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Qualitative Experiences of Rural Postpartum Women and Implications for Rural Social Work

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Abstract. Geographic barriers and shortages of healthcare professionals in rural America have been well documented. These barriers and shortages influence rural women's access to maternity and associated healthcare services during pregnancy and mothers' postpartum period, but their perspectives about these realities have been overlooked. Semi-structured interviews with 24 mothers residing in a rural North Dakota county were conducted to understand their perspectives about both accessing healthcare services and parenting children in a rural context, with emphasis on understanding these mothers' experiences using non-rural maternity care. Thematic analysis of qualitative interview data led to the emergence of three core themes. First, mothers in the sample minimized geographic barriers they had to overcome to access healthcare despite describing significant travel and weather challenges. Second, mothers expressed concern over the lack of affordable and flexible childcare in their rural community. Finally, mothers described different experiences within rural and non-rural settings, noting specific advantages and disadvantages of each. Although our findings cannot be generalized to other rural mothers, local qualitative inquiry can inform and improve the competency of social work services within rural communities.

Keywords: rural, women's health, maternity care, healthcare access, childcare

With nearly all (99.1%) U.S. births occurring in hospitals, hospital-based maternity care is crucial to pregnant women; yet rural women often have limited access to maternity care (Martin et al., 2010; Xu et al., 2009). Rural counties continue to experience steep declines in the availability of hospital-based maternity services. While maternity services were available in 76% of rural counties in 1985, by 2002, only 56% of rural counties maintained these services. In remote rural communities, this trend has been even more pronounced. In 1985, hospital-based maternity care was available in 50% of remote counties; but by 2002, only about 20% of remote counties had hospitals offering maternity care (Zhao, 2007).

As a consequence, rural women face fewer choices in terms of their health needs. Almost half of all U.S. counties had no practicing obstetrician-gynecologists in 2005; and after accounting for population in rural communities, non-metropolitan counties had far fewer obstetrician-gynecologists than metropolitan counties (1.4 vs. 3.3 per 10,000 women) (DHHS, 2007). Family physicians who provide maternity care have also become increasingly rare. In 2000, 23.3% of family physicians provided maternity care; whereas by 2010, this percentage had

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declined to only 9.7% (Tong et al., 2013). Given that many rural maternity services are provided by family physicians, rural women are particularly influenced by this trend.

While social workers may not address the immediate medical needs of pregnant women, rural social workers certainly address many of the psychosocial needs of women during their pregnancies and as new mothers. The generalist social work model is widely used in rural settings, in large part due to the various types of social services a social worker must interact and utilize within in a small community (Riebshleger, 2007). These social services can include: the child welfare system, financial assistance, nutritional counseling, subsidized housing, domestic violence resources, substance abuse, and mental health services.

Yet, there are also shortages of social workers who serve rural areas. Over half of rural counties have no clinical social workers (Gamm, Stone, & Pittman, 2003), and 80% of MSW-level social workers practice exclusively in metropolitan areas (Gale & Lambert, 2006). Due to the comprehensive nature of issues in some rural communities, social work shortages are consequential for rural women's health because of the various supports that social workers can provide.

Besides professional shortages, rural women face barriers simply because of the geographic distance to various healthcare and social service providers in more populated communities. For example, Fordyce, Chen, Doescher, and Hart (2007) found that nearly 40% of all rural residents lived in a community over 60 minutes from an urban area. In many U.S. states, rural residents are a large proportion of the total state population. For example, in an analysis of all 2008 public birth records by Gjesfjeld and Jung (2011), 17.4% of all North Dakota mothers gave birth at a hospital over 40 miles from their county of residence.

Despite professional shortages and geographic barriers, the social work profession continues to work alongside rural women as they navigate their pregnancies and the experience of being a new mother. Given the high rates of poverty in many rural places, rural women may interact with multiple rural social service systems, including the supplemental nutrition for Women, Infant, and Children (WIC) program, financial assistance programs such as Temporary Assistance for Needy Families (TANF) program, housing subsidy programs, as well as the child welfare system. Therefore, given that rural social workers are likely to be on the front-line of providing direct services to rural mothers, there is a need for greater awareness of the rural realities and experiences of rural mothers.

