From hospital to home: Australian midwives' experiences of transitioning into publicly-funded homebirth programs.

Abstract

Background: Over the past two decades, 14 publicly-funded homebirth models have been established in Australian hospitals. Midwives working in these hospitals now have the opportunity to provide homebirth care, despite many having never been exposed to homebirth before. The transition to providing homebirth care can be daunting for midwives who are accustomed to practising in the hospital environment.

Aim: To explore midwives' experiences of transitioning from providing hospital to homebirth care in Australian public health systems.

Methods: A descriptive, exploratory study was undertaken. Data were collected through in-depth interviews with 13 midwives and midwifery managers who had recent experience transitioning into and working in publicly-funded homebirth programs. Thematic analysis was conducted on interview transcripts.

Findings: Six themes were identified. These were: skilling up for homebirth; feeling apprehensive; seeing birth in a new light; managing a shift in practice; homebirth - the same but different; and the importance of mentoring and support.

Discussion: Midwives providing homebirth work differently to those working in hospital settings. More experienced homebirth midwives may provide high quality care in a relaxed environment (compared to a hospital setting). Midwives acceptance of homebirth is influenced by their previous exposure to homebirth.

Conclusion: The transition from hospital to homebirth care required midwives to work to the full scope of their practice. When well supported by colleagues and managers, midwives transitioning into publicly-funded homebirth programs can have a positive experience that allows for a greater understanding of and appreciation for normal birth.

Summary of Relevance

Problem or Issue	Australian midwives who are trained in the hospital system now have the opportunity to provide publicly-funded homebirth.
What is Already Known	Midwives' experiences of transitioning into new models of care are influenced by attitudes within the maternity system as a whole, as well as locally within their workplace. Adequate training and support is required for midwives to successfully transition into new models of care.
What this Paper Adds	Providing publicly-funded homebirth offered midwives an opportunity to work to the full scope of their practice. With adequate support from midwifery managers and colleagues, providing publicly-funded homebirth was a positive experience that improved midwives' practice and fostered a new understanding of and appreciation for normal birth.

Introduction

Homebirth is an uncommon event in Australia with the vast majority of births (96.9%) occurring in traditional labour-ward settings.[1] In 2012, only 1177 births occurred at home, representing just 0.4% of all births in Australia.[1] Despite the low number of women accessing a homebirth, there is evidence of strong consumer demand for access to alternative places of birth such as the home.[2,3] In 2008, the Australian government undertook a National Maternity Services Review (MSR) in order to address the 'issues, gaps and priorities which concern Australian women and their families'.[4, p. 1] Analysis of public submissions to the MSR's community consultation process by Dahlen,[5] revealed that over 60% of the 900 public submissions were from women advocating and requesting homebirth.

In order to meet the demand for safe and affordable homebirth care, a number of publicly-funded homebirth programs have been developed in association with Australian public hospitals over the past 20 years. Currently there are 14 programs operating across New South Wales, Victoria, South Australia, The Northern Territory and Western Australia with further programs under development.[6]

Publicly-funded homebirth programs exist as an extension of the hospital's continuity of midwifery care model, usually known as either a Midwifery Group Practice (MGP) or Community Midwifery Program (CMP). In midwifery continuity of care models, the woman is assigned one primary midwife who provides the majority of her care with the support of other midwives from a small team who are available if the primary midwife is not. The primary midwife cares for the woman throughout the entire antenatal period, is on call to attend the woman's labour and birth, and then continues to provide care in the postnatal period at home following hospital discharge.[7] This model provides the most comprehensive one-to-one midwifery care available within the hospital system.[8]

For the most part, each publicly-funded homebirth program in Australia has been developed in isolation and, as a result, there are a number of differences in the way programs were established and currently operate.[9] Some publicly-funded homebirth programs have a specific team of midwives dedicated to providing homebirth care, while others ensure that the majority of their continuity of care midwives are able to provide homebirth. Midwives working in publicly-funded homebirth programs are usually required by the hospital to become accredited to provide homebirth via attaining a certain set of clinical skills that allow them to work to the full scope of their practice in the community setting.[9] Midwives working in this model remain employees of the hospital and, as such, are covered by the hospital's professional indemnity insurance. These midwives are bound by the same hospital policies

and protocols as when attending hospital births and, in the majority of cases, are able to continue providing midwifery care for women who transfer into hospital from a homebirth. This allows them to maintain continuity of care across the full spectrum of a woman's experience.

