MIDWIVES' EXPERIENCES OF PROVIDING PUBLICLY-FUNDED HOMEBIRTH IN AUSTRALIA

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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.

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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.

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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

CHAPTER ONE: INTRODUCTION

Introduction

Planning to give birth at home is an uncommon choice for women in many high-income countries throughout the world, and Australia is no exception. In 2015, only 0.3% of Australian women had a planned homebirth with the vast majority (97%) of births occurring in traditional labour ward settings (AIHW 2017). Yet, despite the low number of Australian women choosing and achieving a homebirth, there is evidence of strong consumer demand for the opportunity to access alternative birth settings such as the home (Catling-Paull et al. 2013; Dahlen, Jackson, et al. 2011; Rigg et al. 2017). 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. Midwives working in these hospitals now have the opportunity to provide homebirth midwifery care, despite many having never been exposed to homebirth before. The midwives working in this model of care are the focus of this thesis.

Study aim

The aim of this study was to understand midwives' experiences of providing publicly-funded homebirth in Australia. In particular, the study was interested in midwives' satisfaction with working in this unique model of care and the barriers

and facilitators to the provision of publicly-funded homebirth as identified by midwives and midwifery managers working in or with the model.

This PhD forms part of the Birthplace in Australia study, a national cohort study measuring neonatal mortality and morbidity associated with births that are planned at the onset of labour to be at home, in birth centres or stand-alone midwifery units, compared with births in standard hospital labour wards for women at low risk of complications. Another PhD study was completed by Deborah Fox in 2017 as part of the Birthplace in Australia project. This study provided insight into the views of women, midwives and obstetricians regarding transfer from planned homebirth to hospital.

The original contribution my PhD aims to make, both to the field and to the Birthplace in Australia study, is to increase the understanding of maternity care provider's experiences of providing publicly-funded homebirth care, using a qualitative approach. It is intended that this information will provide insight into the acceptability, for midwives, of transitioning from hospital-based to publicly-funded homebirth care and contribute to the further development of the model, supporting its sustainability in the long term.

Background

This chapter provides a background to the study by summarising the overarching issues surrounding homebirth both internationally and in Australia. A general

overview of the Australian healthcare system is given, along with a description of how the private and publicly-funded models of homebirth operate. Firstly, a description of the political climate surrounding homebirth is provided in order to contextualise the issues related to the publicly-funded homebirth model of care.

The politics of homebirth

Whilst in most high-income countries it is now the cultural norm to give birth in hospital, historically this has not always been the case. Up until the mid 1930s the majority of women gave birth at home, attended by a midwife (Fahy 2007; Hunt & Symonds 1995). Since that time, however, hospital has become the default place of birth with other options such as homebirth and birth centres being labelled 'alternative' (Coxon, Sandall & Fulop 2014). In many high-income countries, a woman's choice of birthplace has become highly political, with discourses of risk and blame heavily influencing women's choices (Coxon, Sandall & Fulop 2014; Dahlen, Schmied, et al. 2011).

Although the hospital is afforded status as the default location for birth in many countries, evidence suggests that intervention rates in hospital birth environments are continuing to rise without substantive improvements in outcomes for women and babies (Coxon, Sandall & Fulop 2014; Miller et al. 2016; WHO 2015). Though great developments have been made in the management of complex pregnancy and birth in the past 50 years, there are concerns that the application of technology to the normal physiological process of childbearing has gone too far.

International evidence suggests that there may be iatrogenic risks for women planning to give birth in hospital when they are experiencing a normal, healthy pregnancy due to the over application of technological interventions (Brocklehurst et al. 2011; Cheyney et al. 2014; de Jonge et al. 2013; Hutton et al. 2016; McLachlan et al. 2012). On the other hand, international research into birthplace shows that for women of low obstetric risk, midwifery-led birth centres and homebirth provide a safe alternative to standard hospital care for both mother and baby and are associated with lower rates of caesarean section and obstetric intervention (Brocklehurst et al. 2011; Catling-Paull et al. 2013; Davis et al. 2011; de Jonge et al. 2009; Hutton et al. 2016; Olsen & Clausen 2013).