Qualitative Inquiry: Moving Toward Cultural Competency in Rural Social Work

Besides a few examples of international research on the health needs of rural women, particularly from Canada (Cummins, 2005; Kornelsen & Grzybowski, 2006; Kornelsen, Kotaska, Waterfall, Willie, & Wilson, 2010; Leipert & George, 2008), there is limited U.S.-based research on the experiences and needs of rural women seeking healthcare in general, or more specifically, maternity care. This gap in the literature is particularly concerning because of the importance of culturally competent practice in the field of social work. Daley and Pierce (2011) note that culturally competent social work demands an understanding of the worldview of rural people. With a specific focus on the education of social workers, they write:

Students require the development of cultural competence in their educational preparation to recognize and respond appropriately to the needs of clients and communities. The development of this competence should be an important priority, especially in programs that have rural communities as an important part of their service area. (p. 131)

Further, many models of intervention were developed in urban contexts, and therefore are embedded with assumptions that may or may not reflect the rural experience. As Weinert and Long (1987) assert:

Professionals cannot successfully superimpose models based on urban experiences or professional traditions when dealing with rural populations. The environmental realities of rural living, including distances and work demands, as well as the worldview and values of rural people, must be carefully assessed. The unique aspects of each rural population must be included in any equation which is to yield a relevant, effective human service program for them. (p. 454)

Rural research can unlock greater understanding for rural social work but can also inform urban providers who increasingly work with rural residents. Without greater awareness of rural experiences, we are apt to rely on stereotypes of rural women that are inaccurate. As Kenkel (2003) writes, “by identifying concepts important to different cultural groups and to the *silenced* rural women, culturally sensitive prevention and treatment services can be designed” (p. 189).

Purpose of the Study

Rural research has documented objective barriers rural residents face when seeking healthcare services, such as distance to care, provider shortages, as well as the lack of resources and services; however, we were interested in mothers’ subjective perceptions about these barriers in their community. Thus, the purpose of this study was to qualitatively assess the experiences of 24 rural mothers as they sought healthcare associated with their pregnancy, with emphasis on how these rural women perceived geographic barriers to care. We were also interested in rural women’s perceptions of their community as they began parenting their new child.

Method

Our research was approved by the University of North Dakota Institutional Review Board. With a philosophical stance of pragmatism, we sought to consider the potential connections between these mothers’ experiences and “the outcomes of the research—the actions, situations, and consequences of inquiry” (Creswell, 2006, p. 22). Our research questions were formed with the assumption that women’s responses could be used to improve the services provided to them both within and outside their community. Ultimately, we saw our inquiry as a method for hearing the voices of rural mothers and improving the cultural competency of rural social work practice directed at these mothers.

Despite a clear focus that our conversations with mothers could improve understanding of a rural worldview, our research was also consistent with the aims of phenomenological inquiry. We sought (a) meanings behind human experiences, (b) made efforts not to predict or determine causality, and (c) described experiences rather than using measurements or ratings (Moustakas,

1994). Mothers in our sample had the shared experience of living in a rural community and travelling outside their community to birth their child.

While interviews maintained flexibility to allow for new themes to emerge from the interviews, we did create common interview probes that could provide us some “windows” into their worldviews. All interviews included the following interview questions:

- Tell me about getting to the hospital. What would have been your ideal experience? Did it go how you thought?
- What is the best part of being a mother here? What is the most challenging? What does it mean to you to be a mother?

Sample

Our research reports findings from semi-structured qualitative interviews conducted in November and December of 2010 with twenty-four “new” mothers from a rural county in North Dakota. (All mothers had an infant less than 18 months of age). These women were recruited through one WIC office. This office was within a city that had a population of roughly 4,000 individuals. WIC provides nutrition education and food vouchers to low-income women who are pregnant, postpartum, or breastfeeding, as well as infants and children up to age 5. Due to the eligibility requirements for WIC, all mothers interviewed had family incomes that did not exceed 185% of the federal poverty line.

Participating mothers ranged in age from 18-32 years, with an average age of 24 years. Approximately 70% of the mothers identified as White (N = 17), while one-quarter (N = 6) identified as Mexican-American. One mother (4%) identified as Native American. Fifteen (63%) of the mothers were married, and nine (38%) were single. More than half of the mothers (54%) indicated that they worked outside the home, either part-time or full-time (N = 13), and 38% (N = 9) described themselves as “stay-at-home moms.” Two mothers (8%) were students. All of these mothers described travelling an average of 50 miles, one-way, for delivery services for their babies. Many of these mothers also reported making frequent trips over their third trimester for prenatal visits.

Analysis

Interviews were digitally recorded with participants’ permission and transcribed verbatim. A female research assistant in the Master of Social Work graduate program conducted the interviews. This student and the lead investigator met regularly throughout the study to ensure comparable question probes were being utilized over the course of the interviews while also incorporating new information and understandings into subsequent interviews. As compensation for their time participating in the study, a \$25 gift card from a local grocery store was provided.

