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Women's unmet needs in early labour

Qualitative analysis of free-text survey responses in the M@NGO trial of caseload midwifery

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Objective: to analyse women's experiences of early labour care in caseload midwifery in Australia.

Design: this study sits within a multi-site randomised controlled trial of caseload midwifery versus standard care. Participant surveys were conducted at 6-weeks and 6-months after birth. Free-text responses about experiences of care were subject to critical thematic analysis in NVivo 11 software.

Setting: two urban Australian hospitals in different states.

Participants: women 18 years and over, with a singleton pregnancy, less than 24 weeks' pregnant, not planning a caesarean section or already booked with a care provider; were eligible to participate in the trial.

Interventions: participants were randomised to caseload midwifery or standard care for antenatal, labour and birth and postpartum care.

Measurements and findings: The 6-week survey response rate was 58% (n=1,019). The survey included five open questions about women's experiences of pregnancy, labour and birth, and postnatal care. Nine-hundred and one respondents (88%) provided free text comments which were coded to generate 10 categories. The category of early labour contained data from 84 individual participants (caseload care n = 44; standard care n= 40). Descriptive themes were: (1) needing permission; (2) doing the 'wrong' thing; and (3) being dismissed. Analytic themes were: (1) 'Seeking: women wanting to be close to those who know what's going on'; and (2) 'Shielding: midwives defending resources and normal birth.'

Key conclusions: Regardless of model of care, early labour care was primarily described in negative terms. This could be attributed to reporting bias, because women who were neutral about early labour care may not comment. Nevertheless, the findings demonstrate a gap in knowledge about early labour care in caseload midwifery models.

Implications for practice: Maternity services that offer caseload midwifery are ideally placed to evaluate how early labour home visiting impacts women's experiences of early labour.

Introduction

Early labour

In the context of childbearing, labour is “a process where regular and coordinated muscular contractions of the uterus lead to gradual effacement and dilation of the cervix [first stage of labour], followed by expulsive contractions which result in the birth of the baby [second stage] and placenta [third stage]” (Baddock, 2015, p.470). The first stage of labour is often further divided into early labour (also known as prelabour, latent labour, spurious labour), and active labour (Baddock, 2015). Until the institutionalisation of birth, women and midwives did not make these distinctions between early and active labour (McIntosh, 2013). Women experience labour as a continuum, rather than in stages or phases (Dixon, Skinner, & Foureur, 2013); but in many hospitals, diagnosing the change from early to active labour has become a benchmark for admission.

Recent research has questioned the definition of early labour, i.e. the period of regular contractions before the cervix has reached four centimetres (cm) dilatation (Neal et al., 2010). A large retrospective review (n=62,415) undertaken in the United States (Zhang et al., 2010) found normal progress from 4 to 6cm cervical dilatation may take much longer than previously thought. Therefore, interventions to speed progress in labour prior to six cm cervical dilation may be premature and contribute to a cascade of intervention, particularly caesarean section (Zhang et al., 2010). This redefinition of active labour, now reflected in both American and Australian obstetric guidelines (American College of Obstetrics and Gynecology, 2014; Queensland Clinical Guidelines, 2018), has significant implications for the care of women in early labour as it may prolong the time that women are encouraged to stay at home.

Women’s experiences

Women’s experiences during early labour include feelings of fear and uncertainty (Barnett, Hundley, Cheyne, & Kane, 2008; Fisher, Hauck, & Fenwick, 2006), which can inhibit progress in labour (Buckley, 2015) and increase women’s perception of pain (Floris & Irion, 2015). There is a significant correlation between women’s anxiety state and the degree of pain experienced in early