One explanation for the high intervention rate in hospital is the dominance of the biomedical model of childbirth, i.e. the characterisation of pregnancy and birth as an illness requiring medical supervision and technological intervention (Oakley 1980; Van Teijlingen 2005). Historically, midwifery has been aligned with a worldview that sees childbearing as an essentially normal physiological process that should only be interfered with if absolutely necessary, known as the social model of childbirth (Banks 2001; Kitzinger 2005). Obstetrics, however, is based on a more interventionist approach to pregnancy and birth - commonly referred to as the biomedical model. The biomedical model views the obstetrician as a 'mechanic' and the woman's body as a machine that is capable of breaking down at any time, therefore requiring constant surveillance (Van Teijlingen 2005).

These deeply held opposing philosophical positions play out in maternity care in a phenomenon sometimes referred to as the 'birth wars' (MacColl 2009). The 'birth wars' refers to a struggle for power between midwifery and obstetrics; both sides caring deeply about the safety of women and babies and both sides believing they are best positioned to care for women during pregnancy and birth (MacColl 2009). These politics also play into the debate surrounding women's choice of birthplace.

The likelihood of a low risk woman and her baby experiencing an adverse event are extremely low, whether she chooses to give birth in hospital, at a birth centre or at home (Brocklehurst et al. 2011). Despite this evidence, however, in Australia there is ongoing debate about maternity care including the safety of different birth settings and a woman's right to choose homebirth (Community Affairs Legislation Committee 2009; Dahlen et al. 2010; Fox, Sheehan & Homer 2018; Keirse 2010; Licqurish & Evans 2015; Pesce 2010; Roome et al. 2015).

This debate also occurs internationally and is often polarised by different professional groups having divergent views on the safety of alternative settings for birth. A review of position statements on homebirth from the peak professional midwifery and obstetric bodies in the United Kingdom, United States of America, Canada and Australia by Roome, et al. (2015) found they had widely differing stances. Significantly, some of these divergent positions were reached after reading the same body of research evidence, indicating a level of confirmatory bias

in the interpretation of evidence (Roome et al. 2015). It is likely that having such different interpretations of the same evidence is a result of each group having contrasting interpretations of the inherent safety of childbirth, such as in the social and biomedical models (Roome et al. 2015).

Homebirth, in particular attracts a significant amount of negative attention. Polarisation of attitudes towards the safety of homebirth is well documented in the literature (e.g. Catling-Paull, Foureur & Homer 2012; Chervenak et al. 2013; Cheyney, Everson & Burcher 2014; Coxon, Sandall & Fulop 2014; Ellwood 2008). Traditional midwifery perspectives of birth as a normal physiological process, and traditional obstetric perspectives that emphasise the potential pathology of birth result in a deep division regarding the most appropriate place for a woman to give birth (Roome et al. 2015).

The biomedical model of childbirth's emphasis on the potential for pathology to occur at any moment tends to result in a view that hospital is the safest place for a woman to give birth. In the hospital environment the process of birth can be controlled and emergency care is immediately available in the event of complications arising. The social model of health, however, sees the provision of safe maternity care as encompassing the woman's social, emotional and cultural needs as well as her need for physical safety (Davis-Floyd 2001). Additionally, the social model of childbirth recognises the impact of the environment on the woman and her care provider, as will now be explained.

The significance of birthplace

The environment a woman finds herself in during labour and birth is of great significance for several reasons. Firstly, the built environment has the potential to impact the physiological process of labour as a woman's body interacts with and receives feedback from the space she inhabits (Foureur 2008a; Hammond, Foureur & Homer 2014; Lock & Gibb 2003). Secondly, while the woman may not be cognisant of it, the politics and design of the space influence how she and her caregivers act and behave (Hammond et al. 2013). As Fahy suggests: 'no birth territory can exist outside the gendered, political, economic, social and legal power networks of a given culture' (Fahy 2008bp. 3).

