MIDWIVES' EXPERIENCES OF PROVIDING PUBLICLY-FUNDED HOMEBIRTH IN AUSTRALIA

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for admission to the Degree of Doctor of Philosophy

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Certificate of original authorship

I, Rebecca Coddington, declare that this thesis is submitted in fulfilment of the requirements for the award of Doctor of Philosophy: Midwifery, in the Faculty of Health at the University of Technology Sydney. This thesis is wholly my own work unless otherwise referenced or acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis. This document has not been submitted for qualifications at any other academic institution. This research was supported by an Australian Government Research Training Program Scholarship.

Signature:

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Acknowledgment of Country

I would like to acknowledge the traditional custodians of the Sydney region on which the University of Technology, Sydney stands – the people of the Eora nation. The Eora people are the traditional owners of this land and are part of the oldest surviving continuous culture in the world. I pay my respects to the spirits of the Eora people. I honour the ongoing cultural and spiritual connections to this country and endeavour to act with respect for the cultural heritage, customs and beliefs of all Indigenous people.

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Dissemination

This thesis was submitted in March 2018, as part of the final requirements to fulfil the degree of PhD in Midwifery at the University of Technology Sydney. The early findings were published during the candidature (see Appendix A). Further manuscripts will be submitted for publication in peer reviewed journals after completion oft the thesis. Dissemination of the research that occurred during the candidature is listed below.

Peer reviewed publications

Coddington, R., Catling, C. & Homer, C.S.E. 2017, 'From hospital to home: Australian midwives' experiences of transitioning into publicly-funded homebirth programs', *Women and Birth*, vol.. 30, pp. 70-76.

Conference Presentations

Coddington, R. 'Australian midwives' experiences of transitioning into publicly-funded homebirth programs.' 31st Triennial Congress of The International Confederation of Midwives. Toronto, Canada. June 2017. Oral presentation.

Coddington, R. & Fox, D. 'Birthplace in Australia: Midwives' provision of homebirth in the public and private sectors.' 31st Triennial Congress of The International Confederation of Midwives. Toronto, Canada. June 2017. Poster presentation.

Coddington, R. & Fox, D. 'Qualitative findings from The Birthplace in Australia project: Midwives' experiences of providing homebirth in Australia.' International Normal Labour and Birth Conference, Homebush, Australia. October 2016. Oral presentation.

Coddington, R. 'Seeing birth in a new light: Hospital midwives experiences of providing homebirth services.' University of Technology Sydney Place of Birth Seminar, Sydney Australia 2016. Oral presentation.

Media

How do midwives learn homebirth? 2016, radio interview, 2ser Think: Health, Sydney, 7 October. Recording accessible via: http://2ser.com/midwives-learn-homebirth/

Midwives and homebirth in Australia, 2016, radio interview, Mornings with Nick Rheinberger ABC Illawarra, Wollongong, 11 August. Transcript accessible via: https://www.uts.edu.au/about/faculty-health/news/midwives-and-home-birthing-australia

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ABSTRACT

Background: Homebirth is an uncommon event in Australia, with only 0.3% of all births occurring at home. Despite this low rate, there is evidence of consumer demand for out of hospital births. In order to meet this demand, 14 publicly-funded homebirth programs have been established in Australian maternity hospitals over the past two decades.

Aim: The aim of this study was to explore midwives' experiences of providing publicly-funded homebirth in Australia.

Methods: Twenty one semi-structured interviews were conducted with midwives and midwifery managers who had recent experience of working in publicly-funded homebirth programs. A constructivist grounded theory approach was taken to enable exploration of the underlying social interactions and processes in the area of inquiry.

Findings: Four overarching categories emerged from the data. These were: 'Making the leap from hospital to home', 'Seeing birth in a new light', 'Building trust' and 'Recognising the benefits of publicly-funded homebirth'. Hospital-based midwives who were exposed to homebirth for the first time found their perspective of birth was transformed. Midwives noted a shift in the power dynamics when on the woman's territory and many felt they were witnessing undisturbed birth for the first time.

Midwives and midwifery managers faced challenges in establishing and maintaining publicly-funded homebirth programs. They needed to develop strong, collaborative working relationships with doctors and endured a high level of scrutiny regarding their practice. Overall, the majority of midwives enjoyed working in the model and felt it helped normalise homebirth as an option for low-risk women.

Discussion: Homebirth has previously been regarded as being both geographically and ideologically distant from the hospital. The operation of publicly-funded homebirth programs, however, defies this characterisation by providing a homebirth service via public maternity hospitals and hospital-based midwives. The establishment of publicly-funded homebirth programs within Australian hospitals appears to have had a positive effect on attitudes towards homebirth, not only for women and midwives, but for allied healthcare providers who were previously mistrustful of homebirth.

