from

[referral centre] ... *It's about a six or seven hour drive*
(Participant 42, p. 14)

[Husband's] *father ... was going to be home so we wouldn't hassle the neighbours ... You can't lob in on friends when you've got two children and having another one. That's too much* (Participant 13, pp. 4, 6)

My sister-in-law, who was supposed to be looking after her [daughter], was actually away because I wasn't due, so I then had to ring up a neighbour and get them to look after [first born child] (Participant 39, p. 2)

I call her my substitute mother. They're lovely people, they're in their 80s, so ... The lady that's looking after them [children] ... she had a heart attack just at Christmas time ... So, when she offered [to look after the children], it was like, 'No, no, no, no, no.' You know? If anything happened, I'd be, I'd feel so responsible, but she wouldn't hear no for an answer, literally. She said, 'Nope, they're coming with me. They're not going anywhere else (Participant 29, p. 1)

9. Unnecessary obstetric interventions

A social induction I think they call it, because, my husband being on the land, I was up there on my own and he was back here, but I wanted him to be there and so we set a date and the doctor was going to induce me ... So I had the induction, had a terrible time, so it was forceps delivery after 24 hours and so I had a caesarean (Participant 25, p. 1)

Highlighting story

Carol (pseudonym for Participant 19) lived in a small town, approximately 2 hours from the Base Hospital. She had one child, born by caesarean section, but was very keen to experience a vaginal birth with her second child. The second baby was 9 weeks old at the time of the interview. Carol's story illustrates a number of concepts discussed in this report in relation to other themes as well as obstetric interventions.

Many participants, including Carol, spoke of having to guide and inform the medical experts:

I went on the Tuesday morning to be induced. He did an internal and said that the head was still too high, that ... the baby's head hadn't engaged enough. And I said to him that last time they said that the placenta was laying low, and I said, 'Is that still the problem? Is that the reason why the head's not engaging?' So he did a quick ultrasound and he said, 'Yes.' But never actually looked at the placenta properly, just said, 'Yep, it's still there, laying low and there's a 30% chance of it moving for her head to engage.' So I said that those odds weren't good enough for me, that I would have a caesar the next day.

It was not Carol's choice to have a second caesarean section, but she felt she had no option. All obstetric procedures carry an inherent risk, and surgical birth not only increases the immediate risk of morbidity and mortality for mother and newborn but the risk is trajected into future pregnancies. These risks include adhesions, uterine scar rupture, placenta praevia, placental abruption and the placental implantation disorders, accreta, increta and percreta. Once a very rare obstetric complication (1:19,000 in 1970), placenta accreta risk has increased alongside of the incidence of caesarean section and in 2005 was estimated to be 1:533 births (Wu, 2005). Carol's placenta was abnormally implanted and it cost her her uterus and almost her life:

I just knew straightaway. I had this feeling there was something wrong ... and I could tell by the look on the doctor's face that there was something wrong. As soon as she came out ... I just felt so different after she came out, and then straightaway I said to my husband, who was sitting to my right, 'I feel sick, I feel sick. I really don't feel well.' And they had the mask there for me ... sick into, and I could, my vision was going. I could see the outside of people, but I couldn't see eyes or anything on the inside. Then I heard the anaesthetist say, 'Her blood pressure has dropped to 60. Get the husband out. Get the baby out.' Because, at that stage, the paediatrician had been to my left, and she had [baby] in her arms, and I couldn't see her. I literally could not see her. I couldn't see the outside of this little bundle. Anyway, then [husband] was saying, I could hear him saying, 'What's wrong? What's happened? What's going on?'

Then I kind of come to, I could see people and the doctor actually said to me, '[Carol], there's been a complication.' He said, 'The placenta has grown through your uterus and it has busted, like someone's tried to pull it out, and you've lost too much blood. You've lost 3.5 litres of blood, and you only have five litres in your body. We have to do a hysterectomy.'

So, straightaway they've hooked up blood, because I had to have a cross match done the day before. ... I ended up in Intensive Care. So I didn't get to see [baby] at all that day. I didn't even get to see her. My husband brought her in. When I woke up in Intensive Care, he was there next to me and he had a picture of her which the girls in Maternity had taken a photo of her.

And I woke up very upset because I knew, straightaway, that I'd had to have a hysterectomy, so I was, you know, crying to my husband, saying that I was sorry and he was like, 'Don't worry about it. You know? We've got a girl, we've got a boy, we're blessed, we've got one of each.'

Discussion

Obstetric interventions are becoming more common for all women in NSW (NSW Health, 2007b). The overall induction of labour rate for NSW in 2005 was 25.4% and in the Greater Western Area of NSW, 27.8%. Inductions of labour for other than defined reasons was 9.2% in NSW overall, 6.8% in Sydney South West Area and 11.5% in Greater Western Area (NSW Health, 2007b). The inequitable

distribution of inductions of labour for no defined reason is demonstrated in a rate almost double when comparing urban areas with rural areas.

The cascade of intervention is a well accepted phenomena where initiating one obstetric intervention leads to the need to introduce another (Tracy & Tracy, 2003; Simpson & Thorman, 2007 as examples). Each intervention carries with it, its own risk that increases exponentially. The morbidity and mortality rates associated with obstetric interventions demand that more research be carried out as the full extent of the risks involved are yet to be fully appreciated. For example, although autism is unlikely to be caused by a single obstetric factor and cause and effect need to be carefully established, an Australian study (Glasson et al., 2004) found that autistic children were twice as likely to have been born following an elective caesarean or induction of labour than a child born following spontaneous onset of labour. Glasson et al. (2004) found that the increase in the incidence of autism persisted even when confounding variables such as maternal age were considered.

Induction of labour was commonplace for many of the participants in this study and some even spoke of preterm induction of labour being recommended for convenience and/or to save them the risk of travelling long distances in labour:

We'd set a date, ten days before the due date, to do the induction (Participant 25, p. 3)

Thirty-two weeks, he wanted to induce. And I said, whatever I do, I really don't want induction if I cannot have it. And he said, 'Oh well, because you're so far away and because of the quick labour with [previous baby], I think you should think about it.' So that, I said, 'Well, I'll think about it, but I really don't think so.' Then he pushed it on to me again the third time I went to see him (Participant 7, p. 1)

However, some participants appreciated that their obstetricians would induce them and found it reassuring:

To induce me a week early, because I just wouldn't have made it the 120 kms, was it 140 kms? ... I wouldn't have made it that far in labour. So he induced me a week early, so I didn't have that problem (Participant 23, p. 2)

On the due date, because of the distance that we had to get to the hospital. [obstetrician] actually agreed to induce me ... And then, on the Wednesday I was induced ... I did one contraction and then I had an epidural and the birth was 13 hours and it was very nice and clinical and nice and tidy ... That's why being induced is so good, because you don't know when the baby's arriving, so you don't know how long to stay in [birth hospital 4.5 hours' drive from home] ... It's great to have a doctor that understands you live a long way away and he'll induce you (Participant 13, pp. 1, 8)

Although other participants consented to the induction or prelabour caesarean section, they did **not** feel it was **their choice**:

Mum and Dad had said that to me, you know? Maybe you should stay in town? But I didn't want to do that. Sitting in town waiting for things to happen. But I also didn't want to be induced either (Participant 6, p. 18)

I've had a compromise this time round, that I'll give it three days and then I'll get induced, which is not what I want, but it's what we're going to have to look at for the whole family, not just myself ... it would be really nice to go into a natural labour ... (Participant 14, p. 13)

I had a terrible caesar, [this baby's] caesar was worse than [other child's] ... Probably, the first time around I was just exhausted and so just went through with it. But, with [baby], when I was told the day before that I had to have it, I didn't sleep well at all. I was so nervous. They couldn't find veins down here because I was just scared and tired and nervous ... I just felt nauseous ... Being told 'I just have to take this baby out' ... no real reason (Participant 17, p. 7)

In hindsight, some participants **regretted opting for a prelabour caesarean section** or an induction of labour:

[Induction] did take more of a toll on the body than the other two, because I couldn't stand up, because I couldn't do what I wanted to do (Participant 23, p. 11)

He [bub] got a lung infection, because ... he was three weeks early ... We didn't, see, we didn't have that full information, we were just given a couple of dates [for LSCS] and it fitted in around work, and so that's why we chose the earlier date, which was not a good thing (Participant 24, p. 3)

One participant spoke of how her partner had to be her advocate to avoid another preterm caesarean section:

They were going to give me a caesarean right there and then, but, because I had a cup of tea the anaesthetist said 'No.' ... And I think I was still four weeks early, and [partner] said, 'You can't have the baby yet.' He said, 'Look what happened to [first baby who was born three weeks early and developed respiratory distress]. Wait another week' he said, 'if you're not in labour.' ... Like, they were going to give me the caesarean there and then ... so he got on the phone. He was ringing around, he rang [friend] and he asked for their daughter, who lived in [birth town] to come with me, because we thought I was going to have the baby (Participant 24, pp. 4, 5)

10. Safety

We got into the car at about 12.30am ... And we got to [town, 20 minutes' drive from home], hit our first roo (Participant 22, p. 5)

Highlighting story

Nadine and her partner, Billy (pseudonyms for Participant number 29) left their home very close to term to travel four hours to the Base Hospital. They left behind six children in the care of an elderly couple and the woman was recovering from a heart attack. Nadine and Billy were extremely reluctant to leave their children with this couple and feared the impact it may have on her health. However, the only other alternative was for the children to be split up and put into foster care. This scenario was abhorrent to Nadine, Billy and the elderly couple. This was the first time Nadine and Billy had left any of the children overnight, without either of them being readily available, and the experience of leaving was traumatic, especially for Nadine.