Foureur and Hunter (2006), suggested that a birth setting that evokes feelings of comfort and safety has a greater potential to facilitate optimal physiological processes in the labouring woman's body. On the other hand, research has demonstrated that settings which are unfamiliar and contain bright lights and intrusive noises have the potential to elicit a fear cascade in the body, which can directly impact the course of labour through disruption of the hormonal balance required for progress of labour (Foureur 2008a; Foureur & Hunter 2006; Simkin & Ancheta 2005).

In this sense, the advantages of giving birth at home are multi-faceted. The woman is likely to feel more relaxed in her own environment as the space is familiar and

filled with the furnishings and décor of her choosing. During the birth, the space is inhabited only by people she has invited in, presumably loved ones and the midwives caring for her whom she has grown to know and trust. These two factors influence the hormonal process of labour, creating the optimal environment for unhindered progress (Foureur 2008a; Foureur & Hunter 2006; Simkin & Ancheta 2005).

Research also suggests that the birth environment has a significant impact on midwives and that the familiarity and functionality of the birth environment may be just as important for the midwife as it is for the woman (Bourgeault et al. 2012; Davis & Homer 2016; Hammond et al. 2013; Hammond, Homer & Foureur 2014; Miller 2009; Miller & Skinner 2012). Research by Hammond, et al. (2014) on the design of hospital birth rooms showed that midwives had cognitive and emotional responses to the birth environment that influenced their activities and behaviours. Similarly, Miller and Skinner (2012) theorised that the same midwives practice differently in different settings. Their study of midwives in New Zealand demonstrated that women who planned to birth at home received care that was more evidence-based than care provided by the same midwives in the hospital environment (Miller & Skinner 2012). Although this study was limited in that it only included a small number of midwives, it raises questions about the influence of the home environment on midwifery practice.

These matters are highly relevant to this study because midwives working in publicly-funded homebirth programs provide care for women in both the hospital and home settings. Participants in this study were in a unique position to reflect on the impact of birthplace on their midwifery practice. The following section describes the context in which publicly-funded homebirth models operate: The Australian healthcare system.

The Australian healthcare system

The Australian healthcare system comprises of both government run public hospitals, as well as private hospitals that operate under a user-pays system and private health insurance model. Access to free healthcare in public hospitals is facilitated by a national health financing scheme known as Medicare, first introduced to legislation in 1984 (Bloom 2000). Medicare reduces financial barriers to accessing healthcare for Australian residents by offering free access to public hospitals, subsidised access to medical practitioners and subsidised access to pharmaceuticals for prescription medications.

In addition to being able to access fully-funded public healthcare, over 46% of the Australian population possess private health insurance allowing them access to a wider range of health care options (Australian Prudential Regulation Authority 2017). For maternity care, these options include having continuity of care with a private obstetrician and admittance at a private hospital for labour, birth and the

postnatal period. In 2015, 73% of Australian hospital births were in the public sector with the remaining 27% in the private sector (AIHW 2017).

Maternity services in Australia are provided by a range of different healthcare professionals including midwives, obstetricians, and general practitioners (GP), some of whom have additional obstetric training. Midwife-led care is available in the public hospital system to women experiencing normal, healthy pregnancies. In this model, midwives provide the majority of care and work collaboratively with obstetricians, referring a woman to medical care if problems arise during pregnancy or birth that are outside of the midwife's scope of practice.

There are a number of models that also offer midwife-led continuity of care, known as caseload, midwifery group practice (MGP) or community midwifery practice (CMP). These models allow women to be cared for by the same midwife, facilitating the development of a trusting relationship, which tends to increase women's confidence to give birth (Forster et al. 2016; Homer, Brodie & Leap 2008). A randomised controlled trial in Australia demonstrated that continuity of care by a primary midwife increased women's satisfaction with their care (Forster et al. 2016) and, compared to standard care, made women less likely to have a caesarean section, require analgesia during labour or an episiotomy (McLachlan et al. 2012). In addition, their infants were less likely to be admitted to the special care nursery (McLachlan et al. 2012). Overall, mother and infant safety outcomes did not differ statistically between standard and caseload midwifery care,

suggesting that continuity of care can reduce interventions without compromising health outcomes (McLachlan et al. 2012). These findings are also supported by a systematic review conducted by Sandall et al. (2016) that indicated women who received midwife-led continuity of care were less likely to experience intervention and more likely to be satisfied with their care.