Conclusion: The transition from hospital-based to homebirth care provided an opportunity for midwives to work to the full scope of their practice. When well supported by colleagues and managers, transitioning into publicly-funded homebirth programs can be a positive experience for midwives. Additionally, exposure to homebirth has the potential to transform maternity care provider's attitudes towards homebirth and significantly deepens their understanding of normal physiological birth.

Glossary of terms

This glossary provides an explanation of some of the terms used in this thesis.

Continuity of carer

In midwifery continuity of carer, 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 will be available when the primary midwife is not. The primary midwife will care for the woman throughout the entire antenatal period, be on call to attend the woman's labour and birth, then continue to provide care in the postnatal period at home following hospital discharge up until 6 weeks postpartum.

Midwifery practice

Encompasses the activities, behaviours and tasks that constitute the work of midwives. This is strongly associated with the philosophy of woman-centred care and includes the provision of clinical, physical and emotional care.

Normal birth

A normal labour and birth is powered by the innate capacity of the woman and fetus. Also known as a 'physiological' or 'natural' birth. Although definitions differ, this is generally accepted to mean spontaneous onset of labour during which the woman remains active and moves freely during labour, choosing her own position/s for pushing, and resulting in a spontaneous vaginal birth without interventions or complications.

Homebirth / planned homebirth

A homebirth is defined as when the planned place of birth at the onset of labour is the woman's home, with care provided by registered midwives. Along with care during labour and birth, the woman receives antenatal and postnatal care from her midwife at home or in a community clinic setting. Women who plan to give birth at home have access to the resources ordinarily found in the home (e.g. bath, shower and heat packs for pain relief) and the assistance of a skilled midwife. If a woman requests pharmacological pain relief or requires obstetric intervention, she may transfer to hospital. In the case of an emergency, the midwife can provide basic emergency care until an ambulance arrives for transfer. Midwives can also provide neonatal and maternal resuscitation in the home setting.

Privately practising midwife (PPM)

The term 'privately practising midwife' or 'PPM' in Australia is interchangeable with 'independent midwife' or 'private midwife' in many other countries. Privately practising midwives are self-employed and work either independently or in a group practice with other midwives. They work in the community providing antenatal and postnatal care and may also offer homebirth care or birth support for women planning a hospital birth. The woman pays the cost of care directly to the midwife. In Australia, eligible midwives (midwives so designated in the national register) can offer access to Medicare rebates for antenatal and postnatal care, provided they have a collaborative arrangement with a medical practitioner or public maternity

hospital. At present, there is no indemnity insurance available for the intrapartum aspect of homebirth midwifery care in Australia.

Publicly-funded homebirth

In Australia, publicly-funded homebirth programs offer eligible low-risk women the opportunity to give birth at home under the care of midwives. Such services often exist as an extension of a public hospital's continuity of midwifery care model, usually known as either a Midwifery Group Practice (MGP) or Community Midwifery Program (CMP). Midwives working in publicly-funded homebirth models are employees of the hospital and, as such, are covered by the hospital's professional indemnity insurance.

Transfer

The term 'transfer' refers to the transport of a woman from a planned homebirth to a maternity hospital during the intrapartum period, after the onset of labour or within 24 hours after birth. Transfer from a planned homebirth may occur due to the development of risk factors or complications that make it no longer safe for the woman to give birth at home. Women may also transfer due to a desire for pharmacological pain relief during labour or if she no longer feels comfortable to remain at home.

Woman/Women

The term woman or women is used, for this purpose of this study, to refer to a childbearing woman or women. Referring to the 'woman' may also include reference to the needs of her baby, partner, family and significant others.

Abbreviations

AHPRA	Australian Health Practitioners Regulatory Authority: A national organisation that supports the 14 boards in regulating health practitioners, of which the Nursing and Midwifery Board is one
ACM	Australian College of Midwives: The professional organisation for midwives in Australia
AMA	Australian Medical Association: The union for doctors in Australia
CMP	Community Midwifery Program, usually a continuity of care model
GP	General practitioner
MBS	Medical Benefits Scheme: The Australian public health insurance system
MGP	Midwifery group practice, usually a continuity of care model
NHS	National Health Service: Public health system in the United Kingdom
NMBA	Nursing and Midwifery Board of Australia: The regulatory board for nurses and midwives in Australia
PBS	Pharmaceutical Benefits Scheme: Public funding of health- related tests, investigations and medications in Australia
PII	Professional Indemnity Insurance: Insurance against civil liability incurred by, or loss arising from, a claim that is made as a result of a negligent act, error or omission in the conduct of the midwife.
PPMs	Privately practising midwife: Registered midwives who provide care during pregnancy, labour, birth and the postpartum period (or a combination of some of these) within their own private practice
PPH	Postpartum haemorrhage
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists: The professional body for obstetricians and gynaecologists in Australia and New Zealand