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MATERNITY CARE SUSTAINABILITY IN RURAL AUSTRALIA

Linda K Jones, Sarah Elliott, Lynne Staff*

School of Nursing, Paramedicine and Healthcare Sciences, Charles Sturt University, New South Wales, Australia

Correspondence: linjones@csu.edu.au

ABSTRACT

INTRODUCTION:

In recent years there has seen significant closure of small maternity units particularly in rural regions of Australia. Those small maternity units that do continue to care for childbearing women may only provide antenatal and postnatal care with women giving birth in a larger maternity unit often some distance away.

There are some small maternity units that continue to provide complete care to childbearing women which is the focus of this research. The issue here is that these small rural maternity units tend to only cater for women who are having a low-risk pregnancy. When the women are deemed 'high risk' they will need to transfer to a larger maternity unit for their ongoing antenatal visits and to birth. These larger maternity units are often some distance away requiring women to travel for each antenatal care visit and for birth.

This research aims to explore women's experience of having to transfer their care to a larger maternity unit due to being deemed at risk through interview of 40 women deemed at risk.

METHODS:

Focus of the research was women's experiences of needing to transfer their maternity care and used a qualitative descriptive phenomenology approach. To date seven women have been interviewed.

RESULTS:

This paper presents the preliminary findings from the interviews that have been undertaken to date on seven women. The data is presented under emerging themes which will be refined with further interviews. The emerging themes are 'women had no agency', 'the hidden cost' and 'the journey continues'.

CONCLUSION:

The paper presents the preliminary findings from these interviews. Ultimately the aim is to assess how care can be improved for these women and potential options/models of care and make these small rural maternity units sustainable.

KEYWORDS

rural women, maternity care, high risk, transfer, experiences.

INTRODUCTION

It is estimated that there are 300 maternity units across Australia with approximately 70% classify themselves as being in a rural and remote area (Homer et al., 2010). Though it has been reported, however, that it is challenging to accurately identify the number of rural and remote maternity units due to inconsistency in record keeping (Longman et al., 2014). In recent years there has seen significant closure of small maternity units particularly in rural regions. It is estimated that over the last 20 years 130 maternity units have closed (Bradow et al., 2021). Reasons attributed to this include maternal and neonatal safety due to lack of adequately qualified workforce, specifically midwives and GP obstetricians or anaesthetists. This is partially because these maternity units require 24 hour surgical and anaesthetic coverage onsite (Kruske et al., 2015). These small maternity unit closures are not always, however, because of staffing shortfalls and occur despite the evidence indicating that normal birth can safely occur in these units (Barclay & Kornelsen, 2016; Bradow et al., 2021). Those small maternity units that do continue to care for childbearing women may only provide antenatal and postnatal care with women giving birth in a larger maternity unit often some distance away (Homer et al 2010). There are some small maternity units that continue to provide complete care to childbearing women which is the focus of this research.

There has been some research undertaken where small maternity units have closed resulting in the need for women to access their childbearing care in a larger maternity unit that is often some distance away. Closure of maternity units have resulted in several issues. This includes the potential increased stress and risk to families as birth may occur outside of appropriate healthcare setting as well as the increased costs associated with increased travel and potential accommodation away from home and away from the women's family and support networks (Bradow et al., 2021; Evans et al., 2011; Hennegan et al.,2014; Ireland, 2009; Kruske et al., 2008). Consequently, this results in "significant social and health service risks that in turn exacerbate avoidable clinical risks" (Barclay & Kornelsen, 2016: 10). There are several specific consequences that have been identified in relation to childbearing care of these women following the closure of small maternity units. This includes delay in reporting pregnancy (Ireland, 2009), having no antenatal care (Ireland, 2009; Kruske et al., 2008), presenting to maternity unit late in labour (Ireland, 2009; Kruske et al., 2008), increased out of hospital unplanned births to name a few (Barclay & Kornelsen, 2016; Kildea et al., 2015), and most often needing to relocate to a larger centre to await the birth of their baby (Bradow et al., 2021; Evans et al., 2011; Hennegan et al.,2014) . Much of the work undertaken in this area has been specifically related to the impact on Aboriginal and Torres Strait Islander women in rural areas in Australia and the issues faced with maternity unit closure. Aboriginal and Torres Strait Islander women are usually identified as being of higher risk and are often required to birth in a larger usually metropolitan hospital, forcing them to relocate prior to birth and wait for this to happen. This results in added expense and isolation from any level of support as well as being away from other children and family members (Evans et al., 2011; Hennegan et al.,2014; Ireland, 2009; Kruske et al., 2008).

There are some small maternity units that continue to provide childbearing care for women who are deemed at low risk, meaning that all care is provided by the healthcare staff in that maternity unit. Sometimes women from these maternity units are required to transfer their care to a bigger maternity unit where there is higher level care (Kruske et al., 2015). A retrospective study was undertaken by Kruske et al., (2015) examining clinical outcomes of women who needed to transfer from one small maternity unit to a larger unit. This was from what is called a Primary Maternity Unit in Queensland which is a free-standing birth centre providing childbearing care to women predominantly by midwives in collaboration with general practitioners and limited obstetric, anaesthetic and paediatric support. In this unit women were required to transfer their care if complications arise to a higher-level service or larger maternity unit around one hour away. This study only examined the reasons for transfer and the travel times involved. It did not explore the women's experience of being transferred for care.