29 labour (Floris & Irion, 2015) and the combination of fear and pain influences women's early labour
30 decisions (Cheyne et al., 2007). Women solve their main concern during early labour, safety, by
31 seeking a secure place (Carlsson, 2016). Thus women who view labour and birth as a risky medical
32 event, choose to go to hospital in early labour (Carlsson, 2016). Many pregnant women rely on
33 medical knowledge and expect intervention during labour and birth which may lead women to seek
34 medical validation at the first sign of labour (Miller & Shriver, 2012). Indeed, the main reasons for
35 hospital visits during early labour are uncertainty about whether labour had started and wanting
36 reassurance (Cappelletti, Nespoli, Fumagalli, & Borrelli, 2016). First-time mothers have described
37 'negotiating on two fronts' during early labour; first with their support person about whether or not to
38 call the hospital and second with the midwife over the telephone about whether or not they should
39 come in (Eri, Blystad, Gjengedal, & Blaaka, 2010).
40
41 *Delaying or denying admission*
42 Women often express a preference for being admitted on their initial assessment, feeling the decision
43 to be sent home in early labour is a professional rather than woman-centred response (Nolan, 2010).
44 Admission to birth suite in early labour may precipitate a cascade of intervention associated with
45 higher rates of augmentation of labour and epidural analgesia (Davey, McLachlan, Forster, & Flood,
46 2013; Holmes, Oppenheimer, & Wen, 2001; Lauzon & Hodnett, 2001; Neal et al., 2014; Spiby,
47 Green, Hucknall, Foster, & Andrews, 2007), poorer clinical outcomes (Gharoro & Enabudoso, 2006)
48 and increased health care costs (Spiby et al., 2007). Much of the focus of early labour research has
49 therefore been on evaluating innovations for delaying admission to birth suite including:
50 - the use of formalised assessment criteria (Hodnett et al., 2008);
51 - the application of an algorithm for diagnosing active labour (Cheyne et al., 2008);
52 - comparing telephone advice/triage with home visits in early labour (Janssen et al., 2006;
53 Kobayashi et al., 2017; Spiby et al., 2008b); and
54 - use of a dedicated early labour space within the hospital (Williams et al., 2019).

While some of these studies revealed a trend towards increasing the likelihood for a spontaneous vaginal birth (Hodnett et al., 2008), none achieved statistically significant improvements in their primary outcomes: rates of caesarean section (Hodnett et al., 2008; Janssen et al., 2006; Spiby et al., 2008b) or augmentation of labour (Cheyne et al., 2008; Williams et al., 2019). It remains unclear what impact assessment and support to delay admission in early labour have on women's birth outcomes (Kobayashi et al., 2017).

A recent systematic review of qualitative studies of early labour care experiences concluded that women, labour companions and midwives all found early labour difficult to manage well (Beake et al., 2018). While midwives may discourage women from attending hospital "for their own good" (Eri, Blystad, Gjengedal, & Blaaka, 2011, p. e286) this creates tension "between the goal of delaying admission until active labor in order to decrease the incidence of unnecessary interventions and women's difficulty with managing this part of labor at home" (Marowitz, 2014, p. 645). While midwives arguably should be able to protect women from unnecessary intervention if they are admitted to hospital in early labour, in practice they may act subordinately to the medical paradigm and accept that intervention will automatically occur (Eri et al., 2011). Furthermore, operational issues such as workload, and limits on the maximum time allowed to spend at work, often influence midwives' decisions to discourage women from seeking admission to hospital (Beake et al., 2018). Women's needs during early labour are often subservient to the needs of the institution as midwives attempt to protect the labour ward from inappropriate admissions (Spiby, Walsh, Green, Crompton, & Bugg, 2014). Importantly, of the 21 studies included in the aforementioned systematic review (Beake et al., 2018), none were from Australia, where this study was conducted. The authors of the systematic review identified a significant gap in early labour research, namely how model of care impacts early labour.

Aim and objective

The aim of this paper is to explore one of the secondary outcomes of the M@NGO trial: women's experiences of care. The study was driven by the research question: *How do women experience early labour care within a caseload midwifery model?*

Methods

The study methods and primary outcomes are described in detail elsewhere.[19] Briefly, the researchers conducted a multi-site unblinded, randomised, controlled, parallel-group trial: Midwives @ New Group practice Options (M@NGO: Trials Registry, number ACTRN12609000349246) at two metropolitan teaching hospitals in Australia. Ethical approval was granted through two hospital and two university Human Research Ethics Committees. The funding bodies had no role in data collection, analysis, or interpretation; and no right to approve or disapprove the publication of the finished manuscript.