Whilst caseload models are available at some public hospitals in Australia, they do not usually have adequate capacity to cater for all women who want to receive continuity of midwifery care and not all hospitals offer this option (Tracy et al. 2013). The majority of pregnant women in Australia receive what's known as 'fragmented' care, wherein they meet several different midwifery and obstetric staff at each consultation throughout their pregnancy, birth and the postnatal period (Commonwealth of Australia 2008; Tracy et al. 2013). One of the ways women can access continuity of midwifery care is though a planned homebirth. There are a number of challenges, however, for Australian women who wish to access a homebirth, as described in the next section.

Homebirth in Australia

Choice regarding birth place is known to be a crucial factor in whether a woman perceives her birth experience to be positive or negative (Bryanton et al. 2008). Globally, however, a number of factors limit a woman's ability to choose her place of birth including her economic, social and cultural rights, along with local or

national policy constraints (Sandall, McCandlish & Bick 2012). In Australia, choice is hampered by a lack of alternative options to conventional hospital-based care being widely available (Dahlen et al 2011; Rigg et al. 2017).

For many decades, homebirth has not been a mainstream option for childbirth in Australia (Catling-Paull et al. 2013). According to the most recent data from the Australian Institute of Health and Welfare (AIHW), in 2015 there were 910 homebirths in Australia, representing only 0.3% of all births (AIHW 2017). This compares internationally with rates in 2010 of 2.7% for England, 3.7% for Wales, 1.8% for Iceland, 1.4% for Scotland (Euro-Peristat 2013), 0.6% in the US (in 2012) (Martin et al. 2013); 11% in New Zealand (Davis et al. 2011) and 16.3% (in 2010) for The Netherlands, down from 30% in 2004 (Euro-Peristat 2013). Whilst it is possible that the incidence of homebirth in Australia is under-reported (AIHW 2012), the relatively low rate of homebirth is more likely to be associated with a lack of access to safe and affordable care.

Currently in Australia there are two models of midwifery care available to women who are planning a homebirth. Firstly, a small number of publicly-funded homebirth programs operate throughout the country that eligible women can access through their local maternity hospital. Women's access to publicly-funded homebirth is governed by strict eligibility criteria including the geographical location of their home and/or if their pregnancy is deemed as being at risk of complications. In addition to being low-risk, women must meet a number of other

requirements to be eligible for a homebirth throughout their pregnancy and the final decision is at the discretion of the hospital. At the time of writing, there were only 14 publicly-funded homebirth services operating nationally, limiting women's access to this model of care. Figure 1. shows a map of where these services are located throughout Australia.

The second way women can access homebirth care in Australia is through employing a privately practising midwife (PPM), whose services the woman must seek out and fund herself with some support through Medicare funding for antenatal and postnatal care. In this model, the woman develops a contract for care directly with the midwife. In the past two decades, the number of midwives offering private homebirth has significantly declined, making this option difficult for many women to access. The specific challenges faced by privately practising midwives will be outlined in the next section.

Figure 1. Map of publicly-funded homebirth service locations, Australia.

In 2015, out of the 28,211 registered midwives in Australia who were employed in midwifery, only 241 attended birth at home as the primary midwife (AIHW 2016). Currently, national data collection on homebirth does not identify whether the care was provided by a publicly-funded or private midwife, therefore it is not known how many women are being catered for by each model.