Generally, only healthy women deemed at low obstetric risk are eligible for publicly-funded homebirth and midwives working in the model are expected to follow the Australian College of Midwives 'Guidelines for Consultation and Referral'.[10] Eligibility criteria for women to access publicly-funded homebirth programs tend to be strict, though not all services follow the same policies and protocols.[9] For example, some programs require that women have the glucose tolerance test (GTT) screening for gestational diabetes mellitus (GDM). In such programs, declining the GTT would mean the woman is no longer eligible for publicly-funded homebirth, as would a positive result for GDM. In other programs, however, if a woman declines the GTT, so long as the woman is considered to have an adequate understanding of the possible health implications of her decision, she is free to choose publicly-funded homebirth.

Public hospitals offering home as an option for a woman's birthplace is a somewhat radical concept in Australia where the overwhelming majority of women give birth in a hospital setting. In other high-income nations such as England, The Netherlands and New Zealand where homebirth is more common, midwives tend to be exposed to homebirth during their midwifery education.[11,12] In Australia, however, during their midwifery degree, clinical placement for midwifery students takes place almost exclusively in the hospital setting due to difficulties with securing professional indemnity insurance for students. Exposure to homebirth is not built into the University or practical curriculum and a student midwife who is interested in homebirth would have to seek out practical experiences in this setting of her

own accord. As such, the vast majority of Australian midwives have never attended a homebirth and their involvement in a publicly-funded homebirth program may be their first exposure to this alternative place of birth.

A small number of individual evaluations have been carried out on several of the publicly-funded homebirth programs.[2,13-16] These studies primarily focused on women's experiences of using the service and evaluated safety outcomes for women and babies who planned to give birth at home within this model. While these evaluations offered some exploration of midwives' experiences within individual programs, to date, no national evaluation has been undertaken on midwives' experiences of working in this relatively new model of care.

The aim of this paper is to examine midwives' experiences of transitioning from providing hospital-based midwifery to homebirth midwifery care. It forms part of a larger PhD study conducted by the first author on midwives' experiences of providing publicly-funded homebirth in Australia. It is hoped that the findings of this research will contribute to the normalisation of homebirth in Australia, along with the continuation of publicly-funded homebirth programs and the expansion of both new and existing models in order to meet increasing consumer demand.

Methods

A qualitative study using a descriptive exploratory design was undertaken.[17] Descriptive analysis is recognised as being useful when investigating previously unexamined experiences,[17,18] therefore this design was appropriate for exploring this relatively new way of working for Australian midwives.

The study was advertised through the National Publicly-Funded Homebirth Consortium network via email. The Consortium was established in 2010 by Catling-Paull, Foureur and Homer in order to improve communication between publicly-funded homebirth programs.[9] Its principle aim is to facilitate the sharing of resources between services and has also allowed for a description and comparison of different programs and the collation of data on outcomes for mothers and babies.[9]

Participation in the study was open to all midwives registered to practice who had experience providing publicly-funded homebirth in Australia within the past five years. This time period was chosen so that participants had relatively recent experience of working in the model and also allowed for midwives who had sufficient experience in the model to be able to reflect on their experience of transition. In order to access midwives who may not have been providing clinical care but still played a significant role in the establishment or ongoing management of a publicly-funded homebirth service, the study was also open to midwifery managers. Some midwifery managers also offer care to a small caseload of women as part of their role.