Participants

Pregnant women were randomly allocated to receive caseload midwifery or standard care. Women of all obstetric risk were eligible to participate in the study. Inclusion criteria were: 18 years or older, less than 24 week's gestation with a singleton pregnancy. Women were excluded if they were already booked with a care provider or planned to have an elective caesarean section.

Intervention

Participants were randomised to caseload midwifery or standard care. The caseload model provided antenatal, intrapartum and postnatal care from a primary midwife or 'back-up' midwife. Women allocated to caseload midwifery were given a mobile phone number for their primary midwife, which they could use to contact their midwife during pregnancy and early labour. If the primary midwife was unavailable, the telephone was diverted to a back-up midwife who should also be known to the woman. Caseload midwives triaged women in early labour via telephone; early labour home visits

105 were not provided. Early labour assessments were subsequently co-ordinated between the woman and
106 her midwife to occur in the hospital pregnancy assessment area or birth suite.
107
108 The standard model included care from a general practitioner and/or midwives and obstetric doctors.
109 Women allocated to standard care were given the hospital birth suite or assessment unit telephone
110 number, which they could use to seek advice during pregnancy and early labour. During early labour,
111 shift midwives, usually not known by the woman, triaged women and provided direct advice to either
112 come into hospital for assessment or stay at home and await events.

113 **Data collection**

114 Baseline demographic characteristics and birth outcome data were extracted from medical electronic
115 records. Women's experiences of antenatal, intrapartum and postnatal care were collected via email
116 (with link to the survey URL) or postal hard-copy surveys, sent to women approximately six weeks
117 after birth. One week later, a reminder survey was sent to non-responders. Women who had
118 withdrawn from the trial or experienced fetal loss / stillbirth were not sent a questionnaire. The survey
119 allowed the collection and analysis of both quantitative and qualitative data. Women's experiences of
120 pregnancy and labour care were measured using 7-point Likert scales, with several free text questions
121 (Table 1).

Table 1: Free-text survey items included in analysis

Q15	Please describe any things about your pregnancy that you were particularly happy with.
Q16	Please describe any things about your pregnancy that you were particularly unhappy with.
Q35	Feel free to make comments (about overall birth experience).
Q44	Please describe any things about your labour and birth that you were particularly happy with.
Q45	Please describe any things about your labour and birth that you were particularly unhappy with.

122 The survey included no items (opened or closed) which enquired specifically about early labour care.
123 Therefore, responses to all five questions were subject to qualitative analysis.

124 **Data processing**

125 Data from the 6-week survey were downloaded from the online survey platform into a password
126 protected Excel file. All closed-answer questions / responses and participant identifiers were deleted,
127 except for study numbers which were needed to identify quotes. The modified Excel file was
128 transformed into a series of Microsoft Word documents (e.g. Question 15 file), which were then
129 imported into NVivo11 for data coding.
130

131 **Qualitative approach**

132 The researchers adopted a critical approach to thematic analysis (Clarke & Braun, 2014); commonly
133 used in applied health research (Braun & Clarke, 2014). A critical approach can be applied to an
134 existing qualitative methodology in order to focus on issues of power (Smythe, 2012). Critical
135 thematic analysis, therefore, not only describes participants' experiences; it also interrogates the
136 patterns across participant accounts to ask questions about the wider social forces and structures
137 (Clarke & Braun, 2017). Critical thematic analysis guided our research to include health services
138 (how and why they are organised to provide early labour care as they do) and midwifery workforce
139 (how and why midwives speak and behave as they do during early labour).
140

141 **Researcher characteristics and reflexivity**

142 Rigour is strengthened when researchers are aware of their preconceived ideas and have qualitative
143 expertise. Briefly, the joint first authors led data analysis. The first author is a registered midwife and
144 midwifery researcher with experience working in caseload midwifery models; the second author is a
145 maternity consumer activist. Both authors have: PhD qualifications within the broad topic of
146 maternity services research; qualitative research experience; and philosophical alignment with a
147 critical lens. The third author is a midwifery researcher who was chief investigator on the M@NGO
148 study and is Professor of Midwifery at the lead site. The fourth author was responsible for day to day

