Midwifery 42 (2016) 10–15

Contents lists available at ScienceDirect

Midwifery

journal homepage: www.elsevier.com/midw

Women's experiences with giving birth before arrival

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ARTICLE INFO

Article history:
Received 20 April 2016
Received in revised form
8 August 2016
Accepted 21 September 2016

Keywords:
Birth
Experience
Patient safety
BBA
Born-before-arrival
Out-of-hospital birth

ABSTRACT

Objective: To explore women's experiences with giving birth before arrival.
Design: A qualitative interview study.
Setting: Individual semi structured interviews with women from Western Norway conducted in their homes in 2015.
Participants: 10 women who experienced BBA-births in 2014, or the beginning of 2015. Two primiparous and eight multiparous women participated in the study.
Key findings: Three themes were generated from the analysis. In the encounter with the healthcare services, the women described midwives as gatekeepers defining active labour. Giving birth before arrival was dramatic, but at some point fear of giving birth alone was replaced by feelings of coping, and in hindsight they felt empowered. The women described giving birth before arrival to be a special experience, but this was not always acknowledged by the midwives.
Conclusion and implications for practice: The findings in this study question the cost-benefit of today's maternity care system pointing towards a more differentiated and decentralised care. To enhance patient safety adequate capacity of midwives in the maternity care is essential. Furthermore, good communication skills are key to improving practice and enhancing safety. Further research must be conducted.

Introduction

BBA-births refer to the term *born-before-arrival*. These births often take place at home or en route to hospital, and include all accidental out-of-hospital births for women not planning a home birth (Ford and Pett, 2008; Unterscheider et al., 2011; McLelland et al., 2013). In many countries the incidence of BBA-births is increasing (Hemminki et al., 2011; Unterscheider et al., 2011; Gunnarsson et al., 2014), and they are often handled without a midwife present (Scott and Esen, 2005; Dietsch et al., 2010). The distance from the woman's home to her nearest birthing unit correlates to the incidence of BBA-births (Blondel et al., 2011; Renesme et al., 2013; Gunnarsson et al., 2014). Along with the ongoing decrease in maternity units and centralisation of care the number of BBA-births increases (Neto, 2006; Pilkington et al., 2008; Hemminki et al., 2011).

There is a significant risk for adverse perinatal outcome for babies born before arrival. In Ireland the mortality rate was found to be 27,9 in 1000 BBA-births, compared to 8,5 in 1000 births in the general hospital population (Unterscheider et al., 2011). Other risk factors are low birth weight (Hemminki et al., 2011; Jones et al., 2011; Gunnarsson et al., 2014), prematurity (Jones et al., 2011; Lazic and Takac, 2011; Unterscheider et al., 2011), breech-position (Aladdin et al., 2004; Unterscheider et al., 2011) and hypothermia (Ford and Pett, 2008; Jones et al., 2011; Lazic and Takac, 2011). Furthermore, studies show that BBA-births often occur at night (Aladdin et al., 2004; Scott and Esen, 2005; Ford and Pett, 2008). With respect to the labouring women, studies consider the risk of severe perineal tear, but the results are inconclusive (Aladdin et al., 2004; Ford and Pett, 2008; Unterscheider et al., 2011). Post-partum haemorrhage is not a significant risk factor (Aladdin et al., 2004; Unterscheider et al., 2011) although one study related prolonged retention of the placenta with associated increased blood loss and transfusion requirement (Loughney et al., 2006).

BBA-births are an increasing challenge for the health care system in Norway. Today 7 out of 1000 children are born before arrival, compared to 4 out of 1000 only a few years back (Gunnarsson et al., 2014). In the last 30 years the number of birthing units has decreased from 95 to 51, and the health benefits that we thought we would see after the centralisation, we have not yet seen (Engjom et al., 2014). Moreover, the majority of children born

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http://dx.doi.org/10.1016/j.midw.2016.09.012
0266-6138/

outside of hospital in Norway are not a result of planned homebirths. In 2012 the number of BBA-births was 394, compared to 103 planned homebirths (NIPH, 2014).