Despite evidence of consumer demand for alternative birth settings, there has been a decline in the actual number of homebirths recorded in the past five years. In 2012, there were 1005 homebirths making up 0.4% of all births; this compares with a homebirth rate of 0.3% in 2015, just 910 homebirths out of 304,268 births in Australia that year (AIHW 2014, 2017). It is possible, however, that this data may not reflect the true number of babies being born at home as not all homebirths are reported and a small percentage of women choose to pursue an unattended homebirth. These births are either completely unattended by a professional care provider, known as a 'freebirth', or attended by an unregulated birth worker who may be a doula, ex-midwife or lay midwife (Dahlen, Jackson & Stevens 2011; Rigg et al. 2017). Although it is difficult to attain data on freebirths, their prevalence in Australia is thought to be increasing (Dahlen, Jackson & Stevens 2011; Rigg et al. 2017).

In addition, despite the regulations surrounding the provision of homebirth in Australia becoming stricter, research suggests that some women whose pregnancies are deemed high-risk (and therefore not suitable for homebirth) are still choosing to give birth at home with private midwives who experience a lack of mechanisms for easy collaboration with hospitals (Jackson, Dahlen & Schmied 2012). At times, this has resulted in poor outcomes for mother and baby (Kennare et al. 2010). Women's reasons for avoiding mainstream care typically include a lack of access to woman-centred models of care such as caseload midwifery care, inflexibility of the public system, and previously traumatic experiences in the

hospital system (Jackson, Dahlen & Schmied 2012; Keedle et al. 2015; Rigg et al. 2017). It is evident that, regardless of medical opposition to high-risk homebirth and freebirths due to concerns about safety, some women will still choose to give birth at home (Catling-Paull, Dahlen & Homer 2011).

Midwifery education and homebirth

Midwives' exposure to homebirth during their education has the potential to influence their confidence to provide care to women at home. All Australian midwives are currently educated in the University system, with the practical component of their course primarily taking place in a hospital setting. 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.

For graduates who wish to become a privately practising midwife (PPM), there is now a requirement for them to complete the equivalent of three years full time post-registration experience as a midwife (NMBA 2016). Further to this, all PPMs must provide evidence of current competence to provide pregnancy, labour, birth and postnatal care through completing a professional practice review and have an approved qualification to prescribe scheduled medicines required for practice across the continuum of midwifery care (NMBA 2017b). They must also undertake an additional 20 hours continuing professional development (CPD) per year, in

addition to the 20 hours of CPD required for general registration as a midwife. While there is no official pathway for registered midwives to gain experience in the provision of private homebirth care, anecdotally midwives report an informal apprenticeship system wherein a midwife who is new to homebirth can attend and assist at births before offering homebirth to clients in her own right.

Although this study is focused on midwives who provide publicly-funded homebirth, it is important to be cognisant of the experiences of privately practising midwives (PPMs) in Australia in order to understand the context in which homebirth care exists. The following section describes the difficulties faced by PPMs; the publicly-funded homebirth model will be more thoroughly described later in the chapter.

Challenges faced by privately practising midwives

As described earlier, privately practising midwives (PPMs) are registered midwives who are self-employed and work either independently or in a group practice with other midwives. They work primarily in the community, providing antenatal and postnatal care to women in their own homes and many offer homebirth care. Some PPMs will also provide continuity of care and birth support for women planning a hospital birth.

Currently, PPMs face a number of challenges in providing homebirth care to women. In recent years there have been substantial changes in the way homebirth

is regulated in Australia including the requirement of further qualifications, hospital work experience, additional continuing professional development hours and the mandated attendance of a second midwife at every homebirth. One of the major challenges for PPMs, which currently remains unresolved, is the acquisition of professional indemnity Insurance (PII) cover for homebirth.

PII is insurance against civil liability arising from a claim that is made as a result of a negligent act, error or omission in the conduct of the midwife (NMBA 2016). Prior to 2002, midwives could access insurance cover for homebirths, however the collapse of the international insurance industry in 2001 resulted in the withdrawal of PII for private midwives offering homebirth care (Catling-Paull et al. 2013). Following this, there was a significant decline in the number of midwives offering private homebirth services, though some continued to provide care without the safety net of insurance.

