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Birthplace in Australia: Antenatal preparation for the possibility of transfer from planned home birth

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ABSTRACT

Objective: The aim of the study was to explore how women and midwives prepare, during the antenatal period, for the possibility of intrapartum transfer from planned home birth.
Design: A Constructivist Grounded Theory approach was taken in order to focus upon the social interactions and processes that emerged.
Setting: Urban and regional areas in four states of south eastern Australia.
Participants: Thirty-one semi-structured interviews were conducted with women and midwives.
Findings: There were three sub-categories relating to preparation for the possibility of transfer. These were 'Building the midwife–woman partnership', 'Fostering professional connections' and 'Reducing uncertainty'. The reciprocal trust inherent in the midwife–woman partnership helped women feel safe in relation to the possibility of intrapartum transfer to hospital. Midwives who had positive transfer experiences spoke about their commitment to fostering professional connections with hospitals and health professionals as a part of building the capacity for collaboration if, and when, a transfer occurred. Reducing uncertainty involved preparation that included not only providing information and emotional support to the woman around the possibility of transfer, but also arranging for her to book in to a back-up hospital.

Introduction

The safety of planned home birth for women with low risk pregnancies, when professional midwifery care and adequate collaborative arrangements for referral and transfer are in place, has been supported in a number of studies, especially for women having their second and subsequent babies (Brocklehurst et al., 2011; Catling-Paull et al., 2013; de Jonge et al., 2009, 2013; Hutton et al., 2016; Keirse, 2014). In Australia, relatively few women give birth at home. For example, in 2013, only 0.3% of all births occurred at home (Australian Institute of Health and Welfare, 2015). Publicly funded home births have emerged as a model of maternity care in Australia, with approximately 15 services established in the past decade (Catling-Paull et al., 2011, 2012, 2013; Chapman and Matha, 2011; McMurtrie et al., 2009). Women may also access home birth in Australia by engaging a privately practising midwife, who is self-employed and working either in a group practice or independently. Privately practising midwives provide antenatal and postnatal care in the community and may also offer home birth care and/or birth support in a hospital.

For pregnant women planning to give birth at home, the possibility of intrapartum transfer is real and may be daunting. Transfer rates vary across different settings (Table 1) and range from 8% to 28%, depending on the context. Reasons for variations in transfer rates between services are complex and a detailed analysis is beyond the scope of this article. However, women having their first baby are more likely to require transfer than women having their second or subsequent baby (Blix et al., 2012, 2014, 2016; Brocklehurst et al., 2011; Fox et al., 2014; Tyson, 1991; Wiegers et al., 1998). Other reasons may include variations in local policy and practice around the threshold for transfer, and may depend upon travel time to hospital (longer travel times may mean higher transfer rates due to concerns about potential emergency transfers).

In preparing pregnant women for the possibility of transfer, midwives usually provide information about the processes of transfer and ensure that women are willing to acknowledge the potential that transfer may occur (Vedam and Kolodji 1995). It has been suggested that it may be helpful to frame these discussions in the context of decision making about the safest place to give birth in the clinical circumstances at the time (Ball et al., 2016). There is a paucity of literature that addresses the ways in which women and midwives prepare for the possibility of transfer from planned home birth. This study addresses this gap, by exploring the experiences and views of women, midwives and hospital

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Table 1
Selection of data: transfer rates of women in labour, from planned home birth to hospital.

Author/date	Publication	Country	Total transfer rate (women in labour)	Nulliparous women transferred in labour	Multiparous women transferred in labour
Amelink-Verburg et al. (2008)	BJOG	The Netherlands	27.5%		
Blix et al. (2016)	Acta Obst Gyn Scandinavia	Norway, Denmark, Sweden & Iceland	8.8%	24%	4.8%
Brocklehurst et al. (2011) (Birthplace in England)	BMJ	England	14.2%	35.1%	6.4%
Cheyney et al. (2014) (MANA Statistics Project)	JMWH	USA	10.9%	22.9%	7.5%

staff about what information they need to have in place to assist them in caring for transferred women.