Thematic analysis was utilized to identify core ideas and unified impressions that emerged from the interviews. First, we began with line-by-line coding from the complete transcripts, an open-coding strategy that focuses on the specific aspects of the data by using participants’ own language and meanings (Strauss & Corbin, 1990). We then grouped codes into

larger thematic categories, or axial codes, representing common themes that emerged from the interviews. Both the principal investigator and research assistant independently reviewed these axial codes and collapsed them into core categories representing the most variation in mothers' perceptions and behavior. We engaged in ongoing dialogue over multiple months to produce a comprehensive inventory of ideas, expressions, terms, and phrases that accurately reflected these thematic categories. We also used quantifying techniques (e.g., tables) to confirm that we had reached consensus among our broad thematic categories.

Results

The thematic categories that best reflected interviews included (a) minimization of geographic barriers to care, (b) challenge of obtaining rural childcare, and (c) cost and benefit of rural parenting.

Minimizing Geographic Barriers to Healthcare: "It's Not That Bad"

Mothers psychologically minimized geographic barriers to maternity services regularly. Although women traveled an average of nearly two hours round-trip for prenatal and delivery services, they matter-of-factly described how they coped with the distance between them and their healthcare. The majority of women conceptualized maternity-related healthcare as merely one more resource not found in their specific community, akin to a large grocery store or large commercial retail store. When asked directly about the travel associated with attending prenatal appointments or the travel experienced on the day of the delivery, mothers described this as simply a rural reality. As one woman shared, "It would be nice that I would not have to drive, but that is an ideal world. But that's not going to happen, haha!" Another woman similarly noted, "I wish it was closer, but it was OK." Some women acknowledged that travelling for prenatal appointments meant they would be missing employment, yet also seemed to minimize the impact this had on their personal economic situation. For example, one mother noted, "I don't want to say it was stress. I think it was just more of a hassle from work."

Although mothers minimized the stress associated with their travel to healthcare, they admitted that travel was more complicated when their scheduled delivery was during winter. One mother simply noted it was "really, really stressful, because you run the risk of flipping over or going into the ditch." For another mother, the winter weather proved more difficult because of unreliable transportation. She shared:

It was very overwhelming and hard because it was around wintertime. It was already snowing, and the roads were all ugly. . . We actually got stranded there [while in labor]. I have a Trail Blazer and it actually wouldn't go past 45 I believe. For some odd reason, it kept turning off. It was dark. I was freaking out. I was like 'hello, we have to get out of here.'

For another mother, it appeared a health care provider had inquired about her travel to the hospital, but ultimately, she coped with the realities of winter without hospital assistance. She explained:

All my babies were winter babies so I usually got asked about the weather and how was the drive. . . . She was due [when] there was a snowstorm and we were stuck at home. Luckily she [my baby] was late.

Although respondents seemed to minimize the personal impact of travel on their healthcare, a number of conditions were required for rural mothers to use maternity care outside of their community: reliable transportation, financial resources for gasoline, and the time to make the trip. In some situations, women did not have these resources. As one woman noted, “We had vehicles breaking down and then we didn’t have a ride and sometimes we didn’t have money to go [to prenatal visits].”

Mothers and the Challenge of Rural Childcare

While we did not begin our research considering rural childcare, the challenge of rural childcare quickly emerged in our early interviews, with a particular focus on financial burden and scheduling difficulties. For example, one woman shared, “For having three kids in daycare it was gonna cost us, like, 1200 dollars a month and I just was like ‘oh, heaven’s no.’” The high cost of care also influenced decisions about employment, as exemplified by a woman who explained, “Anything that pretty much that I could get would not pay enough to pay for daycare for all the kids so it was just kind of a . . . not worth it to work at that point.”

Women who were interested in working shortly after their delivery described having to make difficult decisions about the care of both their newborn and the care of other children because of the structure of rural childcare. One woman described the struggle she faced when she was unable to find a childcare provider who could accommodate her work schedule. For this woman, leaving employment was a significant personal sacrifice.

I was working, you know, full-time. I loved my job. I worked for a farmer. Drove truck for him and stuff. . . . She [childcare provider] said she could be booked for up to 3 years. So my problem is I don’t have a daycare. So I had to quit my job and stay home.