Data were collected through in-depth, semi-structured telephone interviews that were audio recorded and later transcribed. Interviews typically lasted between 45 and 60 minutes. Field notes were recorded during interviews in order to identify important ideas and concepts as they emerged. These notes were expanded upon after the interview and formed part of the analysis process. Telephone interviews were chosen as it was not practical to travel to the diverse geographical locations where participants were situated. Telephone interviews are often depicted as a less than ideal mode of data collection because over the phone the researcher loses the ability to see visual cues resulting in a loss of contextual and nonverbal data and a perceived compromise to the development of

rapport.[19,20] Evidence is lacking, however, that phone interviews actually produce poorer quality data.[20,21]

The first author conducted all interviews for this study. Before the formal commencement of the interview she introduced herself to participants and explained her personal experience with homebirth (as a homebirth mother) and motivations for conducting the study. She had never worked with, or had any contact with any of the participants before commencement of the study. As a registered midwife, she was able to build rapport quickly and easily with participants, who were also midwives, over the phone. When compared with face-to-face interviews, telephone interviews offer some advantages including a greater level of flexibility in scheduling, reduction in costs for the research project, and a faster method of collecting data.[22] Further to this, phone interviews allow participants a greater level of anonymity which may encourage respondents to feel more relaxed and better able to disclose sensitive information.[20] For these reasons, telephone interviews are increasingly recognised as having the potential to provide a rich data source for qualitative analysis.[19]

Following transcription of the audio recordings, thematic analysis was conducted on the interview transcripts. Thematic analysis is a qualitative analytic method that allows for the identification, analysis and reporting of patterns and themes within data, thus facilitating the organisation of data into basic and more global themes.[23] The first author coded the data and established the initial themes. These were then shared for discussion and debate between other authors. Themes and their accompanying data were then organised in a computer spreadsheet. This process allowed for a thorough assessment of the strength of each theme; the more data clustered into a theme the stronger the theme until saturation occured. Once initial themes were identified within the data, linkages and relationships

between themes were identified, ultimately achieving the level of abstraction and interpretation presented in the findings.[24]

In order to maintain the confidentially of participants, transcripts were de-identified so that midwives' names and that of their workplace were protected. Midwives' names have been replaced with the term 'Midwife' or 'Manager' and the numbers 1 to 13 chronologically from the first interview to the thirteenth.

Ethical clearance to carry out the study was sought and obtained from the University of Technology Sydney's (UTS) Human Research Ethics Committee, approval number 2014000316.

Findings

Thirteen participants undertook telephone interviews, nine midwives and four midwifery managers. Participants in the study came from each of the five different states and territories of Australia that currently provide publicly-funded homebirth (New South Wales, Victoria, South Australia, The Northern Territory and Western Australia). All of the midwives interviewed had, within the past five years, worked in or managed a public MGP or CMP continuity of care model that offered homebirth as an option for women of low obstetric risk. Four of the participants had current or previous experience as a private practice midwife as well as providing publicly-funded homebirth, while the other nine had only provided homebirth as part of a publicly-funded homebirth program.

Six themes were identified in relation to midwives transition from hospital to homebirth care. These were; skilling up for homebirth; feeling apprehensive; seeing birth in a new light; managing a shift in practice; homebirth - the same but different; and the importance of

mentoring and support. Each of the themes will now be explained with comments from the midwives and managers interviewed used to illustrate the concepts.