149 and data management for the whole project. The fifth author is a consultant neonatologist who
150 provided senior oversight into data management and analysis for the wider project. The last author is a
151 registered midwife and researcher who was a chief investigator on the study and the Professor of
152 Midwifery at one of the sites. The interaction between researchers and participants was limited to the
153 first and fourth authors who recruited women to the M@NGO trial. All authors had presuppositions
154 that caseload midwifery would afford women a better experience of early labour care.
155
156 *Data analysis*
157 The first author had conducted a five-step thematic analysis of all five free text questions; this
158 included immersion in the data by reading all responses and creating an initial coding scheme (Braun
159 & Clarke, 2006). From the full dataset, multiple codes were created including the midwife's personal
160 attributes which was the subject of thematic analysis and has been published (Allen, Kildea, Hartz,
161 Tracy, & Tracy, 2017). A separate 'early labour' code was generated inductively during that process
162 following recognition of the many, largely negative, comments about this part of care. We explored
163 early labour care in more depth by conducting thematic analysis, using a method similar to that
164 described in other studies (eg. Garcia, Evans, & Redshaw, 2004; Henderson & Redshaw, 2017).
165
166 The joint first authors conducted independent purposive searches in NVivo11 for relevant terms and
167 phrases (such as 'early', 'went to hospital', 'telephone', 'sent home', 'return') to ensure all women's
168 free text comments related to early labour care had been identified; then created an initial coding
169 scheme; and adapted the coding scheme to generate simple descriptive themes (Braun & Clarke,
170 2006). The researchers then had a series of meetings to discuss and revise the themes to synthesise
171 descriptive themes and abstract them into higher-level analytical themes (Step 4) and determine the
172 association between categories with a view to explain the findings (Step 5). This process continued
173 iteratively until consensus amongst the research team was achieved, a process which enhances rigour.
174 Participants did not provide feedback on the findings. Negative case examples (e.g. women who
175 described positive early labour care experiences) have been reported.

176 **Results**

177 Eighty-four women (caseload care n=44, standard care n=40) used free-text boxes in the six-week
178 postnatal survey to describe their experience of early labour care (Table 2).

179 [Table 2]

180 Participants were mostly between 20-35 years of age and living in areas of highest socio-economic
181 advantage. Women who provided unsolicited comments about early labour care had mostly given
182 birth for the first time and experienced a vaginal birth; with similar proportions allocated to caseload
183 or standard care.

184 **Descriptive themes**

185 Three descriptive themes were identified in women's responses about early labour care: 1) needing
186 permission; 2) doing the wrong thing; and 3) being dismissed. Each theme included responses from
187 women in both standard and caseload care and are explored below. Illustrative quotations are
188 provided along with diverse cases. Quotations are identified by allocated model of care: Standard or
189 Caseload and by survey question (refer to Table 1). Spelling and typographic errors have been
190 corrected in quotations, and where necessary for fluency, brevity or anonymity, words have been
191 deleted (indicated by …) or inserted (indicated by [square brackets]).

192

193 **Needing permission**

194 In early labour, women contacted the hospital birth suite or their caseload midwife by telephone, and
195 some perceived that they needed permission to go to the hospital.

196 *I was told not to come to the hospital when I felt like I wanted to...I felt like this*
197 *wasn't such a great support at the time. (Caseload, Q45)*

198 *I was strongly discouraged from coming into the hospital until quite late despite*
199 *being in a lot of pain. (Standard, Q45)*

200 Telephone triage was singled out as a negative experience for women, prone to inaccurate
201 assessments which women perceived endangered them and their babies.

202 *What upset me very much was getting to the hospital…She said to call back as it*
203 *could all stop. I knew that it wasn't the case but didn't feel strong enough to*
204 *battle...We parked the car at 10am … and the baby was delivered at 10.58am…. I*
205 *am angry towards the woman who took my first call ... I think the woman on the*
206 *phone was wrong … I could have had the baby in the parking lot. (Standard, Q45)*

207 Where women presented to the hospital in early labour, some perceived that they were denied
208 permission to stay at the hospital. This experience of being sent home was universally a negative one.