They left at night and the car would usually easily travel on one tank of petrol to the town where Nadine was to birth. Soon after leaving, Billy and Nadine noticed the car was experiencing mechanical problems but neither mentioned it to the other, in order to try to protect each other from worry.

Our car was actually playing up and like ... it took about ten minutes to get it up to 100 kmph, actually. ... And I was praying that the car would hold together ... so here's a story for you, 25 kms out of town we broke down (Participant 29, p. 10)

Billy left Nadine in the car in the middle of the night and started walking the 25 kms into town to try to get petrol. Billy actually walked 22 kms with his petrol can before he was given a lift back to Nadine who was waiting in the car:

Yeah, nobody would stop, probably because I was [Aboriginal] ... Walking along the [road] with a jerry can ... You'd have to be, like, a big tough bloke to get out ... Not many people would stop at two o'clock in the morning ... people drove past, I had people shouting out the window, actually. I don't know what they're saying ... and I was walking as fast as I could ... so it took me a good three hours ... And luckily, a man pulled up. He was from [home town] ... and he took me to the service station, and he drove me back. And he didn't accept any money off me or any other (Participant 29, pp. 10–11)

Nadine was petrified in the car in the middle of the night on a rural road and she tried to hide in the back seat so that no one would see her:

I'm laying down in the car so when people drive past they won't see a young girl sitting there ... Turn all the lights off, just in case. People can be awful ... What about if they stopped to see what the car was doing there and ... you know? I might get kidnapped ... And yeah, the service wouldn't work on his phone ... Yeah, and actually, if I did go into labour, he could have been born by the time you got back. That's how quickly his labour

went ... I was very anxious, very, very anxious. I ended up literally hiding down in the car ... I put my head on a pillow and ... I thought if they go past and see me sitting there, they might come back again, like, they might try and help or they might want to be mean. Either way, I'm not going to be seen. Because I know that you'll be back (Participant 29, pp. 10–11)

Discussion

Some participants questioned why they were forced to risk road travel and commented on the paradox of the actual risk of travelling on rural roads in order to reduce the perceived potential risk of receiving antenatal care and birthing closer to their home communities:

What we are seeing now ... in a rural area where there is no service, we are putting 100% of women at risk. We are putting them at risk by forcing them onto the bitumen, driving when they're in labour, making decisions around scheduling their birth, putting them through huge emotional costs and financial costs for, at maximum, the 20% of women that would require medical care. Now, of that 20%, one to two per cent absolute maximum, could endure a serious [risk] even during labour. Of that 20%, the vast majority of them would be screened out during pregnancy and would very safely be cared for at another facility, another service in a bigger area, and that would be totally appropriate ... But yeah, 100% of women are being put in danger for ... essentially one per cent of women (Participant 18, p. 20)

Travel on rural and remote roads is inherently dangerous at night or with sun in the eyes, and kangaroos and livestock on the roads are just some of the dangers described by the participants:

But yeah, the sun makes it difficult and the kangaroos and the drought and, you know? The livestock on the road. It's all, it's all a bit tough (Participant 3, p. 2)

I went into labour with [first born child] at three o'clock in the morning it was dark and there was kangaroos on the road and all those sort of things (Participant 39, p. 2)

Often times the **remote roads are dirt** and have their own hazards:

I've actually got to drive halfway down this [dirt] road and head then back up to [larger town]. So, it's not as though it is, you know, just a direct route anyway (Participant 23, p. 8)

[Large maternity unit] is probably just over 200 kms, but 100 kms of that for me, is dirt ... [hospital chosen for birth] 250 kms about 3 hours' drive. ... It had been raining and we even had difficulties getting out of here then Then with my second son, he came early and it had rained and I went into labour and we then left and we nearly go bogged on the way out ... 40 kms of dirt to get to [chosen birth place] (Participant 39, pp. 1, 3)

Although every effort was made by women and their partners to ensure the car was as roadworthy as possible especially around the time that the baby was due, **mechanical problems** did cause problems on occasions:

I ... had a flat battery in my car ... I had to lift a battery out of a car, lift it out of a Toyota [Landcruiser] and put another one in (Participant 6, p. 7)

One antenatal appointment would often involve **many hours of driving**. This participant described driving a nine hour round trip for each ten minute antenatal appointment:

You drive over, you have an appointment, you don't do anything else, you get back in the car and you come back, you know, in the dark ... one of my good girlfriends was having a baby at the same time, so sometimes we'd go over together [9 hour round trip]. But, in the end, that became too much as well, because we were both heavily pregnant, and it's just too far (Participant 13, pp. 7, 8)

Another participant was on her way home from a breastfeeding class when she had a **car accident**:

With [second pregnancy], I, at 30 weeks, 31 weeks, I had a high speed MVA, rollover ... we were about 50–60 kms from town [going to]... Breastfeeding Association, and there is a group at [town, 200 kms away] ... that's where I was actually on my way to when I had the car accident (Participant 2, pp. 5, 6, 13)

Given the context of a labouring woman and an anxious partner driving many hours to the place of birth, accidents are inevitable:

We got into the car at about 12.30am ... our new car of about three weeks. And we got to [town, 20 minutes' drive from home], hit our first roo. ... I opened my eyes to see the joey go flying across the windscreen. I thought, 'Oh, I don't need to see that right now.' ... Travelled into town then very slowly about 80kms and contractions ... We're very conscious of roos, especially at that time of night. So, we just took it easy and travelled in about 80kms ... We must have passed, that night, 250 kangaroos. ... every dam we passed, there'd be ten that would jump out across the road (Participant 22, pp. 5, 6)

So I'm all fours in the car, yelling at [partner] to rub my back ... And he's driving through town and rubbing my back with the other one, in peak hour traffic ... Because we've got a manual car, he's having to change gears as well ... The pain was just excruciating, so all I was thinking about, rub my back and, I don't know how [partner] was feeling with driving and having to do everything (Participant 6, pp. 4, 11)

When decisions are made about closing rural maternity units, **little bureaucratic consideration appears to be given to road safety** as this participant who lives high in the mountains explains:

The attitude when the [state] government ... were trying to close [hospital in home town] down, was, he said, 'You've got a state of the art health service in [large hospital, 1½ hours' drive from home]' Well, it's more remote up there than what we are, and [one] side, down the river, is quite windy, and a slow road. And the [other] side, down the river, is windy and slow and dirt ... Up here in the hills it's wet, the road, and we've got wombats and kangaroos and fogs. We get very thick fog up here (Participant 6, p. 12)

Some participants perceive that **health professionals** working in hospitals without maternity services **do not consider the risks of driving** in labour along rural roads. It is as if their own fear of labour and birth takes precedence over the woman's safety.

Many women were very concerned about their partners travelling on country roads to visit them. So great was one woman's anxiety for her partner's safety on the road, that she felt it was better that he was not present for her baby's birth:

I felt better that he was here [home town] rather than, you know, driving at some phenomenal speed to try and get there in time, and then to miss out (Participant 3, p. 9)

For one participant, it became obvious that she was going to give birth three hours' drive from the hospital where she had planned to birth. Her partner called an **ambulance** and although there was mobile phone coverage (not always available), unclear mapping meant that the ambulance was unable to find the woman and her partner immediately. When they did find them, the drive to the hospital was very fast:

And so we called the ambulance ... the ambulance actually rang back to check where we were, where our location was ... So we scooted along [in ambulance] ... quite regular contractions and then they just sped up all of a sudden ... we got to about [30 kms from hospital that doesn't usually birth babies] ... the ambulance just took off, they were doing about 160 kms (Participant 13, pp. 3, 13)

Another participant gave very careful thought to the safety of herself and her unborn twins and made a **calculated choice**. For this woman, a planned homebirth was the safest option:

Then my plan was to maintain absolute health, to give birth to my babies gently and normally, at home, in the care of a midwife (Participant 18, p. 13)

I could not believe that travelling, or waiting and travelling, which was, to me, my only option, could in any way be safer. ... My view is that if I'd waited to labour, I would have given birth at [the] power station ... because that's where I would have got (Participant 18, pp. 14, 6)

Other participants make a calculated **decision to stay at home** until very close to their due date or early labour, based on economic reasons and for the sake of family relationships:

... there's no way I could go and look after two boys and run around [city] and do everything. I'd rather be at home ... I was advised to go three weeks before by our GP here, but I've chosen to leave it until now [a week before due date] ... I'm just hoping ... I'm on or after the due date ... I've had easy births. I've had no complications with any of my pregnancies, so I look at that as well. I mean, if I'd started to have troubles this time then I would have gone to [city] earlier (Participant 2, p. 2)

Chapter 4: Recommendations

1. Practice recommendations

I want to say on behalf of rural women, that rural women are crying out for support, and with half the chance, with the education and with the midwifery service available, not only would we see much better outcomes clinically, we would be establishing families in a far more supportive way, and mothering ... So, really, let's put the commerce aside and let's actually put women central to this, because I know that, with the option, women would basically flock to these services (Participant 18, p. 23)

Discussion

What the participants in this research have recommended is in keeping with the findings of multiple state and national maternity service policy documents, many of which were conducted concurrently with this research project (Hirst, 2005; *National Consensus Framework for Maternity Services*, 2008; Department of Health, 2007; Australian College of Midwives, 2007; NSW Health, 2007 as examples). The difference is that for women living in rural and remote areas of NSW, the recommendations are not simply theoretical; they will have significant and positive impact on their health, their finances and their relationships if they are put into practice.