In 2010, however, the National Registration and Accreditation Scheme (NRAS) for health practitioners was established in Australia. Under NRAS, the National Law required that all practitioners have PII arrangements in place in order to cover their practice (Commonwealth of Australia 2013). However, PPMs were unable to comply with this condition, as an insurance product covering the intrapartum period (labour and birth) had not been available since 2002. This meant that, effectively, it would have been illegal for a midwife to provide care to a woman in

labour at home, as the midwife's insurance does not cover the intrapartum aspect of care.

Initially, an exemption to PPMs for the requirement of PII was made available as a temporary measure, however for the past eight years the exemption has continually been extended in one to three years blocks; it is currently due to expire in December 2019. This tenuous situation has deterred many midwives from entering private practice, as have anecdotal stories of vexatious reporting of PPMs to the Australian Health Practitioner Regulation Agency (AHPRA). Whilst stakeholders have attempted to work with the government to resolve the insurance issue, at this time no such resolution has been met.

Consumer demand

There are considerable indications that Australian women desire access to alternative places of birth such as birth centres and homebirth. In 2008, the Australian government undertook a National Maternity Services Review in order to address the 'issues, gaps and priorities which concern Australian women and their families' (Commonwealth of Australia 2008, p. 1). Analysis of public submissions to the Maternity Services Review's community consultation process by Dahlen (2010), revealed that over 60% of the 900 public submissions were from women advocating for, and requesting, homebirth.

Consumers expressed feeling confused as to why homebirth was not supported by the government when women who give birth at home in the care of a privately practising midwife (PPM) save the government and taxpayers a significant amount of money by not engaging in the public health system (Dahlen et al. 2011). These consumers urged the government to provide funding for this cost effective form of care, however, their pleas were not answered (Dahlen et al. 2011; Dahlen, Jackson, et al. 2011; Rigg et al. 2017).

Submissions by professional bodies to the Maternity Services Review also revealed a desire by some medical groups, such as the Australian Medical Association (AMA), to restrict women's access to homebirth. The AMA, a politically influential group, clearly stated in their submission to the Maternity Services Review that with regards to midwifery-led homebirth 'the Federal Government could not reasonably nor responsibly introduce payment arrangements which encourage and sanction such activities' (AMA 2008, p. 10).

Ultimately, the Australian Maternity Services Review identified homebirth as a sensitive and controversial issue and rejected consumers' requests to include homebirth as a viable option when choosing their place of birth (Catling-Paull et al. 2013; Dahlen, Jackson, et al. 2011). This is because homebirth is a highly contentious political issue.

Women's motivations to give birth at home are many and varied. For some women, homebirth is a political act, something Cheyney refers to as a 'systems-challenging praxis' (2008, p. 254). Yet for others, it is simply the most comfortable and convenient place to give birth (Catling-Paull, Dahlen & Homer 2011). Commonly homebirth has been seen as a rejection of the medically dominated maternity care system (Cheyney 2008). In this sense, home as birthplace offers not only geographical distance from hospital, but an ideological distance as well (Burns 2015). This is, perhaps, why the notion of homebirth is so politically volatile.

Consumers have identified the cost of accessing private homebirth as a considerable issue inhibiting access to the model of care. Whilst Medicare rebates are available for antenatal and postnatal care, as there is no insurance covering the intrapartum period, women cannot obtain a government rebate for this aspect of care. In Australia, the average cost to a woman and her family for a private homebirth is between AU$3000 and AU$6000.

Women have reported experiencing financial difficulties in their attempts to pay for the services of a PPM and some found the cost so prohibitive that they felt forced to seek maternity care in another setting (Dahlen et al 2011; Rigg et al. 2017). Recent research by Rigg et al. (2017) indicated that a lack of availability of midwives and the inability of consumers to afford private midwifery care lead to women freebirthing and seeking care from unregulated birth workers in order to

give achieve their desire of giving birth at home. As a response to these issues, publicly-funded homebirth programs have been established throughout Australia.