The World Health Organization (WHO) states that the maternity care system should be both decentralized and differentiated. For the safety of mother and child it is essential that a skilled attendant provides care for the woman (WHO et al., 2015). According to Pettker and Grobman (2015), quality measures on patient safety depend on three factors: structure, process and outcome. Consequently, health care professionals need to evaluate the structure of maternity care, the process on how we handle the labouring women and the risk factors concerning the birth outcome. Reciprocity and communication are essential elements in quality maternity care (Hunter et al., 2008). This is in line with a recent review on patient safety in obstetric care describing how improving communication with women and between professionals is crucial in order to maintain and enhance safety (Severinsson et al., 2015). We find that, for women experiencing BBA-births there is a deficit in WHO's recommendations regarding patient safety. Bearing this in mind, we set up a study in order to explore women's experiences with BBA-births.

Methods

We carried out semi structured interviews with 10 women who had experienced BBA-births (Kvale, 1996; Kvale et al., 2009). To recruit women, a poster with information about the study was displayed in different child healthcare centres across Western Norway. Western Norway was chosen since 50 children born before arrival in Norway in 2012 were born within this limited area (NIPH, 2014). The poster was also published and shared on Facebook. We included women who had given birth from January 2014 to January 2015. To keep the context around the births somewhat similar, limited time frames as well as geographical limitations were set. The women had to be able to speak and understand Norwegian fluently to participate in the study, and for reasons concerning consent they had to be over the age of 18; the age of majority in Norway.

The interviews were carried out between April and June 2015. Two primiparous and eight multiparous women were included. Though this represents a small sample, Malterud argues that in qualitative interview studies the more information the sample holds, relevant for the actual study, the lower number of participants is needed (Malterud et al., 2015). The women were between 25-31 years of age, and they all gave birth at term ranging from 14 days before to 11 days past their due date. All women were healthy and gave birth without complications. Two of the women were in contact with more than one hospital. There were five different hospitals represented in this study.

The interviews were conducted and recorded individually in the women's homes, and lasted from 21 to 38 minutes (mean 28 minutes). The interview guide consisted of four open questions. Initially the women were asked to share their experiences with giving birth before arrival, invited by the question: '*Could you please describe the moment when you understood that the labour had started?*' They were encouraged to narrate freely, describing the situation they were in, the phone calls they made and people they met. Secondly, they were asked how they felt during the experience. The third question encouraged them to say something about what they thought was the reason for not reaching their planned place to give birth, and at last they were asked what kind of care they would prefer if they were to give birth again. There was no time limit to the interviews, and the women were interrupted only when clarification or elaboration was needed. They were offered debriefing or clarification after the interview on situations they had experienced to be challenging (Kvale, 1996; Kvale et al., 2009).

Ethical considerations

Approval for the study was granted by the Norwegian Social Science Data Service (NSD; 41562), and assessed by the Regional Committee for Medical Research Ethics (REC), but considered to be outside the remit of the Act on Medical and Health Research (2015/448A). The study was conducted according to the WMA Declaration of Helsinki Principles for Medical Research in Human Subjects (WMA, 2002).

Data analysis

The interviews were transcribed, and systematic text condensation (STC) was used to analyse the data material (Malterud, 2012). The method is a four step modified version of Giorgi's phenomenological method (Malterud, 2011), and it goes as follows: 1. Each interview was read to find temporarily themes and gain an overall impression. 2. Meaning units describing the women's experiences of giving birth before arrival were marked and the text was organised into code groups. 3. Subgroups were identified in each code group, and meaning units in all subgroups were then summarised and condensed. 4. In the end the text condensates formed the basis for our final analytic text. Quotations were used to elucidate the findings. In line with Malterud (Malterud, 2011) we used a project log to note down our reflections and arguments in the process.

Findings

Three themes were generated from the analysis. In the encounter with the healthcare services, the women described midwives as gatekeepers defining active labour. Giving birth before arrival was dramatic, but at some point fear of giving birth alone was replaced by feelings of coping, and in hindsight they felt empowered. The women described giving birth before arrival to be a special experience, but this was not always acknowledged by the midwives.

There is no standard to when a woman is in active labour, and this complicates everything

Most women described their contractions to be irregular and thought giving birth would be more painful. They pointed out that it is impossible to know beforehand how the body responds to contractions, and one woman noted that there is no blueprint to labour. Many described other women being in labour for a longer time, and for those who were multiparous the birth started differently this time. They were confused and felt uncertain when to contact the midwife. They described how they used smartphone apps, pregnancy books or called the clinic for advice. Most women experienced a sudden turning point in labour, and one multiparous woman described it like this:

> *"I was on the floor when I heard a sound and felt the water break. It was like someone had hit a switch. There was no doubt that this was contractions!" (Interview 6).*

Several women called the clinic numerous times and received different advice each time. They believed irregular contractions to