Skilling up for homebirth

Midwives described the process of 'skilling up', which referred to developing competence in the range of midwifery skills necessary for attending women at home. Commonly these skills were intravenous cannulation, perineal suturing and maternal and neonatal resuscitation. Once competent in these skills, midwives were proud of their ability to work as autonomous practitioners and provide a complete service for the women in their care, for example:

> *'Being able to facilitate an entire experience from 20 weeks all the way through to 6 weeks postpartum with everything in the middle. I find that really satisfying actually'.* Midwife 2

Designation as the primary midwife for a homebirth required each midwife to have witnessed several births (commonly between two and five) and then act in the role of second midwife for several more. Once this process was complete and the necessary midwifery skills attained, they were able to attend a homebirth as the primary midwife. All services required a second midwife to be present for every homebirth. This supervision model was seen as an excellent way to introduce new midwives to homebirth in a supportive environment. For example, one manager said:

> *'We've got all these new midwives coming in and it's amazing. One whose only been in with us for… six weeks, she's been at two [homebirths], but because she hasn't been at homebirths before, she'll then have an accredited midwife on who knows what's going on. Then she would ring when transition is starting or when she feels she needs someone or if there's a problem.'*
>
> Manager 2

The supervision model was available for both new and experienced midwives. Even after being deemed competent, midwives were encouraged to engage the support of their colleagues whenever they felt unsure. As illustrated here:

> *'…just because you're deemed competent doesn't mean that you can't say "oh it's been a year since I've done one, I'm feeling a bit wobbly I might need an extra person". You know, that's fine!'* Manager 1

Midwives also reported participating in emergency drills in order to maintain the skills they had acquired. These were usually conducted in collaboration with obstetricians, anesthetists, ambulance workers and other allied health staff. This midwife explained her team's ongoing training, stating:

> *'We do two [homebirth drills] a year and we go to one of our houses and we have a day. So the morning is based on the drill and then a lot of teamwork and team building and things like that because you want to feel comfortable with the person that's with you [in an emergency].'* Midwife 5

Midwives saw maintaining their skills and building good relationships with allied health professionals as essential to providing safe homebirth care.

Feeling apprehensive

Midwives providing publicly-funded homebirth in Australia come from a variety of different backgrounds. In this study, four reported a previous involvement in homebirth either working as a private practice midwife (PPM), attending homebirths with a PPM colleague out of personal interest, or through their midwifery training in another country (namely England and New Zealand). The vast majority (nine out of 13), however, had no previous exposure to homebirth and expressed that initially they were apprehensive about being the midwife responsible for a woman's care at home.

Midwives commonly retold the story of the first homebirth they attended with many describing the acute anxiety they felt around practising in an environment so different to their usual place of practice, the hospital. This midwife described the shock of seeing a physiological third stage for the first time in the home setting:

> *'The first home birth I went to she had a baby in the water and I'd come from a tertiary centre in Sydney and you clamped and cut that cord and had the Synto [Syntocinon] within a minute, probably within seconds and she was having a physiological [third stage]… I'd never seen one of those before. And the baby was born in the water and it took a good 30 seconds to pink up and take its own breath and in my head I was like, "[Swears]…they've got to clamp that cord and get it to the oxygen." And it just started breathing on its own and it sounds so ridiculous now…'* Midwife 3

Some midwives even described feeling physically ill at their first homebirth, as reflected in this midwife's experience:

> *'Actually, I've spoken to a couple of my colleagues and they've all had very similar experiences when they're first exposed to a planned birth at home... They all go home and are thoroughly ill afterwards... I think there's a lot of adrenalin when you're in that first experience.'* Midwife 2

One midwifery manager described how midwives in her team who were reluctant to attend homebirths eventually came around:

> *'A lot of people are a bit funny about it… And then gradually, people just ... They get a woman who decides half way through her pregnancy she wants a homebirth and so then they might think, "Well..." Or they get called: "Can you go out to this woman?"… And over time, it's just been an evolution because you see now it's sort of normal. It's nothing wacko or different.'* Manager 2

Despite the initial apprehension felt by some, since their involvement in publicly-funded homebirth all midwives interviewed had become strong advocates of the model and felt that working in the program had been an important step in their midwifery career.