The publicly-funded homebirth model in Australia

Despite the controversy surrounding homebirth, in Australia a small number of publicly-funded homebirth models have been set up by maternity hospitals throughout the nation. Publicly-funded homebirth is an innovative model of care that accommodates the wishes of some women to access homebirth with the care of a qualified midwife who is covered by insurance and networked into a maternity health service that will provide back up if necessary. The first publicly-funded homebirth program commenced over 20 years ago in Western Australia. Since that time, several services have developed in other States and Territories - most since 2004 (Catling-Paull, Foureur & Homer 2012). Currently, 13 publicly-funded homebirth programs are operating in Australia (14 at the time of data collection), with several more in the planning phase.

These programs are based within the public hospital system and are usually available to women of low obstetric and medical risk. Midwives working in this model of care are employees of the hospital and, therefore, are covered by the hospital's professional indemnity insurance (Catling-Paull, Foureur & Homer 2012). Midwives are carefully selected to work in the model; some programs seek to employ midwives with previous experience of working in caseload midwifery

models or homebirth practice, while others mentor midwives who are existing hospital employees (Catling-Paull, Foureur & Homer 2012).

Eligibility criteria for women to access publicly-funded homebirth models tend to be strict, though not all services follow the same policies and protocols (Catling-Paull, Foureur & Homer 2012). Generally 'low-risk' women who live in the catchment area are eligible for publicly-funded homebirth. Low risk refers to a woman with no past family, gynaecologic or obstetric history that may increase her risk of an adverse outcome, no pre-existing or pregnancy related hypertension or diabetes, maternal age greater than 14 and less than 45 years, Body Mass Index greater than 17 and less than 35 and parity less than five (have previously given birth less than five times). Further to this, women accepted onto the publicly-funded homebirth program need to undergo a series of screening tests during pregnancy to assess for the development of any further conditions considered to increase the risk of adverse outcomes. Midwives providing publicly-funded homebirth are generally expected to follow the Australian College of Midwives 'National Midwifery Guidelines for Consultation and Referral' (ACM 2013). If there is any deviation from the norm during pregnancy or birth midwives are obliged to consult with, or refer the woman to, obstetric care at the hospital they are affiliated with.

As each of the publicly-funded homebirth programs have been developed individually by the hospital they are affiliated with, there are a number of

differences in the way programs were established and currently operate. Each service collects data differently and uses different definitions and guidelines for reporting. This makes publishing outcomes for the combined services quite challenging and until recently there was a distinct lack of publicly available information about the characteristics, development and outcomes for publicly-funded homebirth programs (Catling-Paull, Foureur & Homer 2012).

In order to remedy this, the National Publicly-funded Homebirth Consortium was established in 2010 by Catling-Paull, Foureur and Homer (2012). The Consortium facilitates a sharing of resources between services and has also allowed for a description and comparison of different programs and the collation of data on outcomes (Catling-Paull, Foureur & Homer 2012). The Consortium proved to be a valuable resource for this study as it provided a direct means of communication with midwives working in publicly-funded homebirth models in Australia.

My interest in this topic

My interest in this topic is both professional and personal. I am a mother to two young boys who were born at home in 2009 and 2013. In both pregnancies I received excellent, personalised, compassionate care from experienced private midwives in the comfort of my own home. I was myself a midwife and was young, healthy and well-informed. Both births were completely straightforward, yet my decision to give birth at home was often met with shock and concern from friends, family members and strangers. Even women who were somewhat supportive of

my choice would comment on how 'brave' I had been to give birth at home, adding that they could never do it themselves. This is when I discovered, first-hand, the tangible fear of homebirth that exists in the community.

Over the years my interest and passion for homebirth grew and while completing my Bachelor of Midwifery Honours (2010-2012), I developed a greater awareness of the politics of maternity care. It was then that I began to understand more fully why people were so fearful of homebirth and also recognised some of the drivers behind the continually increasing intervention rates in birth. I realised that many Australian maternity care providers were limited in their understanding of birth, because they had only ever witnessed it in the hospital environment. Marsden Wagner's (2001) philosophy that 'Fish can't see water', helped me to understand that if individuals have only ever witnessed birth in an environment of fear and intervention, they are generally unaware that birth can happen any other way.