209 *Emotionally I wasn't able to cope … The midwives advising us when we first got*
210 *there to go home made me feel emotionally uneasy. (Standard, Q45)*

211 *I was scared to go home during labour but [I was] told I would have to as [I was]*
212 *not far dilated (Caseload, Q45)*

213 In some cases, women reported that it was the intercession of their support person that secured them
214 permission to stay at the hospital.

215 *When I presented to the hospital for the second time and was obviously very*
216 *distressed and shattered I was still only 4-5 cms dilated and was told that I was*
217 *not far enough along and I should go home! We only stayed as my husband could*
218 *see how distressed I was and he insisted we stay. (Caseload, Q45)*

219 Being 'allowed' to stay at the hospital was regarded as a milestone by many women, a turning point
220 after which they felt more positive about their care experiences.

221 *Once my water broke and [I was] allow[ed] to stay hospital, it was good.*
222 *(Standard, Q44)*

223 Many women reported wanting to be admitted to the hospital sooner than they had been able to secure
224 admission. For many, this was a pragmatic concern about travelling by car or walking from the
225 carpark in advanced labour.

226 *I felt it would be better if I can get to hospital earlier because it is very hard for a*
227 *labour[ing] woman to get to the car and travel to hospital and walk to the birth*
228 *place when she is in pain every few minutes … [the hospital] should encourage*
229 *[women] to go to hospital earlier rather than stay home to wait for the "right*
230 *time". (Caseload, Q35)*

231 Some women reported that they had been ‘allowed’ to stay in the hospital despite ‘only’ being in early
232 labour. This was perceived to be a woman-centred response to their experience of early labour.

233 *I had a very long pre labour (30 hours) but one of my midwives … gave me*
234 *<u>amazing support and encouragement</u>. She allowed me to stay in the birth centre*
235 *until I went into actual labour instead of sending me home which was much*
236 *appreciated as I was <u>exhausted</u> by that stage. (Caseload, Q44)*

237 *I was asked if I wanted to go home … but being my first baby, [I] felt it better to*
238 *stay at the hospital, hence being moved to level 4 while I was still in pre labour*
239 *(there's nothing 'pre' about it). (Standard, Q35)*

240 **Doing the wrong thing**

241 When women arrived at the hospital and were assessed as being in early labour, some respondents
242 from both groups reported being made to feel that they had done the wrong thing.

243 *When we first arrived, we were made to feel we had done the wrong thing… It*
244 *turned out to be the right thing to have done as baby was born in less than 3*
245 *hours. (Standard, Q45)*

246 Some respondents perceived that they should limit their requests for telephone support.

247 *I also felt very pressured not to phone or go into the hospital during the night*
248 *which is when my labour pains were the most intense. It felt like I was interrupting*
249 *the midwives. (Caseload, Q35)*

250 *Over the phone midwives in delivery suite were awful. I did not feel comfortable to*
251 *call and this put my baby in danger (Standard, Q35)*

252 Some women also reported being uncomfortable with perceived instructions about when they were
253 permitted to seek telephone advice.

254 *I had been told by the midwives "If the water breaks at night and all looks clear,*
255 *do not call us until the morning, try and get some sleep." I did do this and luckily*
256 *all was clear, I just didn't like that instruction. (Caseload, Q35)*

257 Women reported receiving conflicting advice during early labour, particularly about when to go to the
258 hospital.

259 *Wasn't happy that they tried to send me back home when we were on our way into*
260 *hospital …We had been into the hospital earlier in the day when my waters broke*
261 *and the midwives had advised us to come back to hospital when contractions were*
262 *that far apart so when we were then told to go back home... emotionally I wasn't*
263 *able to cope. (Standard, Q45)*

264 *My main midwife was happy for me to come in to hospital when contractions were*
265 *5 min apart, whereas the midwife who was on duty asked me to stay home several*
266 *times and was asking me to stay until the contractions were 3 min apart.*
267 *(Caseload, Q45)*

268 There were a few participants who reported feeling welcomed upon their arrival at hospital.

269 *The ability to contact 24/7 via mobile was very reassuring. Calling my midwife to*
270 *advise the labour had started, by the time I got to the hospital my arrival had*
271 *already been organised I even had a greeting at the front desk. Great advice and*
272 *good options were given to consider. (Caseload, Q15)*

273 *When I arrived I was sent to the delivery suite and the staff there were wonderful*
274 *too - they even took me to the birthing centre so I could get in the bath. (Caseload,*
275 *Q35)*

276 **Being dismissed**

277 Respondents from both groups perceived that their accounts of labour and need for early labour care
278 were dismissed by midwives, leading to a sense of 'not being taken seriously'.