Seeing birth in a new light

Several midwives described the first time they attended a homebirth as being a revelatory experience. They recounted feeling as if they were seeing birth 'in a new light', despite having many years of midwifery experience. This midwife explained her change in outlook:

> *' I had facilitated almost a thousand births when I started working in MGP, but I had never seen a woman birth so calmly and physiologically as I did when I saw that woman birth at home… It was a completely new experience for me.'* Midwife 2

For some midwives, facilitating homebirths dramatically changed their perspective of hospital birth, as this midwife described:

> *'I actually think in a negative way it kind of changed how I felt about hospital birth because I remember the first homebirth I went to, I was euphoric and then I was hit with this horrible kind of resentment... I was so upset and frustrated for the amount of women that miss out on experiences like that.'* Midwife 1

Midwives acknowledged that not all pregnant women were interested in or suitable for homebirth. However, many expressed that they felt the publicly-funded homebirth model should be available to all women in Australia and that home needed to be viewed as a legitimate alternative to hospital for low-risk women.

A shift in practice

The woman's home was a different work environment for midwives and this was acknowledged to have an influence on their practice. Whilst midwives emphasised that the

same hospital policies applied to women at home, many of them noted subtle changes in the way they interacted with and cared for women. This midwife described the way the home environment influenced her:

> *'…one of the big things about birthing at home is I think you're not on high alert because you're less distracted with the goings on of the hospital. You're not hearing emergency bells out in the corridor. I think you are more in-tune with what the woman's body is doing and I think you're able then to facilitate change when change is indicated… I think that's almost why home birth can be safer than hospital birth for low-risk women.'* Midwife 2

Several midwives noted the difference in power dynamics when attending a woman at home. This was perceived to alter the way the midwife interacted with the woman and her partner, as this midwife identified:

> *'… you're a visitor in the home. Where in the hospital it doesn't matter what you do to change that perception, you're in control to a greater degree. So the control part of it is huge for me because... you're there as an invited guest in somebody else's labour when you're in the home environment.'* Midwife 3

The concept of being on the woman's territory was viewed in a positive light. Midwives observed that when women were on their territory they were able to relax into labour. This also alleviated the perceived need for the midwife to protect the woman's birth space as revealed by this midwife:

> *'… I think part of my job as a midwife is protecting the birthing space and I feel that at home it's a lot easier to do that because we don't have doctors coming while doing rounds, and pharmacists, and anaesthetists, and the other midwives. I think just keeping… the people down to a minimum I think makes a big difference.'* Midwife 2

Along with changes to their practice in the home environment, some midwives described how attending homebirths had prompted them to change the way they practice during hospital births. One midwife said:

> *'I feel like I'm able to facilitate normal in the hospital better now that I see what normal at home is like and I think I'm better at making the hospital environment more home-like for women.'* Midwife 2

Overall, midwives felt their experience of providing publicly-funded homebirth had improved their midwifery skills and their understanding of and appreciation for normal birth.

Homebirth - the same but different

Midwives identified practising in the home environment as being 'the same, but different' to hospital. As they became more familiar with homebirth, an awareness of similarities between hospital and home brought comfort to the midwives as they realised that the midwifery skills they had developed in their hospital practice were still effective in a woman's home. This midwife describes her realisation:

> *'As much as I always believed in homebirth, it is a little bit scary when you go to your first one until you realise how normal it is. But you are… You're still a midwife as well, you've got all the skills, it's just a different setting…'* Midwife 1

Midwives felt reassured that the same policies and protocols they followed in the hospital setting remained in place when caring for women at home. This manager describes the way her team operate:

> *'They don't do anything differently; they follow the same guidelines. When we wrote our guidelines we tried to align them with what everyone else is doing. They don't do anything more… special or different. They just do it in a different space.'* Manager 1

Overall, midwives felt protected by having the same set of rules to follow and they also believed this made the model safe for women and babies. However, some expressed frustration regarding policies they perceived to be 'too strict', as described here:

> *'It can be really frustrating working under really ... Um… They're not limiting policies but they can be a little strict sometimes.'* Midwife 2

The primary point of difference identified by midwives between hospital and home was the relaxed atmosphere of the home environment. One manager stated:

> *'…you can see a difference in the women and their family because they're very much in control because it's their environment. So it's nice to see that... The whole atmosphere is a lot more relaxed.'* Manager 3

This was perceived to greatly improve women's experience of labour and thought to facilitate normal birth. For midwives, being in the home environment also tended to help them feel more relaxed. The same manager reflected:

> *'As a midwife, it's just a totally different experience… much more relaxed. Even though people say, "Oh, God, I don't know how you take on that responsibility," Well it's just a woman who is birthing who supposedly has no complexities, so what's the issue, really? It's very much more relaxed than in the clinical setting.'* Manager 3

As midwives gained more experience with providing publicly-funded homebirth, their confidence grew. Reassured by working within the guidelines and policies they were familiar with, they became aware of the benefits of the home environment both for the woman and her family, and for the midwife herself. This enabled midwives to enjoy providing homebirth as they began to relax into their new role.

The importance of mentoring and support

Midwives described the positive effects of the mentoring and support that was offered to them when working in publicly-funded homebirth programs. At a homebirth there were

always two, or sometimes three, midwives present for the labour and birth. Many enjoyed the support offered by colleagues present at the birth, as this midwife detailed:

> *'I'd feel different if I was on my own. I enjoy having two [midwives] because you've just got a second pair of hands and a second perspective; which often isn't needed, but when it is you're very thankful that it's there.'* Midwife 3

Midwives also described the benefits of working alongside one another. It was noted that once qualified, midwives rarely work directly alongside each other in the hospital environment, which limits opportunities for observing and learning from one another. Working closely with colleagues at a homebirth allowed midwives to learn from one another in a supportive environment. For example, this midwife reflected:

> *'You often don't realise how or why you do things the way you do until someone picks you up on it, and then there's definitely that security within the practice to be like: "Oh hey, you do this. How come you do that? It might not be the best way to do it, why don't you try this?" … That constructive criticism, but in a really friendly, loving way that is just meant to help you improve.'* Midwife 1

The majority of midwives reported positive experiences of transferring women from home who required hospital care and this was seen as a major advantage of the publicly-funded homebirth model. This manager described how midwives working in the publicly-funded homebirth program interacted with core staff during a transfer:

> *'When they have to bring a woman in whose transferring, they come in and they're still part of one big team. It doesn't really matter. They just work a slightly different rostered system and they're giving birth in a slightly different environment, but they're still their teammate.'* Manager 1

However, not all midwives felt well supported. Some described being heavily scrutinised by the media, hospital management and other health professionals who weren't supportive of homebirth, for example:

> *'Every opportunity in the media [homebirth] is demonised. It's actually quite a difficult model to work in. There's still a great deal of resistance between hospital and home birth. This was a major problem when I was doing it. If you felt the need to transfer a woman in, you never quite knew what you were going to get, you never knew what reception you were going to get.'*
>
> Midwife 9

Considering that each of the 14 publicly-funded homebirth programs around Australia have been developed in isolation from one another, it is unsurprising that there are differences in midwives' experiences of working within the model. As there is no standard mode of operation, individual programs seem to vary significantly in terms of the level of support they offer midwives. Acceptance of the homebirth program appears to depend upon the beliefs and actions of individual health professionals and the culture within their respective hospitals.

Discussion

Six major themes were identified to explain midwives' experiences of transitioning from providing hospital birth to homebirth care in publicly-funded models. Midwives described in detail the practical skills required to provide care for a woman at home and the process of witnessing and assisting at homebirths before taking on the role of primary midwife. It was clear that midwives took the responsibility of caring for women at home very seriously and acknowledged that, for some midwives, this felt daunting at first.