For another woman, she found it difficult to find care for her newborn. She stated, “All the daycares are full or they don’t accept babies or children who aren’t potty-trained. I work overnights so that makes it even harder ‘cause there’s absolutely no daycare for overnights.”

It was clear that when mothers could not find daycare and did not have help from family or friends, they saw some part of their life would be compromised. This was demonstrated by one mother as she considered graduation. “They [the school] worked with me and they all tried to get me to graduate, but when he was born I did not have daycare and my mom could not stay home with him from work.” While some women described having to quit their jobs or school due to childcare issues, some described working with their partners to share childcare responsibilities while they both attempted to work. One woman said:

I don’t know, I just don’t really have a childcare. Between him and me, we try to work something out. Basically like we try to work it to where I don’t have to worry about babysitters for a long amount of time or whatever. I usually find a

way so that we don't have to put them in daycare. It's expensive anyway, very expensive.

Parenting in Rural Communities: A Mixed Picture

Respondents were asked about perceived benefits and challenges of parenting within a rural community. Mothers frequently described their connections with others and the feeling of safety as the biggest benefits of parenting in a rural community. One woman explained, "You know who your children are playing with and where they are. . . . My oldest daughter has a friend who lives right across the street so I just watch her from my window when she is going to play so that is really handy." In addition to knowing their neighbors, these mothers identified safety as a benefit of parenting in their community. One mother shared, "The town is very peaceful. I am not afraid of like leaving my door unlocked when I forget. I don't feel like somebody going to come in and like rob our house or whatever."

Conversely, these women identified the lack of resources and activities for themselves and their children as a concern in their community. One mother said, "There is not much we do around here. . . . It is a problem." Many women echoed this sentiment, suggesting their community needed more activities for kids. For example, given the cold climate and long winters, a number of mothers described the need for affordable options for indoor play. One woman simply said, "just anything indoors". Another mother suggested the need for an "indoor play area . . . but something that was affordable for moms on a one-family income". A number of women independently voiced this idea of an indoor play structure, referencing a type of playground located at a regional mall located 40 miles away from their community. One mother mentioned that their community previously had a bowling alley and video arcade that provided some community entertainment for children.

These impressions about their community also led to discussions of rural mothers' perceptions of, and contrasts between, rural and non-rural healthcare services. Mothers viewed the non-rural hospital as having more resources, such as advanced technologies and specialists. One woman, impressed at the choices and professionals available to her, shared these impressions about her postpartum time in the hospital, "I kind of liked the bigger hospital system where they do not really know you . . . all the different people had come in, you know, describing the diets. I had somebody come in and talk to me about the lactation and everything as he was having troubles latching on."

Alternatively, some mothers commented on the more personal touch and slower pace of rural hospitals. One mother explained, "They were friendlier here [local] than over there [non-rural delivery hospital]. Over there was most like rush, rush, rush, rush and I did not like that." In the larger, non-rural hospital, some of the women felt anonymous when trying to navigate care. One woman who experienced depressive symptoms after her delivery, described challenges and barriers she faced when attempting to engage with the larger hospital:

When we tried reaching out to them [delivery hospital], they were always busy or they were always booked. Like if it was not an emergency they booked you out a month from when I called. I was like, 'what am I going to do that whole month?' . . . I am going to go crazy so I never really went back to the [hospital].

Discussion

In sum, our sample of rural mothers (a) minimized geographic barriers to maternity care; (b) experienced difficulty obtaining rural childcare; and (c) saw differences between rural and non-rural healthcare and community environments.

We found rural women's minimization of geographic barriers to healthcare unexpected. Instead of frustration or anger about the travel burden to maternity care, mothers clearly placed the responsibilities of obtaining healthcare services squarely upon themselves. In fact, mothers perceived geographic distance from resources as a basic reality of living in a rural place. While the origin of this worldview was not obvious, one plausible explanation is that rural residents are acutely aware of the lack of resources available to them and adjust their expectations accordingly. Given the lack of large grocery stores and few entertainment options, these rural mothers may perceive the lack of local maternity services as consistent with the lack of other desired resources.

Another interpretation of this minimization is the "flip-side" of psychological resiliency. In the face of geographic distance to healthcare that women could not control, a stance of minimization could help these women cope with the barriers experienced with healthcare. However, it is not clear from our research the personal consequence of this coping strategy. Leipert (2006), for example, in her work with rural Canadian women, found that some rural women coped so positively with the lack of healthcare access that problem-solving about health issues tended to be overlooked. This theme requires further study because such a stance would seem to complicate efforts made by social workers to advocate for the healthcare needs, and perhaps social service needs, of rural mothers and children.