There has been some research undertaken looking at outcomes when women are required to transfer from rural hospitals to larger facilities during an obstetric emergency (Rigby et al., 2018). For instance, women in threatened premature labour are often transferred to larger facilities during pregnancy in case they birth a premature infant because they are in preterm labour, premature preterm rupture of membranes or have an antepartum haemorrhage (Rigby et al., 2018). The aim of this research was to ascertain the clinical reasoning behind the transfer of these women.

The focus of this research is when women are booked into a small maternity unit, usually that is rural or remote, for their childbearing care but are deemed to be at a high risk, determined by the risk assessment guidelines. This can be because of their 'advancing' age, high BMI or development of gestational diabetes, hypertension, just to name a few. These women consequently must travel past the local maternity unit to attend antenatal care visits and of course childbirth in the larger maternity unit. Under these circumstances women are travelling some distance for their antenatal appointments, waiting for some time to see, usually a different doctor each time and then returning home. When they are due to birth, these women often have to then relocate themselves close to the hospitals or are induced so that the labour and birth are 'planned'.

There appears to have been little exploration of women's experience when they are deemed at risk and are required to transfer their care and have their antenatal and childbirth in a larger maternity unit that is usually some distance away. This research aims to explore women's experience of having to transfer their care to a larger maternity unit due to being deemed at risk through interview.

METHODOLOGY

There is a need with this research for an approach that focuses on people consciousness of experiences of a phenomenon. In this case women who have to transfer their antenatal and childbirth care to a larger maternity unit. Such an approach that would be suitable is phenomenology which is the study of a phenomenon as a 'lived experience' or as it is meaningfully experienced (Whitehead et al, 2020). It is the role of the researcher to look, listen, feel, view, experience and go with the individual on their experience and thereby investigate, describe, interpret and extrapolate meanings of the essence of the phenomenon (Whitehead et al, 2020). Phenomenology provides such a means to achieve this goal and is the methodology that will be used for this research. This research is exploring an area with there is limited literature and as such used a qualitative exploratory phenomenological approach.

SETTING

Women who live in a rural and remote part of NSW and are booked into a local maternity unit for childbearing care who are then deemed at risk and required to have their antenatal care and childbirth in a larger maternity unit.

Recruitment

Recruitment of the women occurred through a specific research project social media site. Inclusion criteria is women over 18 years who had booked into a small rural or remote maternity unit for their childbearing care who are required to have their antenatal and birth care transferred to a larger maternity unit for ongoing care. These women will be a convenience sample and recruited postnatally around 10 to 12 weeks or more after birth. It is anticipated that 40 to 50 women will be recruited or until saturation of data and no new information is revealed.

DATA COLLECTION

Ethics approval was obtained from the Charles Sturt University Human Research Ethics Committee in November 2023. All participants received a copy of the Participant Information Sheet and Consent Form prior to commencing the interviews. Informed consent was obtained prior to starting the interview. Data collection began in August 2024.

Semi structured interviews were used. This technique for data collection uses an interview guide with set questions for discussion. The questions are open ended and non-directive designed to trigger and stimulate an open discussion. In other words, the guide is flexible enough to facilitate the interviewer to follow leads and areas of interest (Whitehead et al., 2020). Interviews occurred through Zoom, were audio recorded and lasted for approximately 40-60 minutes. This was then transcribed verbatim utilising zoom and checked for accuracy.

DATA ANALYSIS

Transcripts were deidentified with participants choosing their pseudonym from a list of gem names. Thematic analysis is a systematic process that allows the researcher to go through three major steps of: identifying patterns in the data; classifying or encoding the patterns; and interpreting the patterns.

RESULTS

Twenty-six women have responded to the expression of interest to be part of this research to date. These women have been contacted to organise an interview. Included thus far are women who have had to transfer their maternity care due to being low high risk, high high risk and also situations where the local hospital has closed, does not have a maternity service, or has been on bypass and women have had to transfer care as a result. High high risk includes women who have had to be admitted to another

hospital for ongoing care for things such as premature labour. Low high risk includes women with such concerns as a high body max index, high blood pressure or diabetes. These women require extra surveillance but are usually not admitted into hospital.

Overwhelmingly the women who have been interviewed have expressed gratitude for the opportunity to share their experience with many reflecting that this is the first time they have spoken about their experience. This paper presents the preliminary findings from the interviews that have been undertaken to date on seven women. The data is presented under emerging themes which will be refined with further interviews. There are no direct quotes added at this stage of the data analysis as this is preliminary findings. The emerging themes are 'women had no agency', 'the hidden cost' and 'the journey continues'.