Our findings reveal that the primary reason midwives were apprehensive about attending homebirths was due to a lack of exposure to homebirth leading to uncertainty about their ability to provide suitable care. Midwives were conscientious about ensuring they had the appropriate skills to keep women and their babies safe, however their stories of successfully transitioning into the model demonstrate that it is not necessary for midwives to have prior homebirth experience in order to provide suitable care in a publicly-funded program. Indeed, all of the clinical skills required by midwives to attend homebirths fall under the normal scope of practice for a registered midwife. Effectively, this means that all registered midwives could work in the model if they desired. However, for a few of the programs, finding midwives who want to work in the model has proven challenging.

Publicly-funded homebirth programs have had mixed success in attracting midwives to work in this new model of care. Whilst many of the programs have easily maintained adequate staffing levels, others have faced challenges in recruiting midwives to work in the model, and in some cases chronic understaffing has even led to the suspension and possible closure of the program. Yet our research illuminates that simply exposing midwives to homebirth with the support of midwifery colleagues not only increases their desire to provide homebirth care, it also increases their understanding of and appreciation for normal birth.

In the United Kingdom (UK), midwives' confidence to provide out-of-hospital birth services was examined by McCourt et al.[25] as part of the Birthplace in England research programme. Unlike in Australia, the UK's National Health Service's policy requires that every maternity service is able to provide care for women who desire homebirth.[25] Although this model appears to provide an excellent level of choice for women and serves to normalise homebirth by making it freely accessible, McCourt et al's[25] qualitative study found that many community midwives and managers lacked the confidence to provide homebirth care for

446 women due to a lack of experience. Midwives reported feeling that they did not attend
447 homebirths often enough to maintain their skills and feel confident in their ability to provide
448 safe homebirth care.[25] This notion was reiterated by women who had used the homebirth
449 service, some of whom felt the midwives had actively discouraged them from choosing
450 homebirth and/or did not provide optimal care.[25] Although the findings of the study are not
451 directly applicable to the Australian setting, the experience of midwives in the UK provides
452 some insight into the strengths and relative success of the publicly-funded homebirth model
453 in Australia.
454
455 A significant challenge to the success of publicly-funded homebirth models in Australia are
456 negative attitudes towards homebirth from the general public and some members of the
457 medical community, leading to a lack of support from the government.[5,26-28] Despite
458 international evidence supporting planned homebirth as being safe for women with low-risk
459 pregnancies,[29-34] the safety of homebirth still remains unresolved in the hearts and minds of
460 many maternity care practitioners. This is reflected in the differing stances of peak
461 professional groups representing midwifery and obstetric bodies[35] some of whom are for
462 homebirth, and others strongly against. This conflict also tends to play out on local levels,
463 leading to internal political struggles within individual maternity services.
464
465 Midwives and obstetricians personal experiences, thoughts and feelings towards homebirth
466 are important because health care providers' attitudes have the potential to influence
467 women's decisions.[36-38] As outlined earlier in McCourt's[25] study, women in the UK felt
468 discouraged from choosing homebirth by midwives who lacked the confidence to provide it.
469 In addition, an American study by Vedam, et al.,[36] examined whether nurse-midwives'
470 experiences with planned homebirth impacted on their attitudes and practice. The results
471 suggested that educational and clinical experiences with planned homebirth significantly

predicted favorable attitudes towards homebirth.[36] This is in-line with the findings from our study wherein midwives' who had never been exposed to homebirth before were more apprehensive towards providing homebirth. It was clear that these midwives not only felt unsure of whether they possessed the appropriate midwifery skills to provide care at home, they were also unsure about the concept of homebirth altogether. However, after their first exposure to homebirth, they felt reassured that homebirth was not only safe, but that it could potentially provide great benefits to women and babies, leading midwives to see birth 'in a new light'.