As a result of this study, the researchers make the following practice recommendations:

1. Provide maternity care as close to home as possible.
2. Improve health outcomes for Aboriginal women and babies through culturally safe maternity services.
3. Provide publicly funded, stand-alone primary birthing units.
4. Support midwifery-led care for healthy women in their local areas.
5. Provide continuity of care.
6. Provide women with options of accessing midwifery and/or medical services of their choice.
7. Ensure women are treated with kindness and respect in a pleasant and safe environment.
8. Ensure adequate information about choices is provided.
9. Ensure access to medical help where necessary.

1. Provide maternity care as close to home as possible

All participants expressed a strong desire to have maternity care as close to home as possible. This is supported by the *National Consensus Framework for Maternity Services* (2008) which argues the principle for access to maternity services for rural women: 'Women should have access to safe maternity care consistent with their assessed level of risk as close as possible to where they live (Principle 2.1); Rural women must be able to access antenatal, postnatal and support services in their own communities even if birthing services are not available' (Principle 2.2).

2. Improve health outcomes for Aboriginal women and babies

The first goal of the Department of Health in Western Australia (2007) in their report on improving maternity services is to 'improve health outcomes for Aboriginal women and babies'. Kildea (2006) has strongly argued that if health outcomes for Aboriginal women and babies are to be improved then traditional Aboriginal women's knowledge must be recognised as authoritative and women must be given the opportunity to birth 'on country' (locally) in culturally safe birthing units.

The participants in the study who identified as Aboriginal and the Aboriginal midwife expressed a strong desire to birth in a culturally safe environment. At the very least they wanted health professionals to be respectful of them. Many spoke of the ideal to have a free-standing birth centre where they could give birth locally, supported by Aboriginal kin and midwives. Specific details of how this birthing centre would work were described:

I'd want a Aboriginal birthing centre. Other women could access it, but they would need to understand that it is Aboriginal ... and they were to accept our customs, our birthing plans ... For a start, placentas are not supposed to be touched by men. The placenta is only to be touched by a woman. The women should be given the right to, I mean, be asked if they wish to take home the placenta for their ceremonies, whether they were smoking ceremonies, they bury it. And that tradition really should be given back to the girls. And the grandparents, and the mother that's actually there. This is their baby ...

There shouldn't be a limit on who's in the room. The room should be large enough to accommodate two to four people, but, as support people ... Usually, you'll find that there's either a grandmother or mother or an aunt, so that's the extended family support. These girls are comfortable with family members ...

Staff members would be very, selected very carefully ... It wouldn't be based on an interview. I'd be actually assessing the person as a whole, their manner, and the way they address Aboriginal people. They'd be on a trial period for three months ...

It's the women's choice whether they come in or whether arrangements would be made for us, for someone to go out. But I find that with

Aboriginal women, there's always a group, either they turn up as a group or you go to their home, there's a group.

And the other thing is, if they were happy that someone else had delivered at the same time, to actually go to the same clinic ... The clinic wouldn't be a one on one, it would be a support network for the mums to share what they're going through, their experiences, what they're having trouble with. So, it's a shared knowledge, and by that shared knowledge, then, that knowledge is getting back to the community members. ... And it then encourages the girls to have their support network in the community ... I would try to bring back that tradition, the networking tradition, especially with these girls, because, I mean, these girls are on their own. Their matriarchs are no longer there, they've lost their culture, but if you've got someone that has some knowledge ... of how our systems used to work, we could reintroduce that ... [instead of] allowing our culture to die (Participant 34, pp. 8–11)

They should have an Aboriginal birthing centre ... where Aboriginals were employed, because, you know, like, they're more understanding of Abor, with the culture and everything, and they know how to treat their own people ... Aboriginal midwives ... Trained in birthing and that ... Where you can have your aunties and that too ... They talk much better to and understand what they're going through and everything. I reckon that would ... It would be a lot more caring too (Participant 36, p. 24)

3. Provide publicly funded, stand-alone primary birthing units

There is in-principle support from NSW Health for the concept of birthing units. NSW Health (2007, p. 21) recommends 'an expansion in publicly funded, stand-alone primary birthing units to give women more birthing options and provide extra support during and after pregnancy.'

4. Support midwifery-led care for healthy women in their local areas

The majority of the participants spoke of their desire to give birth locally and their acceptability of a midwifery-led model of care to facilitate this choice:

But all the wishes in the world out here, would be to have more midwives in the local hospital that are up to date with their midwifery skills (Participant 7, p. 5)

Some women need medical staff and, but every woman needs a midwife ... So I think that if we had that strong, primary midwifery focus that took women from early pregnancy right through labour and birth to at least that six weeks postnatally, then we would really be establishing strong women and you know, giving them those appropriate skills and support (Participant 18, pp. 18, 19)

My preference would have been a birthing centre with a midwife. ... next best thing would be a midwife who could follow you through antenatally,

during labour and postnatally ... The affinity that you have with a midwife ... most of the doctors that I've dealt with come from a very medical orientated view ... The medical model invariably clashed with the midwifery model where it's very woman-centred. ... but if you've found that midwife who you'd express your concerns to, who you could see really had your interests at heart, was very woman-centred ... with that comes positive experiences. And, one thing that I have noticed is that ... the experience for the woman doesn't stop the moment they walk out of the maternity unit. It's something that stays with you for the rest of your life and that is so important (Participant 22, pp. 16, 17)

I have a lot of confidence in the midwives ... I would support midwives helping birthing women in town ... As long as I know that they are up to date with everything and regularly having training and all that kind of thing ... (Participant 2, p. 19)

[Town] needs a midwife. ... Yeah, [midwife] would be huge. I think it would make a huge difference. ... the financial support and a midwife, you know? (Participant 24, pp. 7, 15)

Midwives ... so you can go for regular checkups with someone that knows what's going on, not just an ordinary GP (Participant 27, p. 7)

The views expressed by the participants in this study are also those of the Rural Health Workforce Australia, The Royal Australian College of General Practitioners, Rural Doctors Association of Australia, Australian College of Midwives, Australian College of Rural and Remote Medicine, Royal Australian and New Zealand College of Obstetricians and Gynaecologists in the *National Consensus Framework for Rural Maternity Services* (2008) document.

Low risk women in rural areas should have access to maternity care provided by midwifery models of care operating within an integrated service network (*National Consensus Framework for Rural Maternity Services*, 2008, p. 9)

Midwifery-led care is as safe as routine maternity care and is less costly than interventionist obstetric models of care (Hodnett, 2002; Tracy & Tracy, 2003; Barclay, 2008). To facilitate midwifery-led models of care, some participants had already given thought to how they might be funded to provide a cost effective caseload model, given current financial restraints. Fontein (2007, p. 37) defines caseload midwifery as a 'model of care providing relational continuity between each woman and midwife by continuity of midwifery carer throughout the full process of pregnancy, birth and the postnatal period, responsive to the needs and preferences of the individual woman'. Such a model would be acceptable to many of the participants:

I mean, there is no way that they couldn't provide that service within current parameters. They have midwives sitting there doing knitting on roster, on shift, and ... often seeing no-one for days on end ... and then getting busy. I mean, that's how maternity units work, we know that ... and

by reducing interventions as well, and those flow on costs, those social costs that in an area like [rural town] are huge (Participant 18, p. 19)

... if I was to develop a model, it would come back to that whole case study model where the mother has an opportunity to at least choose a midwife ... I know, in [small town with closed maternity service], for a small town, we still have quite a number of trained midwives, and so I think, 'Why not take use of that knowledge and ... everything that they have to offer professionally, and use it?' For me, personally, I would like the choice of a midwife, but that's someone who you could develop a great rapport with, who you could really discuss your issues and your concerns. I find that you don't get that opportunity in a doctor's surgery (Participant 22, p. 16)

For midwifery-led caseload models of care to be sustainable in rural areas, a number of issues would need to be addressed. First, there needs to be a collegial team of health professionals who respect each others' skills and knowledge base. The Australian College of Midwives (2007) Rural Maternity Services policy is reflected in the words of this participant:

I think there has to be a very collegial team base. Like, team approach across care providers, and if I could design it from scratch, I would have a very strong continuity midwifery model for all women, but then, having that continuity of midwifery model very much link in with medical services on the basis of clinical need so that every single woman, regardless of where she was at, of what type of pregnancy and birth, she could have ... that support of midwifery care (Participant 18, p. 17)

Second, there needs to be an acceptance that outcomes for healthy pregnant women and their babies do not improve when anaesthetic and surgical availability are a prerequisite to a woman labouring and birthing in a rural maternity unit. As Leeman and Leeman (2002, p. 129) argue, 'The presence of a rural maternity care unit without surgical facilities can safely allow a high proportion of women to give birth closer to their communities.'

Third, midwives need to be willing and prepared to work to their full scope of practice, as defined by the International Confederation of Midwives (2005):

A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery.

The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures.

The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and child care.

A midwife may practise in any setting including the home, community, hospitals, clinics or health units (Adopted by the International Confederation of Midwives Council meeting, 19th July, 2005, Brisbane).