The aim of this study, therefore, was to explore antenatal preparation for the possibility of intrapartum transfer from planned home birth, for women, their midwives and hospital staff. This includes the ways in which pregnant women planning to give birth at home prepared for the possibility of transfer, what their midwives did to support their preparation, and what antenatal preparations hospital staff found assisted them to provide optimal care for women transferred into their birth unit. Issues related to intrapartum and postpartum phases of care are not addressed in this article. We have previously published on processes and interactions during intrapartum transfers from planned home birth (Fox et al. 2018).

Methodology

This article is derived from a larger, qualitative PhD study exploring the views and experiences of women, midwives and obstetricians involved in the intrapartum transfer of women from planned home birth to hospital. In Australia, obstetricians may counsel women about their place of birth choices but do not usually have a role in preparing women for the possibility of transfer from planned home birth. Hence, data from obstetricians is not included in this article. The data collected from the interviews with obstetricians, related to processes and interactions during intrapartum care, is published by us elsewhere (Fox et al. 2018).

Grounded theory was used, to emphasise the conceptualisation of social interactions and processes involved in human experiences (Charmaz, 2014; Dey, 2004; Hall et al., 2013; Skeat, 2010). The constructivist approach to grounded theory was taken because of its capacity to facilitate the exploration of views and experiences of women and their caregivers, the views of caregivers in regard to other caregivers, as well as the processes of interaction and the contexts and environments in which they occur. Constructivist grounded theory is also able to account for the structural backgrounds from which these aspects are derived (Charmaz, 2011).

Methods

Data generation (collection and analysis)

The term ‘data generation’ is used in constructivist grounded theory to encompass data collection and analysis, because these two processes occur simultaneously. Thirty-one semi-structured interviews were conducted with women and midwives in 2014 and 2015. The interviews were audio recorded and transcribed immediately. Field notes were taken, to describe the setting and context of the interview, and to make note of significant non-verbal actions and interactions.

Initial and focussed coding, categorising, constant comparison and theory development was undertaken simultaneously, whilst further interviews took place, according to the methods of grounded theory analysis outlined by Charmaz (2014).

Sampling

Grounded theory methodology involves two phases of sampling, namely initial sampling and theoretical sampling. The initial plan was to recruit a purposive sample of 10 women and 10 midwives. Participants were recruited from private midwifery practices, two publicly funded home birth programmes and personal networks, across four states of south eastern Australia; New South Wales, Victoria, South Australia and Tasmania.

Recruitment

Formal approaches to key stakeholders of publicly funded home birth programmes were made during the ethics application process in early 2014. Midwifery managers of the two responding publicly funded home birth programmes kindly arranged meetings to engage the midwives’ participation. The home birth midwives were interviewed about their views and experiences of transfer, and they were also asked to identify women who had been transferred and who might be willing to be interviewed. Privately practising midwives and women who had engaged privately practising midwives were recruited through personal networks of the authors and theoretical snowball sampling.

Due to the midwifery sample including different groups of midwives (midwives from private home birth, public home birth and hospital settings), who offered rich and complex data, theoretical saturation was not reached until after 21 interviews with midwives.

Theoretical sampling

Theoretical sampling is the process of identifying and refining nascent theoretical ideas and pursuing them in future interviews (Birks and Mills, 2015). The data generation process in Constructivist grounded theory involves simultaneous data collection and analysis, constant comparison of data and codes and memo writing. These processes enable theoretical sampling and create the abductive process. Abduction is a combination of induction and deduction, in which the research commences inductively, nascent theoretical concepts are developed, and then tested deductively through theoretical sampling. The sampling process evolves and the interview questions are refined as data is analysed (Charmaz, 2014; Dey, 2004; Skeat, 2010).

Interviews were conducted with:

1. Seven women who, in the past three years, had planned a home birth with a privately practising midwife and were subsequently transferred to hospital during labour or with their baby soon after birth.
2. Three women from publicly funded home birth programmes who, in the past three years, had planned a home birth and were subsequently transferred to hospital during labour or with their baby soon after birth.
3. Seven privately practising midwives who, in the past three years, cared for women as described above (1) at home.
4. Six midwives from publicly funded home birth programmes who, in the past three years, cared for women as described above (2) at home.
5. Eight midwives working in a hospital who, in the past three years, experienced receiving women as described above (1 and 2).