279 *Midwife that I saw first when I was in labour... I wasn't very happy with how laid*
280 *back she was. [I] felt like what I was saying wasn't taken seriously enough.*
281 *(Standard, Q45)*

282 *My midwife did not recognize that I'm in labour and made arrogant comments*
283 *regarding my pain threshold when I was 6 cm dilated and she thought I am having*
284 *pre-labour contractions. (Caseload, Q35)*

285 Women perceived that dismissive assessments of their stage of labour often did not match their
286 subsequent experience. It was interesting to note that many women described timing of their
287 admission to hospital (either in terms of cervical dilatation or hours until their baby was born) in ways
288 that many clinicians might regard as 'good timing', but for the woman, this was too late.

289 *She [midwife] advised that I was not in active labour yet and may need to go*
290 *home. But bub was born within the next hour! (Caseload, Q45)*

291 *I'm not happy with when I have a sign to give birth then I went to hospital but*
292 *baby not come yet. Midwife sent me home and said I will give a birth tomorrow*
293 *afternoon, but I gave a birth after that in 3 hours. (Standard, Q16)*

294 Having their bodily experiences dismissed was perceived by many women as a distressing
295 lack of support.

296 *I felt very discouraged and deflated by the midwife at times… she told me I was*
297 *NOT in labour and if I'd hadn't had a [caesarean section] previously that I would*

298 *be sent home! This was extremely discouraging and I was devastated. I didn't feel*
299 *supported at all … I understand I may have been in early labour but she could*
300 *have rephrased her comment so it didn't come across so harshly. Women in labour*
301 *need encouragement not to be shut down like that. (Caseload, Q45)*

302 *Midwife also dismissed my thoughts on how far my labour had progressed at*
303 *home and this made me panic, despite the fact I was 5cm dilated when I arrived at*
304 *the delivery suite. (Standard, Q35)*

305 Women often attended the hospital in early labour seeking emotional support but perceived that this
306 need was readily dismissed by midwives. This lack of access to emotional support was singled out as
307 an aspect of labour and birth care that the woman had been particularly unhappy with (ie Q45).

308 *Being told it is best I went home when only dilated 3cms… I felt the need to be*
309 *close to those who know what's going on. (Standard, Q45)*

310 *I needed some reassurance at that time [early labour] as this was my first*
311 *pregnancy and [I] was not sure what to expect but also [wasn't sure about] how*
312 *long I could continue … as it had been going on for so long. (Caseload, Q45)*

313 *I did not know what to do and who to ask for help…. so physically and mentally I*
314 *felt <u>totally lost</u>. (Standard, Q45)*

315 For one woman, encouragement to stay at home in early labour had been an empowering experience.

316 *I was encouraged to labour at home and I think it helped me to allow my body to*
317 *do what it is designed to do. (Standard, Q44)*

318 In rare cases, not being taken seriously led to women birthing their babies prior to their arrival in the
319 birth suite or feeling neglected during their labour and birth.

320 *I was advised to stay at home during labour for another hour and consequently*
321 *delivered at home with my husband. (Standard, Q35)*

322 *Baby born in ambulance. I felt the advice given over the phone by midwife was not*
323 *specific to me personally and how I was labouring. I was told to wait till*
324 *contractions were regular and four minutes apart; that never eventuated. I had no*
325 *time to get to the hospital in the end. (Caseload, Q45)*

326 **Analytical themes**

327 In the final stage of our analysis, descriptive themes were critically analysed to establish two higher
328 order themes:

329 - Seeking: Women wanting to be close to those who know what's going on
330 - Shielding: Midwives defending normal birth and resources