Many NSW midwives have worked in a medicalised model of care and as a result may not feel willing, competent or confident to work to their full scope of practice, as this participant who was also a midwife expressed:

[Midwives] they're frightened to make decisions ... because of the legalities of their actions. ... I do feel that we rely a lot on machines now to what we used to. ... Instead of the old ... the hands on ... I think we're pretty quick to grab a machine, instead of relying on our skills that we have achieved. The basics are not there anymore. I just think there's too much intervention (Participant 34, p. 8)

Some participants either expressed or alluded to their perception that midwives were not working to their full scope of practice:

[Midwife] ... she called the doctor when the baby was coming, so ... So, yeah, midwives don't normally deliver up there (Participant 23, p. 4)

But, if you did have any sort of technical questions, [midwives] sort of couldn't help you. They would just, would measure how low you were and check your pulse and heart rate and that sort of thing. So it was only very basic care, I suppose (Participant 12, p. 1)

And it is very sad to walk into that hospital and to see all those midwives and none of them practising ... Because we have quite a healthy growth rate in [town closest to home, 70 kms away] ... I know of at least 12 women currently who are pregnant, and are all travelling out of town because there's no antenatal care provided in town (Participant 22, p. 17)

Preparation of midwives to work to their full scope of practice must occur at the preregistration level and then be continued post registration. The Australian College of Midwives has strategies such as MidPlus which provide the framework to help ensure continual and sustainable midwifery confidence and competence. More area health services are looking at caseload midwifery models of care as a cost effective means of providing quality maternity services to healthy pregnant women and their babies. At a preregistration level, tertiary institutions must play a vital role in providing midwifery education that is available to students living and working in rural areas. The participants in this study have also demonstrated the need for more Aboriginal midwives.

When asked what women would like most from maternity services, participants in this study had very similar requests to other women in previous similar research (Garcia et al., 1998; Gready et al., 1995; Green et al., 1998; Lavender & Chapple, 2003 as examples). That is, participants desired to have confidence and trust in the midwife or medical practitioner involved in their antenatal, labour/birthing and postpartum care. They wanted individual care from a midwife who they knew and with whom they had built a relationship during their pregnancy.

5. Provide continuity of care

Continuity of care is an evidence based concept known to improve outcomes for women and their newborns (Homer, Brodie & Leap, 2008). It is seen as integral to improving women's experiences of pregnancy (Department of Health Western Australia, 2007). Furthermore, this policy framework recommends that if women's experience of childbirth is to be improved:

It is essential that midwives and GPs are recognised as key providers of care for healthy women with low obstetric risk and their babies [and there must be] an increase for capacity for midwives to provide one-to-one care to women throughout pregnancy, labour and childbirths, facilitating greater individual support, and enabling continuity of care (Department of Health Western Australia, 2007, p. 12).

6. Provide women with options of accessing midwifery and/or medical services of their choice

In this study, some participants did express their desire to travel long distances to access a private obstetrician in a private hospital setting; for example *I'd like to see an obstetrician in* [large town, 1.5 hours away] (Participant 15, p. 9)

7. Ensure women are treated with kindness and respect in a pleasant and safe environment

Some participants described situations in which they had been treated inhumanely and expressed a desire to be treated with kindness and respect.

8. Ensure adequate information about choices is provided

The participants believed they had a right to adequate information and explanations about choices for childbirth. They wanted to be listened to and to have a real choice in the place and type of birth they could have.

9. Ensure access to medical help where necessary

Like the participants in the above mentioned studies, women living in rural and remote areas wanted to have access to medical help if complications arose.

A model of midwifery education

A model of preregistration midwifery education has been developed at Charles Sturt University (CSU) in response to the issues highlighted in this research project. Since 1990, CSU has offered preregistration midwifery education to students who are already registered midwives. The course was developed to meet the needs of rural women and service providers and is provided by distance education. It has continued to evolve and expand until at the time of writing, there are 63 students enrolled in the postgraduate Diploma of Midwifery. However, further strategies need to be added to complement this program as the critical shortage of registered midwives presently plagues all of Australia, but is especially evident and worsening in rural and remote areas (Australian College of Midwives, 2007). The Bachelor of Midwifery (BMid) degree is proposed as a three year distance education/flexible learning course leading to registration as a midwife. It is another strategy designed to help ensure women living in regional, rural and remote Australia have greater access to midwifery and maternity services closer to their home communities through addressing the registered midwife shortage.

When making the decision to proceed with developing and offering the BMid course, CSU midwifery academics considered the needs of rural childbearing women first and foremost. This research project, *Birthing experiences of women living in rural and remote areas of NSW*, confirmed the need for midwifery graduates who would live in rural and remote NSW and be prepared to work in midwifery-led models of care. The program will enable students to study, live and work close to their rural and remote home communities.

Data from this study indicate that the financial, personal, relationship, physical and emotional costs of women having no choice but to move away from their rural and remote communities to birth is unacceptable from a human rights perspective. Over 130 rural maternity units have closed at a time when the birth rate is rising (Australian College of Midwives, 2007). Evidence indicates that smaller maternity units are at least as safe as larger units (Tracy et al., 2005) so one of the philosophical underpinnings of the course will be to provide a midwifery workforce to enable small, medium and large maternity units to remain open and reopen. To facilitate this process, students will be primarily recruited from the rural areas where they live and enabled through flexible learning strategies, to undertake midwifery studies while continuing to reside in their local area. The purpose of this is to help create and maintain a sustainable midwifery workforce prepared to practise in both existing and midwifery-led models of care in regional, rural and remote Australia. Priority of student access will be given to Aboriginal health workers wishing to become registered midwives for their local communities.

The rural focus of the CSU BMid curriculum is in part, also a response to the Australian College of Midwives Position Statement of Rural Maternity Services (Australian College of Midwives, 2007). The Australian College of Midwives (2007) identifies that midwives make a vital contribution to the health and wellbeing of rural women and babies as both primary carers and as an integral part of a multidisciplinary health team.

2. Policy recommendations

The antenatal/birthing experience

Women in rural and remote areas deserve family centred care in the same way as the rest of the community. Therefore there is a need to significantly reduce the need for women and their families to travel as much as possible. When this is essential there should be adequate financial recompense and support services available that reduce the associated stresses. We therefore recommend:

- that antenatal care be provided to women in their home communities by midwives and that this reinforce continuity of care
- that local GPs be trained to provide appropriate maternity services in small communities
- that choices of birthing experience be expanded by developing birthing services in small communities
- that birthing services, including antenatal care, be covered by *Medicare* for midwifery-led services when not provided by the public health system
- that maternity services be bulk billed to reduce the costs for women and families
- that services provided by rural midwives and general practitioners be backed by tele-obstetric advisory services when required.

Continuity of care in local communities

Regarding the provision of continuity of care in local communities, we recommend:

- that funding be provided up front to pay for associated travel and accommodation costs for families and other children and their carers, where women have to leave their communities (either by choice or because their situation has become complex)
- that child care services and accommodation units be added to regional hospitals for families having to travel for birthing
- that women be facilitated back to their local hospitals as soon as possible after their birth
- that midwives provide postnatal care to women across the community/ maternity unit interface.

Financial support

Regarding financial support to rural families, we recommend:

- that financial support be provided up front for any costs associated with travel and accommodation away from home for antenatal/birthing process
- that the baby bonus be provided to rural and remote women for the purpose for which it was established: for costs associated with raising a child (not to recoup costs associated with the birth)
- that families be provided with financial support for medical bills, travel and accommodation costs and child care and for lost income if they are required to travel away from home.

Future developments in rural maternity services

Regarding future developments in rural maternity services, we recommend:

- that lessons be learnt from Canadian and New Zealand models of maternity care that enable healthy women to stay in their local rural and remote communities to birth
- that models of caseload midwifery be developed that provide a cost effective, continuity of care maternity service for healthy women during pregnancy, labour, birth and the postpartum/newborn periods
- that women's choices be increased so they have the options of moving away from or staying within their local community to receive continuity of care
- that collegiality between midwives and medical practitioners be enhanced
- that midwives and general practitioners be encouraged to work to their full scope of practice, receiving additional education/supervised practice to ensure safety where required
- that the physical, emotional and professional needs of midwives and general practitioners be considered in order to maintain sustainability of rural and remote maternity services.

Midwifery and general practitioner education

Regarding midwifery and general practitioner education, we recommend:

- that funding be provided to universities (commonwealth) and health facilities (state) to enable more midwives to be educated and registered
- that adequate funding be provided to ensure midwifery practise for student midwives is fully supervised
- that indemnity insurance costs be fully covered for midwives and general practitioners providing maternity services and this insurance be extended to

cover students of midwifery and medicine working under supervision in rural areas

- that registered nurses in rural areas be provided with opportunities to study postgraduate midwifery as close as possible to their home communities
- that Aboriginal health workers and enrolled nurses in rural areas be provided with opportunities to study undergraduate midwifery as close as possible to their home communities
- that caseload midwifery be integral to all preregistration midwifery education programs
- that midwives and general practitioners working in rural and remote areas of NSW should be skilled in the use of ventouse and perineal suturing (Ireland et al., 2007)
- that courses such as *Advanced Life Support in Obstetrics* need to be accessed by midwives and general practitioners and their certification renewed at least every five years
- that the potential be realised for online learning and online communication to enhance both educational opportunities and clinical consultations for midwives and general practitioners practising in rural and remote areas of NSW.

For details of the proposed model of care, refer to the Executive Summary in this report.

Chapter 5: Conclusion

Strengths of the study

Many journal articles, departmental reports, professional organisation position statements and the like have been written in recent years about the decline in rural maternity services. Much of this literature has been used to inform the background and discussions in this study. However, those impacted most by rural maternity services and the lack thereof, are pregnant and birthing women but their voices have largely been absent in the literature. This study has centred around women living in rural and remote New South Wales who have been forced out of their local communities to labour and birth. Previously silenced voices have been valued and made audible. The women living in rural and remote areas have spoken, been heard and documented. Their experiences, stories and knowledge form the foundation and the framework throughout the study.