Our results also suggest that childcare issues present a substantial challenge for many rural mothers. Many women expressed how the cost of childcare impacted their decision not to work outside the home. When mothers considered working after giving birth, they often commented on low-wage jobs available to them compared with the high cost of childcare. Some mothers ultimately decided that it was more cost effective to stay home with their children. Mothers also expressed concern that many childcare providers were only open during traditional hours daytime hours that did not accommodate employment requiring early morning, evening, or weekend hours. Given the agricultural-based economy of rural areas as well as the general growth of the service sector, availability of affordable childcare in rural areas is a critical issue. This theme is consistent with rural research conducted in a northern Michigan community. Ames, Brosi, and Damiano-Teixeira (2006) documented a lack of childcare provided outside traditional daytime working hours. They speculated that childcare might be less available because rural providers are often caring for their own families during these non-traditional times.

Finally, our findings demonstrate that rural women viewed their community as having important benefits to parenting, including safety and sense of community. Many of the mothers discussed feeling safe in their community and found comfort in the idea that those in their community knew one another and cared about each other. Yet, women admitted lacking desired services and resources for themselves and their families. There was awareness that rural living meant relinquishing various health and recreational opportunities for them and their families.

From access to prenatal classes to indoor activities for their children, they were aware that these opportunities were unavailable.

While rural women appreciated the substantial resources available in urban hospitals, they also described having a more impersonal experience. Some women felt that the non-rural care reflected the faster pace of the urban environment, while their local, rural healthcare providers were friendlier and took more time with them as patients or clients. These findings suggest potentially important opportunities for collaboration between rural social workers and urban providers, including social workers. Communication and coordination of client care may provide an opportunity for rural social workers to follow up with rural women who have received non-rural healthcare and help them access necessary resources when they return to their rural community.

Due to the nature of qualitative inquiry, the findings of our research are limited in generalizability to a specific, self-selected group of mothers using WIC resources in a rural North Dakota county. Despite this limitation, we see promise in how qualitative methodologies can improve the cultural competence of social work practitioners. By studying the realities of rural subpopulations, in this case low and middle-income rural mothers with infants, rural social work practice can have greater relevance in shaping rural service delivery systems.

Implications for Social Work

With limited number of healthcare professionals serving the needs of rural mothers, social work professionals in rural environments can be a vital resource to supporting rural mothers during pregnancy and as new parents. As generalists in rural communities, the social work profession is aware of the social context of rural motherhood. As noted by one rural practitioner in research conducted by Riebschleger (2007):

You have to learn the community values and the unwritten rules . . . You've got to listen a lot . . . You've got to know people on one side of the mountain are different from people on the other side of the mountain and . . . people way up in the mountain are different from town people . . . It's the whole notion of diversity within groups (p. 210).

We see this understanding of rural worldviews as pivotal to both competent direct practice but also the advocacy of initiatives that improve rural environments. With various different intervention models directed at rural populations including telehealth, mobile health care, and rural transportation services, social workers should listen intently to how rural mothers perceive these "improvements". Historically, rural perspectives are often overlooked. Professional advocacy should consider rural perspectives before advancing initiatives, often developed in non-rural settings, that intend to improve the health and wellbeing of rural populations.

While only specific to one community, our work confirms a crisis of quality childcare in rural communities. This appears to be a critical issue for rural families; yet, community stakeholders may be relatively unaware of this crisis (Ames et al., 2006). Our findings were consistent with a report issued by the *National Association of Child Care Resource & Referral Agencies* (2010) on childcare in rural areas which notes that childcare is cost prohibitive for

many rural mothers. There are also fewer choices and the care tends to be of poor quality. We believe social workers can educate the public and policymakers about these childcare needs. Improving the access and availability of safe and affordable childcare is an important component to improving the lives of rural families. In addition, “family-friendly” policies including paid sick days, parental leave, and flextime can also help support rural mothers. Unfortunately, these policies are less available to rural mothers than urban mothers (Glauber, 2009).

We encourage more research and attention to the perspectives of mothers living in rural communities. Rural places offer both challenges *and* opportunities, yet these opportunities are often hidden from view. Social workers can use research methods to help gain greater understanding of these “insider” perspectives and help counter a deficit-perspective that attempts to explain rural places. When rural settings are only seen through a lens of deficits, it becomes difficult for the public, as well as the social work profession, to see the possibilities, opportunities, and linkages that can be leveraged to support rural mothers and their families.

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