331 These two analytical themes capture the tension in women's interactions with midwives during early
332 labour.

333 **Seeking**

334 Women seek support and security by attending the hospital, responding to the dominant medicalised
335 discourse around childbirth in Australia: that birth is inherently dangerous, whereas hospitals are safe,
336 and bodily knowledge and birthing expertise lie outside of the woman herself. Women's experiences
337 of 'needing permission' and 'doing the wrong thing' were perceived to restrict their access to the
338 support and security that they sought, while 'not being taken seriously' reinforced the perception that
339 the only "real knowledge about their 'condition' is medical/midwifery/technological knowledge, not
340 their own instinctive womanly knowledge" (Janssen et al., 2009, p.335). This externalising of
341 expertise over their bodily experiences, leaves women with a need to hand over responsibility for their
342 own wellbeing, and the wellbeing of their baby (Carlsson, Hallberg, & Odberg Pettersson, 2009).
343 Telephone support mostly failed to meet women's needs during early labour and for some, poor early
344 labour care resulted in babies born before arrival to hospital or very soon after admission.

345 **Shielding**

346 When women sought support and security, they were met with strategies aimed at delaying and
347 avoiding admission. Shielding may be intended to defend normal birth, since early admission is

associated with higher rates of intervention and midwives may perceive themselves to be powerless to prevent intervention that accompanies early admission to hospital (Eri et al., 2011).

Midwives in standard versus caseload models of care may also be driven by different priorities. In standard care, midwives may practice 'with institution' rather than 'with woman.' A 'with institution' approach conceptualises only active labour as the "real" work of midwives (Janssen et al., 2009). Standard care midwives may have 'with institution' priorities including managing busy units where available birthing rooms and midwifery staffing allocations do not account for provision of early labour care. In caseload practice, shielding resources may be targeted towards managing the midwife's workload and time constraints, to ensure that the midwife is able to be there for the woman in active labour, birth and the early postpartum period and doesn't 'run out of hours' caring for women in early labour (most will need to hand over care after 12 hours).

However, the interplay between women 'seeking' and midwives 'shielding' highlights a gap in woman-centred care (Carlsson, 2016; Janssen et al., 2009). Given the similarities between the responses of women in the caseload and standard models of care, it would appear that this gap was not ameliorated by continuity of care from a known midwife.

Discussion

Women's free-text comments about early labour care were almost universally negative. Women's experiences of early labour care, and their perceptions of early labour care quality, were not measured in the six-week postpartum survey; nor in other recent evaluations of caseload midwifery (Lewis et al., 2016; McLachlan et al., 2012). Likewise, the Cochrane Review of midwifery models of care (Sandall, Soltani, Gates, Shennan, & Devane, 2016) included ten studies that reported maternal satisfaction with aspects of maternity care, but none specifically examined women's experiences of early labour care. This paper attends to that gap by exploring women's free-text responses to open ended questions, highlighting both the significance of early labour care to women and the largely unstudied potential of caseload midwifery to meet that need.

374 Caseload midwifery has been conceptualised as a model which enables midwives to go 'above and
375 beyond' to help women feel empowered, nurtured and safe during pregnancy, labour and birth (Allen
376 et al., 2017). Caseload midwifery models are ideally organised to be able to flexibly meet women's
377 needs, which can include home visiting during early labour. Early labour home visiting could be a
378 woman-centred way of minimising early presentation to hospital, potentially improving clinical
379 outcomes by ensuring there is a skilled provider present for an imminent home birth and
380 accommodating women's preference for being admitted on initial attendance (Scotland, McNamee,
381 Cheyne, Hundley, & Barnett, 2011). Indeed, delaying admission to hospital may be one of the
382 mechanisms by which some RCTs of caseload midwifery have demonstrated reductions in the
383 caesarean section rate (Davey, McLachlan, & Forster, 2013).
384
385 Medicine promulgates the message that birth is dangerous outside of hospital (Roome, Hartz, Tracy,
386 & Welsh, 2015), it is therefore reasonable for women to present to hospital in early labour seeking
387 care and support. If there is widespread uptake of the change in the definition active labour (from
388 ~4cm to 6cm) there are likely to be further restrictions on when women are 'allowed' to enter birthing
389 units, with a concomitant increase in this critical early labour period (by ~9 hours) for more women
390 (Zhang et al., 2010). While most midwives aim to provide woman-centred care, they can be
391 overwhelmed by heavy workloads and external pressures that impact their ability to do so (O'Connell
392 & Downe, 2009).
393
394 Telephone assessment may not be a woman-centred alternative to hospital attendance as our
395 respondents reported particularly negative experiences. A Welsh mixed methods study including
396 telephone interviews with first-time mothers reported that dissatisfaction with early labour telephone
397 contact was associated with unclear advice, unmet needs, unaddressed anxieties and negative midwife
398 manner (Green, Spiby, Hucknall, & Richardson Foster, 2012). An English mixed methods study
399 reported that in response to non-labour admissions, feedback from consumers, and research evidence,
400 approximately half the surveyed hospitals (83/170 units) had made changes to their early labour
401 service to include home assessments, telephone assessment tools and/or triage units (Spiby, Green,