Participant recruitment was not intended to be representative. The participants came from all over rural and remote New South Wales and from towns, villages, camps and properties served by all the non urban area health services. Participants who identify as Aboriginal, anglo-Australian and from culturally and linguistically diverse backgrounds were included. Most were interviewed in their own homes. Some participants were privately insured and some were socio-economically disadvantaged. Some participants were illiterate and others had a graduate education. All had stories and experiences of immense value to share.

This study could and should be replicated in other states and internationally.

Limitations of the study

Given the nature of the methodology used, the findings of this research are unable to be generalised. Nor was it the aim of the study to generalise findings but rather to reach a new and better understanding of what it means for women to leave their homes, families and communities and travel long distances on dangerous roads to labour and birth.

Forty-two individual participants were interviewed during forty-five interviews. As stated, the recruitment of participants was not intended to be representative but rather purposive. Women were recruited through word of mouth, Country Women's Association networks, radio announcements and newspaper articles. This small sample of participants shared an enormous depth and quality of data. It is the richness of this data that provides the study with heightened validity.

In spite of our utmost motivation and endeavour, a power gap still occasionally surfaced during the interviews. Women knew that all but one of the research team was a midwife and they sometimes asked:

What do you want to know? (Participant 12, p. 1)

Very soon, their desire to share information that they thought the interviewer wanted to hear was negated. Once women were reassured that we wanted to hear their stories, we wanted to listen to what they thought was important, any desire to please the research team was abated. This is evidenced by the participants' honesty, openness and the depth of their sharing.

The study collected retrospective accounts of women's experience when they travelled away from their home communities to birth. Consequently, it is acknowledged that recall bias may affect the accuracy of some of the concrete details provided. Women's feelings about their experience have possibly been clarified or even accentuated over time.

Avenues for further research

As discussed more fully in the literature review, the hypothesis that 'forced evacuation of women from their rural and remote NSW communities to labour and birth in distant maternity units improves maternal and neonatal outcomes' has never been formally tested.

The validation process and therapeutic value for informants participating in phenomenological research could be significant and needs to be more extensively explored.

Ireland et al. (2007) argue that more research is required to determine the levels of skills and competencies required for midwives practising in rural and remote areas.

Research which explores Aboriginal women's fear of midwives needs to be conducted and strategies developed to enhance cultures of connection and trust rather than fear and bullying in maternity units.

Having initiated a collaborative partnership with researchers from The University of British Columbia (Jude Kornelsen, Professor, Department of Family Practice, personal communication, July 2006), it is anticipated that this study will form the foundation for international research. In further collaboration with researchers from other states in Australia, Canada and New Zealand, the experiences of women living in rural and remote areas will be compared and contrasted and the models of care best suited to meet the short and long term needs of pregnant and birthing women, their infants, families and communities will be identified.

Conclusion

In one generation, the closure of over 130 maternity units in rural areas has caused women, midwives and rural communities to reframe healthy pregnancy and childbirth into a condition that necessitates specialist anaesthetic and obstetric services. Until this study was attended, the impact of the women forced to travel long distances to access antenatal, intrapartum and postnatal care had been anecdotal. This report focuses on the findings of a study funded by the Nurses and Midwives Board of NSW, where forty-five interviews were attended. The participants, over forty women and some of their partners, living in rural and remote areas shared their stories of having to move away from their communities to birth. A total of seventy-three pregnancy and birthing experiences were described.

Many times their shared experiences demonstrate that what is happening to rural and remote women is a violation of their human rights. The financial burden for maternity services has shifted from the public purse to individual women. At a time of incredible personal adjustment, women are separated from partners, children, family, community and country. Women have no choice but to travel long distances on dangerous roads for basic antenatal care and in late pregnancy or early labour to birth. Obstetric interventions such as induction of labour and elective caesarean are offered in an endeavour to reduce the distress caused by enforced isolation from all that comforts them. Some women shared their experiences of racial discrimination and even their intense fear that their babies would be taken from them at the larger maternity units where they birthed. Clearly, the imposed transfer of women from their home communities to birth is a human rights issue!

The final words of this report belong to the participants. Their words reflect the strength and resilience of women living in rural and remote Australia. On describing her birth by the side of the road en route to hospital, one participant shared:

Luckily we had a torch! (Participant 16, p. 3)

The second quote illustrates that although women living in rural and remote areas are resilient and strong, they are also acutely aware of the inequities in acceptable maternity services between rural/remote and urban areas. They have a strong desire to labour and birth locally. They believe they have a right to basic midwifery services close to where they live. As one participant summed up:

Like, this is Australia, it's the bush but ... (Participant 27, p. 10)

References

- Acker, J, Barry, K & Esseveld, J 1983, 'Objectivity and truth: Problems in doing feminist research', *Women's Studies International Forum*, 6, 4, pp. 423–435.
- AIHW (Australian Institute of Health and Welfare) 2003, *Rural, regional and remote health: A study on mortality*. Canberra: AIHW.
- Arias, E, MacDorman, M, Strobino, D & Guyer, B 2003, 'Annual summary of vital statistics – 2002', *Pediatrics*, 112, pp. 1215–1230.
- Australian College of Midwives 2007, *Rural maternity services*, Position Statement, February 2007.
- Australian Rural Nurses and Midwives 2007, *Coonabarabran one of many: Closure of maternity units is the bush*, Media Release 14.11.07.
- Barclay, L 2008, 'Women and midwives: Positions, problems and potential' *Midwifery*, 24, pp. 13–21.
- Beddoe, A & Lee, K 2008, 'Mind-body interventions during pregnancy', *Journal of Obstetric, Gynecologic and Neonatal Nursing*, 37, 2, pp. 165–175.
- Bell, A & McFarlin, B 2006, 'Maternal and fetal stress responses during birth: Adaptive or maladaptive', *Journal of Midwifery and Women's Health*, 51, 5, pp. 319–320.
- Benner, P 1985, 'Quality of life: A phenomenological perspective on explanation, prediction and understanding in nursing science', *Advances in Nursing Science*, 8, 1, pp. 1–14.
- Benner, P (ed.) 1994, *Interpretive phenomenology: Embodiment, caring and ethics in health and illness*. Thousand Oaks, California: Sage Publications.
- Birth Rites* (videorecording) 2002, Australia: JAG Films.
- Braverman, P, Marchi, K, Sarnoff, R, Egerter, S, Rittenhouse, R & Salganicoff, A 2003, *Promoting access to prenatal care: Lessons from the California experience*. Menlo Park, California: The Henry J. Kaiser Family Foundation.
- Cameron, B & Cameron, S 2001, 'Outcomes in rural obstetrics, Atherton Hospital 1991–2000', *Australian Journal of Rural Health*, 9, 1, S39–42.
- Carver, N 2004, 'What is happening to maternity services in Victoria?', *Australian Midwifery News*, 4, 2, Winter, p. 21.
- Chamberlain, M & Barclay, K 2000, 'Psychosocial costs of transferring indigenous women from their community for birth', *Midwifery*, 16, 2, pp. 116–122.

- Crotty, M 1998, *The foundations of social research: Meaning and perspective in the research process*. London: Sage.
- Curtis, P, Ball, L & Kirkham, M 2006, 'Why do midwives leave? (Not) being the kind of midwife you want to be', *British Journal of Midwifery*, 14, 1, pp. 27–31.
- Dahlen, H, Barclay, L & Homer, C 2008, in press, 'The novice birthing: Theorising first time mothers' experiences of birthing at home and in hospital in Australia', *Midwifery*, doi:10.1016/j.midw.2008.01.012
- Declaration of Alma-Ata 1978, VI, World Health Organization, Alma-Ata http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf
Accessed 23.3.08
- Department of Health 1970, *The Peel Report*. London: Her Majesty's Stationary Office (HMSO).
- Department of Health 2007, *Improving maternity services: Working together across Western Australia. A policy framework*. Perth: Government of Western Australia Health Policy and Clinical Reform.
- Dietsch, E 2003, *The lived experience of women with a cervical screening detected abnormality: A phenomenological study*, PhD thesis, Charles Sturt University, Bathurst.
- Dietsch, E & Davies, C 2007, 'The Nocebo Effect for women in waiting', *Collegian*, 14, 3, pp. 9–14.
- Downe, S 2006, 'Engaging with the concept of unique normality in childbirth', *British Journal of Midwifery*, 14, 6, pp. 352–356.
- Eby, L & Brown, NJ 2005, *Mental health nursing care*. Upper Saddle River: Pearson Prentice Hall.
- Elder, R, Evans, K & Nizette, D 2005, *Psychiatric and mental health nursing*. Mosby, Sydney: Elsevier.
- Fahy, K, Foureur, M & Hastie, C 2008, *Birth territory and midwifery guardianship: Theory for practice, education and research*. Sydney: Elsevier.
- Felbinger, D 2008, 'Incivility and bullying in the workplace and nurses' shame responses', *Journal of Obstetric, Gynecologic and Neonatal Nursing*, 37, 2, pp. 234–242.
- Fenwick, J, Gamble, J & Hauck, Y 2006, 'Reframing birth: A consequence of Caesarean Section', *Journal of Advanced Nursing*, 56, 2, pp. 121–130.
- Fontein, Y 2007, 'Making the transition from 'being delivered' to 'giving birth'', *MIDIRS Midwifery Digest*, 17, 1, pp. 35–40.