Decisions regarding birthplace are closely linked with issues of power and control for both mothers and midwives.[39,40] The home as a setting for birth can be interpreted as being both geographically and ideologically distant from the hospital.[41,42] Indeed, Cheyney refers to women choosing homebirth in the United States as a 'systems challenging praxis';[42, p. 254] a political act of rejecting the dominant obstetric model of childbirth. In this sense, it is understandable that there may be a level of discomfort felt by midwives who are employees of the hospital when they begin supporting women to homebirth. This uneasiness is reflected in our findings by the midwives' initial apprehension to attend homebirths and their careful insistence that the same policies and guidelines they follow in hospital are always followed at a homebirth. This is one of the ways in which publicly-funded homebirth is constructed to be 'the same but different' to hospital birth.

It is important to consider the impact that being in the woman's home environment might have on midwives. A growing body of evidence suggests that the environment a midwife is practicing in has the potential to impact her caregiving behavior.[43-45] For example, in New Zealand, Miller and Skinner[46] compared birth outcomes for women who gave birth at home and in the hospital setting within the care of the same midwives. Their research found that

despite receiving care by the same midwives working across both settings, women who gave birth at home were more likely to give birth without intervention and more likely to receive evidence-based care.[46] Miller and Skinner[46] strongly argue that care commonly offered in hospital as 'routine', is not always evidence-based.[47] However, when working in the home setting, midwives tended to support physiological birth by allowing events to unfold with minimal interference.[46]

Hammond, et al.[43] suggest that evidence of midwives' practising differently in different settings might be explained by the impact of the environment on midwives' neurobiological responses. They illuminate that the production and release of oxytocin in a midwife's body allows her to be in a state of calm and connection when caring for women during labour and birth.[43] This neurobiological response can be triggered by the midwife's experience and perception of the physical environment.[43] In our study, midwives explicitly described feeling more relaxed in the home environment without the constant interruptions, noise and sense of urgency they felt in hospital. The theory by Hammond, et al.[43] regarding the impact of the environment on care provider's behavior gives weight to the midwives' experience in our study and this same theory was demonstrated in Miller's[46] research described above. It is clear that if midwives feel more relaxed in the home environment, they are likely to be giving better care.

Our study provides insight into midwives' experiences of transitioning into publicly-funded homebirth programs, however it does have limitations. The sample size of 13 is small, though given that this is a relatively new model of care only operating across 14 sites in Australia, the total population of midwives who have worked in the model is not very large. A further limitation is in the potential for section bias; its possible that midwives' who self-selected to take part in the study were more likely to have strong feelings, be they positive

or negative, about publicly-funded homebirth which may mean we are missing the middle-ground. Another limitation is that participants in the study weren't offered to opportunity to provide feedback on whether they felt the findings accurately reflected their experiences.

Our study demonstrates that it is possible for midwives without prior experience of homebirth to transition into providing homebirth care in the publicly-funded model. Mentoring and support from other midwives and managers was a crucial factor in the midwives' sense of confidence and willingness to work in the model. Without support from managers and midwifery colleagues, midwives struggled to stay working in the model. Those who were well supported went from 'feeling apprehensive' to 'seeing birth in a new light'. As a result, some midwives reported a change to their midwifery practice in hospital as they strived to emulate positive aspects of the home environment.

Conclusion

Publicly-funded homebirth is an innovative model of care that accommodates the wishes of some women to access homebirth. For midwives, transitioning from providing hospital to homebirth care requires them to work to the full scope of their practice and cooperate with both midwifery and obstetric colleagues. This study has highlighted that, when supported adequately by midwifery managers and colleagues, midwives transition into providing homebirth care with ease and may discover unexpected benefits to working within this model of care.

The experience of providing homebirth care transformed midwives' views of normal birth and facilitated an unanticipated improvement in their midwifery practice. Further to this, the experience tended to transform midwives into strong advocates for homebirth.

549 Exposure to homebirth during midwifery education would serve to normalise homebirth for
550 midwives who will, in turn, communicate this positive message to the women they care for.
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