WOMEN HAD NO AGENCY

Generally, women felt that they were invisible through the process and more of a number than a person. Women felt that healthcare professionals focused on the baby and ignored that there was a women carrying that baby. Healthcare professionals were too busy to care for the women even to the extent of not informing the women what was happening to them and what to expect. Women commented that they were so shocked about the suddenness to transfer, and in part, this was caused by not being given any knowledge of what was happening to them or what to expect. There was also no continuity of care for women, resulting in them having to repeat their story over and over to a different health provider at each visit. They expressed their frustration at having to do this.

This frustration extended to the lack of communication between the local hospital and the hospitals that women were transferred to. Women commented that the hospital they were being transferred to did not know enough about them. Furthermore, several women mentioned that they were pushed out of their bed as the this was needed for someone else. One woman was removed from her bed and left for three hours in a waiting room until she and her infant were 'officially' discharged.

For the women who were interviewed antenatal and postnatal care was the most problematic. This was because of the travel that was involved with having to transfer and the implications that this had on them personally. There were some women who reported having their antenatal care undertaken over the phone from the transferring hospital, but with no personal contact with anyone from the hospital they were transferred to. This is an area that needs further exploration in the remaining interviews.

THE HIDDEN COSTS

Having to transfer care involved a cost to the women. This included having to take time off from work to attend for care. As a consequence of the distances between maternity units, women had added costs of overnight accommodation and meals. This also meant the women were away from their families and support. This travel also entailed a cost of fuel for the car they travelled in. In some cases, partners had to take time off work to be with the women at this time.

In addition, there was the emotional cost of this transfer of care. Women reflected about the toll that this had on their partners and support people. More importantly was the toll that being transferred had on the women themselves, as illustrated here:

"Just because a woman seems strong on the outside and can hold their own, doesn't mean she isn't crumpling on the inside. It would be fair to say I could have PTSD from our journey, never diagnosed but a definite no from me for ever having more children. I couldn't do that again and come out sane." (Sapphire)

AND THE JOURNEY CONTINUES

Once the baby is born, these challenges for the women and her family continue and do not stop following the birth. There are often protracted nursery stays for the infant, with all that this entails. Once the infant(s) is discharged, ongoing check-ups of the baby are required, which occur at the hospital they were transferred to. These visits also entail the costs of travel, accommodation and meals. Further was the ongoing anxiety and concern these women expressed with the continued difficulties they had previously experienced.

Despite all of this, however, women expressed their gratitude for the care they had received. This can be summarised by the following:

"We really do live in a lucky country. But it is hard when you are from regional Australia." (Sapphire)

DISCUSSION

Overwhelmingly the women who have been interviewed had expressed gratitude for the opportunity to share their experience with many reflecting that this is the first time they have spoken about their experience. Generally, women felt that they were invisible through the process and more of a number than a person. Women felt that healthcare professionals focused on the baby and ignored that there was a women carrying that baby. Healthcare professionals were too busy to care for the women even to the extent of not informing the women what was happening to them and what to expect. The focus on the baby, or fetocentric care has been previously discussed in the literature as an issue identified by many women (Yates, 2016) and is reported to contributed to perceptions of birth trauma and related development of post traumatic distress (Harris & Ayers, 2012).

Women having to transfer care involved several costs. This included having to take time off from work to attend for care. As a consequence of the distances between maternity units, women had added costs of overnight accommodation and meals. This also meant the women were away from their families and support. This travel also entailed a cost of fuel for the car they travelled in. In some cases, partners had to take time off work to be with the women at this time. This has previously been identified in research into this area (Bradow et al., 2021; Evans et al., 2011; Hennegan et al.,2014; Ireland, 2009; Kruske et al., 2008).

In addition, there was the emotional cost of this transfer of care. Women reflected about the toll that this had on their partners and support people. This has also been reported in the literature and what has contributed to women not having further children (Bradow et al., 2021; Evans et al., 2011; Hennegan et al.,2014; Ireland, 2009; Kornelson et al., 2001; Kruske et al., 2008).

Once the baby is born, these challenges for the women and her family continue and do not stop following the birth. This is particularly the case for women who birth prematurely as the baby remains in hospital, sometimes for some time. Women then continue to travel to the hospital or stay there for some time to be with their baby. The increased psychological toll for these women can sometimes be significant.

This is an under investigated area with increasing numbers of women being transferred for care. This will contribute valuable data that will help inform practice, health service and health policy development.

CONCLUSION

This research aimed to explore women's experience of having to transfer their care to a larger maternity unit due to being deemed at risk through interview. Interviews have been undertaken on seven women to date. The emerging themes are 'women had no agency', 'the hidden cost' and 'the journey continues'. This indicates that having to transfer care to a larger maternity unit during childbearing has a significant toll on women and their families. More work needs to be undertaken to ascertain from the support people and health professionals to understand their experiences.

AUTHORSHIP:

All authors have contributed to the conception of this research, writing of research grant application, undertaking the research and the development of this paper. Authors have approved the final version of this paper.

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CONFLICTS:

The authors declare that there are no conflicts of interest involved with this research and preparation of this paper.

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