- Foureur, M 2008, 'Creating birth space to enable undisturbed birth' in Fahy, K. Foureur, M & Hastie, C 2008, *Birth territory and midwifery guardianship: Theory for practice, education and research*. Sydney: Elsevier, pp. 57–77.
- Gadamer, HG 1975, *Truth and method – outline for a philosophical hermeneutics*, trans. G Barden & W Doerpel. New York: Seabury Press.
- Garcia, J, Redshaw, M, Fitzsimons, B & Keene, J 1998, *First class delivery: A national survey of women's views of maternity care*. London: Audit Commission, NPEU.
- Glasson, E, Bower, C, Petterson, B, de Klerk, N, Chaney, G & Hallmayer, J 2004, 'Perinatal factors and the development of Autism: A population study', *Archives of General Psychiatry*, 61, 6, pp. 618–627.
- Gready, M, Newburn, M & Dodds, R 1995, *Choices – Childbirth options*. London: National Childbirth Trust.
- Green, J, Renfrew, M & Curtis, P 2000, 'Continuity of care: What matters to women, review of the evidence', *Midwifery*, 16, pp.186–196
- Groft, J & Robinson Vollman, A 2007, 'Seeking serenity: Living with HIV / AIDS in rural Western Canada', *Rural and Remote Health*, 7, 677, pp. 1–11.
- Grzybowski, S, Cadesky, A, & Hogg, I 1991, 'Rural obstetrics: A 5-year prospective study of the outcomes of all pregnancies in a remote northern community', *Canadian Medical Association Journal*, 144, 8, pp. 987–994.
- Gunnar, M 2000, 'Early adversity and the development of stress reactivity and regulation', in C Nelson (ed.), *Effects of early adversity on neurobehavioural development: The Minnesota Symposia on child psychology*. Mahwah (NJ): Lawrence Erlbaum Associates, pp. 163–200.
- Hancock, H 2007, 'Low birth weight in Aboriginal babies – A need for rethinking Aboriginal women's pregnancies and birthing', *Women and Birth*, 20, pp. 77–80.
- Hodnett, E 2002, 'Caregiver support for women during childbirth', in *The Cochrane Library*, Issue 2. Chichester, UK: John Wiley and Sons.
- Hollins Martin, C 2008, 'A tool to measure fathers' attitudes and needs in relation to birth', *British Journal of Midwifery*, 16, 7, pp. 432–437.
- Homer, C, Brodie, P & Leap, N 2008, *Continuity of care*. Sydney: Elsevier.
- Hirst, C 2005, *Rebirthing: Report of the review of maternity services in Queensland*. Brisbane: Queensland Health.

- Hundley, V, Tucker, J, van Teijlingen, E, Kiger, A, Ireland, J, Harris, F, Farmer, J, Caldwell, J & Bryers, H 2007, 'Midwives' competence: Is it affected by working in a rural location?' *MIDIRS Midwifery Digest* 17, 4, pp. 490–497.
- Hutchinson, S, Wilson, M & Wilson, H 1994, 'Benefits of participating in research interviews', *Image: Journal of Nursing Scholarship*, 26, 2, pp. 161-164.
- Imeson, M & McMurray, A 1996, 'Couples' experiences of infertility: A phenomenological study' *Journal of Advanced Nursing*, 24, 5, pp. 1014–1022.
- Ireland, J, Bryers, H, van Teijlingen, V, Hundley, V, Farmer, J, Harris, F, Tucker, J, Kiger, A & Caldwell, J 2007, 'Competencies and skills for remote and rural midwifery care: A review of the literature', *MIDIRS Midwifery Digest*, 17, 3, pp. 434–440.
- International Confederation of Midwives 2005, *Definition of the midwife*, 19th July, 2005, Brisbane, Australia.
- Keltner, NL, Schwecke, LH & Bostrom, CE 2003, *Psychiatric nursing*. 4th edn. St Louis: Mosby.
- Kildea, S 2003, 'Risk and childbirth in rural and remote Australia', paper presented at the 7th National Rural Health Conference: The art and science of healthy community: Sharing country know-how, Hobart, Tasmania, 1–4 March.
- Kildea, S 2006, 'Risky business: Contested knowledge over safe birth services for Aboriginal women', *Health Sociology Review*, 15, 4, pp. 387–396.
- Kirkham, M 2007, 'Traumatised midwives', *Association for Improvements in Maternity Services Journal*, 19, 1
<http://www.aims.org.uk/Journal/vol9no1/traumatisedMidwives.htm>
 Accessed 23.3.08
- Kitzinger, S 1962, *The experience of childbirth*. London: Victor Gollancz.
- Klein, M 2005, 'Obstetrician's fear of childbirth: How did it happen?', *Birth*, 23, 3, pp. 207–209.
- Koch, T 1998, 'Story telling: Is it really research?', *Journal of Advanced Nursing*, 28, 6, pp. 1182–1190.
- Kornelsen, J & Grzybowski, S 2005, 'The costs of separation: The birth experiences of women in isolated and remote communities in British Columbia', *Canadian Woman Studies*, 24, 1, pp. 75–80.
- Kornelsen, J & Grzybowski, S 2006, 'The reality of resistance: The experiences of rural parturient women', *Journal of Midwifery and Women's Health*, 51, 4, pp. 260–265.

- Kornelsen, J & Grzybowski, S 2008, 'Obstetric services in small rural communities: what are the risks to care providers?' *Rural and Remote Health*, 8, 943 (Online).
- Lavender, T & Chapple, J 2003, *Evaluation of different models of maternity care. The views of women and midwives*. London: Department of Health.
- Laws, P & Sullivan, E 2005, *Australia's mothers and babies 2003*. Sydney: AIHW National Perinatal Statistics Unit (Perinatal Statistics Series No. 16).
- Leap, N 1997, 'Making sense of 'horizontal violence' in midwifery', *British Journal of Midwifery*, 7, 3, pp. 160–163.
- Leeman, L & Leeman, R 2002, 'Do all hospitals need caesarean delivery capability? An outcomes study of maternity care in a rural hospital without onsite caesarean capability', *The Journal of Family Practice*, 51, 2, pp. 129-134.
- Leonard, V 1994, 'A Heideggerian phenomenological perspective on the concept of a person', in P. Benner (ed.), *Interpretive phenomenology*. Thousand Oaks, California: Sage Publications, pp. 43–63.
- Lundgren, I 2005, 'Swedish women's experience of childbirth 2 years after birth', *Midwifery*, 21, pp. 346–354.
- McMurray, I, Connolly, H, Preston-Shoot, M & Wigley, V 2008, 'Constructing resilience: Social workers' understanding and practice', *Health and Social Care in the Community*, OnlineEarly Articles, accessed 2.4.08.
- Minichiello, V, Sullivan, G, Greenwood, K & Axford, R 2004, *Research methods for nursing and health science*. 2nd edn. Sydney: Prentice Hall.
- Moster, D, Lie, R & Markestad, T 2001, 'Neonatal mortality rates in communities with small maternity units compared with those having larger maternity units', *British Journal of Obstetrics and Gynaecology*, 108, pp. 904–909.
- National Consensus Framework for Rural Maternity Services* 2008, Rural Health Workforce Australia, Royal Australian College of General Practitioners, Rural Doctors Association of Australia, Australian College of Midwives, Australian College of Rural and Remote Medicine, Royal Australian College of Obstetricians and Gynaecologists.
- National Institute for Clinical Excellence 2005, 'The use of electronic fetal monitoring' *NICE Guideline C*. www.nice.org.uk/guidance Accessed 17.6.08.
- NSW Health 2003, *The NSW Aboriginal perinatal health report*. Sydney: NSW Department of Health.
- NSW Health 2007a, *A new direction for NSW: State health plan towards 2010*, Sydney: NSW Government.

- NSW Health 2007b, *NSW mothers and babies 2005*. Sydney: NSW Government. www.health.nsw.gov.au/pubs/2007/pdf.mdc05.pdf accessed 29.7.08.
- Oakley, A 1993, *Essays on women, medicine and health*. Edinburgh: Edinburgh University Press.
- Orr, S, Reiter, J, Blazer, D & James, S 2007, 'Maternal prenatal pregnancy-related anxiety and spontaneous preterm birth in Baltimore, Maryland', *Psychosomatic Medicine*, 69, pp. 566–570.
- Parliament of Australia 1999, 'Rocking the cradle: Inquiry into childbirth procedures'. Canberra: Senate Community of Affairs Committee.
- Parsons, J, Merlin, T, Taylor, J, Wilkinson, D & Hiller, J 2003, 'Evidence-based practice in rural and remote clinical practice: Where is the evidence?', *Australian Journal of Rural Health*, 11, pp. 242–248.
- Reiger, K & Dempsey, R 2006, 'Performing birth in a culture of fear: An embodied crisis of late modernity', *Health Sociology Review*, 15, 4, pp. 364–373.
- Roberts, K & Taylor, B 1998, *Nursing research processes: An Australian perspective*. Melbourne: International Thomson.
- Rosenblatt, R, Reinken, J & Shoemack P 1985, 'Is Obstetrics safe in small hospitals? Evidence from New Zealand's regionalised perinatal system', *The Lancet*, 24, pp. 429–432.
- Rourke, J 1998, 'Trends in small hospital obstetrical services in Ontario', *Canadian Family Physician*, 44, pp. 2117–2124.
- Roxon, N 2007, *Audit of health workforce shortage in rural and regional Australia*, Department of Health and Ageing, Media Release 10.12.07.
- Scherman, S, Smith, J & Davidson, M 2008, 'The first year of a midwifery-led model of care in far north Queensland', *eMedical Journal of Australia*, 188, 2, pp. 85–88.
- Simpson, K & Thorman, K 2005, 'Obstetric "conveniences": Elective induction of labor, Caesarean birth on demand and other potentially unnecessary interventions', *Journal of Perinatal and Neonatal Nursing*, 19, 2, pp. 134–144.
- Sonn, C & Fisher, A 1998, 'Sense of community: Community resilient responses to oppression and change', *Journal of Community Psychology*, 28, 5, pp. 457–472.
- Stott, K (Presenter) 2005, 'Colours of Caroline', *Australian Story* Television Production: Sydney: Australian Broadcasting Commission.