402 Richardson-Foster, & Hucknall, 2013). Doing early labour care well relies on an enabling
403 environment that includes reclaiming emotional support as a valid part of midwives' roles (O'Connell
404 & Downe, 2009), recognising the importance of these early labour hours to women and adjusting the
405 service model to enable midwives to provide the support some women need.
406
407 There is a dearth of research examining the impact of early labour *care* at home. Where research has
408 been conducted, it has focussed on *assessment* at home, where the emphasis is on midwives
409 diagnosing the onset of 'active labour' and authorising women to transfer to hospital. Randomised
410 controlled trials (RCTs) have found that assessment at home reduces the number of visits to hospital
411 in the latent phase of labour (Janssen et al., 2006), and is perceived by women more favourably than
412 telephone support (Janssen & Desmarais, 2013). Early labour assessment in the woman's home has
413 also been found to increase women's satisfaction with care (Janssen & Desmarais, 2013; Spiby et al.,
414 2007; Spiby et al., 2008a). However, reorienting home visiting in early labour towards *support* rather
415 than just *assessment* may confer greater benefits. Such a reorientation could reverse the roles found in
416 a hospital setting, such that the woman, rather than the midwife, has authority in the environment. In
417 retaining authority, women are not required to be "docile" or give up their own embodied knowledge
418 and power (Fahy, Foureur, & Hastie, 2008). Other studies of women who have managed the latent
419 phase of labour at home, reported that doing so relied on the woman's sense of power, autonomy, and
420 bodily and mental strength (Carlsson, Ziegert, Sahlberg-Blom, & Nissen, 2012). Early labour support
421 at home would also carry the benefit of (and indeed require) recognising early labour as an important
422 and valuable part of each woman's birth process (Reed, 2013).
423
424 **Limitations**
425 A limitation of this study is that it did not use in-depth data collection methods like interviews to
426 answer the research question. Furthermore, the survey did not ask women specifically about their
427 early labour care experiences. Participants who offered comments may have had experiences that
428 were different from the experiences of other women. Strongly negative or positive emotional
429 experiences are likely to be lasting, and are therefore more likely to be recalled even when not

430 explicitly prompted (Kensinger, 2009). The preponderance of negative impressions documented here
431 may have been an artefact of these women having particularly long, short or otherwise difficult latent
432 phases of labour, or being particularly fearful of childbirth.
433

434 The sample was purposive to the extent that women who were randomised to caseload, but crossed
435 over to standard care, were excluded from qualitative analysis. However, it is possible that early
436 labour care in hospital was provided to women in the caseload group, on occasion, by rostered
437 midwives unknown to them. This can happen if women present to hospital without calling their
438 midwives first, or if they arrive while their midwife is still travelling. In this instance, rostered
439 midwives may conduct an initial assessment; therefore, women's experiences in this case would
440 reflect being cared for by an unknown midwife. Instances of this in the data were rare, with the
441 caseload group usually referring to "my midwife", but it is a potential limitation.
442

443 This study was undertaken in two large maternity hospitals in Australia. It is not known if the results
444 are transferrable to caseload midwifery models in other settings, for example health services that offer
445 early labour assessment and/or birth at home.
446

447 **Conclusion**

448 Midwifery continuity of care models should evaluate the quality of the early labour care they provide.
449 Research on how best to provide early labour care, including early labour support at home, is
450 recommended.
451

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455

456

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