- Tracy, S, Barclay, L & Brodie, P 2000, 'Contemporary issues in the workforce and education of Australian midwives', *Australian Health Review*, 23, 4, pp. 78–88.
- Tracy, S, Sullivan, E, Dahlen, H, Black, D, Wang, Y & Tracy, M 2006, 'Does size matter? A population-based study of birth in lower volume maternity hospitals for low risk women', *BJOG: An International Journal of Obstetrics and Gynaecology*, 113, 1, pp. 86–96.
- Tracy, S & Tracy, M 2003, 'Costing the cascade: Estimating the cost of increased obstetric intervention in childbirth using population data', *British Journal of Obstetrics and Gynaecology*, 110, pp. 717–724.
- Trewin, D & Madden, R 2005, *The health and welfare of Australia's Aboriginal and Torres Strait Islander Peoples*. Canberra: Australian Bureau of Statistics and Australian Institute of Health and Welfare.
- Uvnas Moberg, K 2003, *The oxytocin factor: Tapping the hormone of calm, love and healing*. Cambridge Ma: Da Capo Press.
- van Wagner, V, Epoo, B, Nastapoka, J & Harney, E 2007, 'Reclaiming birth, health and community: Midwifery in the Inuit villages of Nunavik, Canada', *Journal of Midwifery and Women's Health*, 52, 4, pp. 384–391.
- Viisainen, K, Gissler, M & Hemminki, E 1994, 'Birth outcomes by level of obstetric care in Finland: A catchment area based analysis', *Journal of Epidemiology and Community health*, 48, pp. 400–405.
- Wadhwa, P 2005, 'Psychoneuroendocrine processes in human pregnancy influence fetal development and health', *Psychoneuroendocrinology*, 30, pp. 724–743.
- Wagner, M 2007, 'Birth and power', in W Savage (ed.), *Birth and power*. London: Middlesex University Press, pp. 35–44.
- Walsh, D & Downe, S 2006, 'Appraising the quality of qualitative research' *Midwifery*, 22, pp. 108–119.
- Watson, J, Hodson, K & Johnson, R 2002, 'Developing strategies to gather information about the maternity experiences of Indigenous women in acute care settings', *Australian Journal of Rural Health*, 10, pp. 147–153.
- Wu, S, Kocherginsky, M & Hibbard, J 2005, 'Abnormal placentation: Twenty year analysis', *American Journal of Obstetrics and Gynecology*, 192, 5, pp. 1458–1461.
- Younger, J 1995, 'The alienation of the sufferer', *Advances in Nursing Science*, 17, 4, pp. 53–72.

Appendix 1: Closest town population, distance for antenatal care and birth and synopsis of birth outcomes

Key:

Population of town:	Place of birth:	Birth outcomes:
1 = <100 2 = 101 – 499 3 = 500 – 999 4 = 1,000 – 1,999 5 = 2,000 – 3,999 6 = >4,000	A = Home B = Side of Road C = Ambulance D = District/Rural Hospital E = Private Hospital F = Base Hospital G = Tertiary Referral Centre H = Midwifery-led Birth Centre	1 = Mother and baby well 2 = Mother well, baby unwell 3 = Mother unwell, baby well 4 = Mother and Baby unwell C/S = Caesarean Section C/S3 = Caesarean Section with triplets IOL = Induction of labour NVB = Normal vaginal birth NVB2 = Twins VBreech = Vaginal breech birth VBAC = Vaginal birth after Caesarean

Pregnancy/Birth # (Participant #)	Home Code	Distance travelled for ANC (kms/hrs)	Place of Birth Code	Distance travelled for birth (kms/hrs)	Birth Outcome
1 (2)	4	280 / 3.5	G	589 / 7	NVB - 1
2 (2)	6	350 / 4	H	650 / 8	NVB - 1
3 (3)	5	180 / 2	E	300 / 3.25	Vbreech - 1
4 (5)	6	N/A	D	N/A	NVB - 1
5 (6)	1	102 / 2	F	102 / 2	NVB - 1
6 (6)	1	102 / 2	F	102 / 2	NVB - 2
7 (7)	3	134 / 1.5	F	211 / 2.5	NVB - 1
8 (7)	3	211 / 2.5	D (en route)	134 / 1.5	NVB - 1
9 (7)	3	211 / 2.5	F	211 / 2.5	NVB - 1
10 (8)	6	350 / 4	F	350 / 4	NVB - 1
11 (8)	6	350 / 4	F	350 / 4	IOL/VB - 1
12 (8)	6	350 / 4	F	350 / 4	NVB - 1
13 (9)	2	200 / 2.5	E	200 / 2.5	IOL - C/S - 1
14 (9)	2	200 / 2.5	D (en route)	120 / 1.75	VBAC - 1
15 (10)	6	200 / 2.25	E	765 / 9	NVB - 1
16 (10)	6	200 / 2.25	E	765 / 9	C/S - 1
17 (11)	6	102 / 1.25	F	102 / 1.25	NVB - 1
18 (12)	4	109 / 1.5	F	109 / 1.25	NVB - 1
19 (12)	4	109 / 1.5	F	109 / 1.25	NVB - 1
20 (13)	1	350 / 4	E	350 / 4	IOL /VB - 1

Pregnancy/Birth # (Participant #)	Home Code	Distance travelled for ANC (kms/hrs)	Place of Birth Code	Distance travelled for birth (kms/hrs)	Birth Outcome
21 (13)	1	350 / 4	C (en route)	200 / 2.5	NVB - 3
22 (14)	4	300 / 3.25	E	300 / 3.25	IOL / VB / PPH - 3
23 (14)	4	300 / 3.25	E	300 / 3.25	NVB - 1
24 (15)	4	400/ 4.5	E	400 / 4.5	IOL / VB -1
25 (15)	4	400 / 4.5	E	400 / 4.5	IOL / VB -1
26 (16)	4	325 / 3.5	E	325 / 3.5	NVB - 1
27 (16)	4	325 /3.5	B (en route)	325 / 3.5	NVB - 1
28 (17)	4	109 / 1.5	F	109 / 1.5	C/S - 1
29 (17)	4	109 / 1.5	F	109 / 1.5	C/S - 1
30 (18)	6	154 / 2 (and home)	A (planned)	Home (and booked 154 / 2)	NVB2 - 1
31 (19)	4	109 / 1.5	F	109 / 1.5	C/S - 1
32 (19)	4	109 / 1.5	F	109 / 1.25	C/S - 3
33 (20)	4	325 / 3.5	E	325 /3.5	NVB - 1
34 (20)	4	325 / 3.5	E	325 /3.5	C/S - 2
35 (22)	5	270 / 3.5	D	270 / 3.5	NVB - 1
36 (22)	5	170 / 2.25	D	170 / 2.25	NVB - 1
37 (23)	3	111 / 1.25 225 / 2.75	D	225 / 2.75	IOL - 3
38 (23)	3	200 / 2.25	D	200 / 2.25	C/S - 1
39 (24)	6	0/0 (local Midwife)	F	420 / 4.5	C/S - 1
40 (24)	6	350 / 4	F	350 / 4	C/S - 2
41 (24)	6	350 / 4	F	350 / 4	C/S - 1
42 (25)	6	250 / 3	E	700 / 8.5	IOL - FF - C/S - 1
43 (25)	6	0/0 (RFDS)	E	700 / 8.5	C/S - 1
44 (25)	6	350 / 4	E	700 / 8.5	C/S - 1
45 (26)	6	0/0 (local)	F	672 / 8	C/S - 1
46 (26)	6	0/0 (local)	F	700 / 8.5	C/S - 1
47 (26)	6	700 / 8.5	G	1000 / 12	C/S3 - 2
48 (27)	6	350 / 4	F	350 / 4 (RFDS)	NVB - 3
49 (27)	6	350 / 4	F	350 / 4	NVB - 1
50 (27)	6	350 / 4	F	754 / 9	NVB - 1
51 (28)	6	350 / 4	F	350 / 4 (RFDS)	NVB 30/40 - 2

Pregnancy/Birth # (Participant #)	Home Code	Distance travelled for ANC (kms/hrs)	Place of Birth Code	Distance travelled for birth (kms/hrs)	Birth Outcome
52 (29)	6	0/0 local	G	761 / 9	NVB - 1
53 (29)	6	0/0 local	G	761 / 9	NVB - 1
54 (29)	6	420 / 5	F	350 / 4	NVB - 2
55 (30)	6	350 / 4	F	350 / 4	NVB - 1
56 (30)	6	350 / 4	F	350 / 4	NVB - 1
57 (31)	2	200 / 2.5	E	200 / 2.5	NVB - 1
58 (31)	2	200 / 2.5	A (unplanned)	200 / 2.5	NVB - 1
59 (32)	2	200 / 2.5	E	200 / 2.5	IOL - 1
60 (32)	2	200 / 2.5	E	200 / 2.5	IOL - 1
61 (33)	5	105 / 1.25	D	105 / 1.25	NVB - 1
62 (35)	5	0/0 (local)	F	371 / 4 (RFDS)	IOL - C/S -3
63 (36)	5	0/0 (local)	F	371 / 4	IOL - 1
64 (37)	5	0/0 (local)	F	371 / 4 (RFDS)	IOL - C/S -3
65 (38)	5	0/0 (local)	F	371 / 4	IOL - 2
66 (39)	1	250 / 3	D	250 / 3	NVB - 1
67 (39)	1	250 / 3	D	250 / 3	NVB - 1
68 (39)	1	250 / 3	D	250 / 3	NVB - 1
69 (40)	5	130 / 1.5	D	130 / 1.5	NVB - 1
70 (41)	1	150 / 2	F	150 / 2	NVB - 1
71 (42)	1	115 / 1.5	F	115 / 1.5	NVB - 4
72 (43)	5	95 / 1	D	95 / 1	NVB - 1
73 (44)	5	300 / 3.25	E	300 / 3.25	NVB - 1
73 (45)	1	100 / 1	F	115 / 1.5	NVB

Appendix 2: Cover letter to potential participants

(Printed on Charles Sturt University Letterhead)

Dr Elaine Dietsch
Principal Investigator: Midwifery Research Team
Charles Sturt University
School of Clinical Sciences

Date

Telephone: 02 69 332782
Fax: 02 69 332866
Email: edietsch@csu.edu.au

Dear

Thank you for considering participating in the research project, *Women's experiences of birthing away from their rural and remote NSW communities*, which will be listening to women's experiences of having to move away from their home community to give birth. During this project, it is the depth of your experience and your willingness to share that will be highly valued.

The enclosed information is designed to give you more details about the project. If you have any questions or concerns then please contact me on 69 332782 and I would be very happy to discuss them with you. If you ring me and leave your phone number, I will return your call, to reduce the cost of the phone call for you. If you prefer, you could email me.

If, after reading the information, you would like to participate in the study, would you be kind enough to complete the consent form enclosed and return it in the stamped, self-addressed envelope. I will then contact you to arrange a time and place that suit you for the taped interview.

Thank you for considering this invitation to participate.

Yours sincerely

Elaine Dietsch
On behalf of the Midwifery Research Team

Appendix 3: Plain language statement

(Printed on Charles Sturt University Letterhead)

INFORMATION STATEMENT

Women's experiences of birthing away from their rural and remote NSW communities

The purpose of this study is to learn from you about your experience when you had to move away from your home community in rural/remote NSW to give birth to your baby. Women like you who have had to move away from their home community to give birth in the last two years, will be interviewed by one or two members of the Midwifery Research Team. All interviewers are Registered Midwives who are employed as lecturers at Charles Sturt University (CSU) at Wagga Wagga.

The initial interview will last approximately one hour. One to two other much shorter interviews may be required to ensure that the information you have shared and the way we have interpreted your story are accurate and true. These subsequent interviews may be by telephone. The first interview will be audiotaped and then written out word for word. These taped and written interviews will then be studied extremely closely by the Midwifery Research Team. The knowledge gained from you during the interview will then be used to increase understanding and positively influence midwifery practice in rural and remote areas of NSW.

Each interview will be different, because the researcher will follow your lead – it is your story that is important to us! During the interview you will be asked to describe, in as much depth as possible:

1. Your experiences during pregnancy and birth;
2. The impact for you when you transferred to a larger centre to give birth; and
3. Anything else that you believe is significant or may have some relevance.

Should you have any questions or concerns before, during or after the interview, then please feel free to express them at any time and we will do our best to answer them. You may choose to turn the tape recorder on or off at any time.

Some women may find sharing during the interview an upsetting experience. The recalling of traumatic and/or distressing events can be extremely difficult for some women. Throughout the interview and following it, you will be offered time to discuss issues, ask questions and seek further information. A referral to a counsellor can be given if you desire.

Your interview will be audiotaped, written out and then studied very carefully. You will be able to choose another name for the written transcript and all identifying information will be changed. The town where you live will not be identified. The audiotapes and a copy of the typed interview will be stored in a locked filing cabinet in a university office until the conclusion of the study. Five years later they will be destroyed.

Please know that you are under no pressure to participate. Your decision to choose to participate or not will be known by no other person except the research team members interviewing you and I, unless you choose to tell someone. Your decision to choose to participate or not, is respected.

You may withdraw from the study at any time. Should you withdraw from the study, all tapes and transcripts will be destroyed and not used as part of the research.

Please know that you have the following rights:

- absolute confidentiality;
- you are under no pressure to participate and may withdraw at any time;
- if you choose to withdraw from the study, all tapes and typed transcripts of your interview will be destroyed;
- to choose your own identifying information (false names etc);
- should you share any information that shows a child is at risk of physical, emotional or sexual abuse, then please know that the interviewer has the moral and legal obligation to notify the *Department of Community Services* who will help ensure that child is protected;
- to have the interview at your choice of venue and at a time that is convenient for you and available to the interviewer;
- to share as much or as little information as you would like and you may always refuse to answer a question or discuss an issue;
- to turn the audiotape on or off at any time; and
- to complain, if ever you feel the researcher may be acting unethically.

The results of this research project will be published in professional midwifery and health journals and will be presented at conferences. It is hoped that findings from this research project will be used to inform and influence practice and policy related to maternity services in rural and remote NSW.

Charles Sturt University's Ethics in Human Research Committee has approved this project. If you have any complaints or reservations about the ethical conduct of the project, you may contact the Committee through the Executive Officer:

Executive Officer
Ethics in Human Research Committee
The Grange
Charles Sturt University
Bathurst NSW 2795

Phone: 02 6338 4628
Fax: 02 6338 4194

Any issues you raise will be treated in confidence and investigated fully and you will be informed of the outcome.

For any more information, please contact the principal researcher:

Dr Elaine Dietsch
Principal Investigator: Midwifery Research Team
Charles Sturt University
School of Clinical Sciences

Telephone: 02 69 332782
Fax: 02 69 332866
Email: edietsch@csu.edu.au

Appendix 4: Informed consent form

(Printed on Charles Sturt University Letterhead)

INFORMED CONSENT FORM

Women's experiences of birthing away from their rural and remote NSW communities

Principal investigator:
Dr Elaine Dietsch
Principal Investigator: Midwifery Research Team
Charles Sturt University
School of Clinical Sciences

Telephone: 02 69 332782
Fax: 02 69 332866
Email: edietsch@csu.edu.au

I,, being aged over 18 years, consent to my participation in the research project entitled, *Women's experiences of birthing away from their rural and remote NSW communities*.

The purpose of the research has been explained to me, including the potential risks and discomforts associated with the research. I have read and understood the written explanation given to me and I have been given the opportunity to ask questions about the research and received satisfactory answers. I understand that I am free to withdraw my participation in the research at any time and that if I do I will not be subjected to any penalty or discriminatory treatment.

I understand that the interview will be audiotaped. I understand that any information or personal details gathered in the course of this research about me are confidential and that neither my name nor any other identifying information will be used or published.

Charles Sturt University's Ethics in Human Research Committee has approved this study. I understand that if I have any complaints or concerns about this research I can contact:

Executive Officer
Ethics in Human Research Committee
Academic Secretariat
Charles Sturt University
Private Mail Bag 29
Bathurst NSW 2795

Phone: 02 6338 4628
Fax: 02 6338 4194

Signed by:

Date:

Name printed:

.....

Address:

.....

.....

.....

.....

Telephone:

.....

Appendix 5: Non-standard questionnaire

NON-STANDARD QUESTIONNAIRE

Feminist principles will guide the research project and the interview process. Each participant is recognised as more than a source of data – she is exquisitely a person. It is the participants' stories that are essential to this project and their experiences are accepted as both valid and valuable.

Data will be collected during indepth interviews with either one or two of the research team members, depending on the desires of the woman. Interviews will resemble a conversation rather than a survey, questionnaire or interview per se. Non-specific, open-ended prompts that are designed to avoid influencing participants' responses in any way will be utilised. Prior to the first interview, participants will be given information that they will be asked to share information related to two prompts. The first will relate to their pregnancy and birth experience. The second will relate to the impact of being transferred to a referral centre. These are the primary prompts and the only definitive 'questions' to be asked, although participants are invited to share anything else they believe is relevant or significant.

However, it is anticipated that women may raise more specific issues and on doing so, the researcher may utilise other prompts or probes to learn more from the woman. These prompts have been modified but are based on those used by Kornelsen and Grsybowski (2006). They are not directive, exhaustive or complete but may include concepts such as the woman's perception/experience of:

Childbirth experiences, for example:

- the circumstances during which she left her home community to go to the referral centre
- what was it like to leave
- what was her greatest concern
- who went with her for personal support and were these the people she would have chosen
- did she need to leave extended family, other children, partner and how was that for her
- what arrangements had to be made in order for her to leave
- how was the trip to the referral hospital/town
- did she feel safe on the journey and/or on her arrival
- what a good birth and/or a safe birth means to her.

Services and care providers, for example:

- maternity services available in the local area
- satisfaction with services in both her home community and those at the referral unit
- how well did those services meet her practical, emotional, physical and/or spiritual needs
- what are the most important maternity services

- in an ideal world, what services would be offered
- how have maternity services changed over the past number of years
- does she or anyone close to her have experience of birthing in the home community and if so, how did that experience differ from the most recent birth
- how maternity services might be improved for women in her town/area
- how choices were respected or disrespected by caregivers, the health system and/or her family
- assessment of professional support given to her during pregnancy, birth and afterwards
- were the caregivers present at the birth those people she would have chosen to be there
- was there anyone she would have liked to have been with her who wasn't.

Practical concerns, for example:

- related to finances, child care, own or partner's employment
- relationships with partner, children, family, friends
- possible future experiences.

© Charles Sturt University 2008

ISBN: 978-1-86467-205-3