When I embarked on my PhD studies in 2012 and became part of the Birthplace in Australia project, reading qualitative research from the Birthplace in England study piqued my professional interest in the topic of publicly-funded homebirth. Christine McCourt's (2012) manuscript addressed UK midwives' readiness to provide care for out of hospital births. Key findings of the research were that many community midwives and managers lacked confidence to provide care for women in homebirth, and the women in their care noticed this (McCourt et al. 2012). These findings prompted my interest in exploring how midwives working in our

Australian publicly-funded homebirth services were managing their transition from hospital-based to homebirth care. I was interested to know what sort of support they needed and whether witnessing and being involved in homebirth altered their perception of birth.

I was also aware of one publicly-funded homebirth program that had recently ceased operating due to low staffing and lack of support from management, despite the achievement of excellent outcomes over ten years of operation. This sparked my interest in exploring how publicly-funded homebirth models could be sustained in the long term, particularly when they operated in a culture that is generally unsupportive of homebirth.

Justification of the research

Publicly-funded homebirth services offer the opportunity, for some Australian women, to access government subsidised homebirth care provided by midwives who are networked into mainstream maternity services. It is important that consideration is given to the experiences of both women and midwives involved in publicly-funded homebirth, in order to support the success and long-term sustainability of the model.

To date, a small number of evaluations on publicly-funded homebirth services have been published (e.g. Catling-Paull et al. 2013; Hider 2011; McLachlan et al. 2016; McMurtrie et al. 2009; Nixon, Bryne & Church 2003; Thiele & Thorogood

1997). These studies were primarily focused on the outcomes for mothers and babies amongst local publicly-funded homebirth services, along with the perceptions and experiences of women engaging them.

The first national report of maternal and neonatal outcomes for Australian women planning a publicly-funded homebirth was authored by Catling-Paull, et al (2013). Whilst the sample size was not large enough to draw conclusions about the safety of homebirth, the rates for caesarean section, postpartum haemorrhage, third degree perineal tears, stillbirth and early neonatal death were low, affirming the safety of these programs (Catling-Paull et al. 2013).

Additionally, a survey by McLachlan et al. (2016) explored midwives' and doctor's views and experiences of publicly-funded homebirth in one state of Australia (Victoria). This research showed that most midwives thought the model was safe, however doctors held mixed views about the safety of the model, with one third thinking it was unsafe (McLachlan et al. 2016). Of particular interest for this study was that midwives who had direct experience of working in the publicly-funded homebirth model were more likely to think that it was safe (McLachlan et al. 2016), giving weight to the notion that exposure to homebirth influences notions of acceptability.

There is yet to be any substantial research on Australian midwives' and midwifery managers experiences of working in or with publicly-funded homebirth programs.

This study generated new insight into the challenges and successes of publicly-funded homebirth programs. This research offered a unique opportunity to explore midwives' and manager's experiences and satisfaction with providing publicly-funded homebirth, contributing to a better understanding of the feasibility of further expanding the provision of publicly-funded homebirth in Australia in order to meet consumer demand.

Thesis outline

This thesis is presented in nine chapters. The contents of each chapter are briefly described below:

Chapter One has provided a background to the study by describing the political and practical context within which the publicly-funded homebirth model exists. This chapter briefly describes the models of homebirth care available to Australian women, along with a discussion of existing research on the topic and justification for this study.

Chapter Two provides a review of literature relevant to the topic, including international literature on the safety of homebirth, the significance of the birth environment and midwives' experiences of providing homebirth care.

Chapter Three provides an overview of the methodology of the study, grounded theory. The constructivist approach to grounded theory that was employed for this

study is also outlined in this chapter with reference to its influence on the techniques of data collection and analysis employed.

Chapter Four provides a detailed account of the setting and participants involved in this study, along with a comprehensive description of the methods of data collection and analysis that were employed. Ethical considerations for the research are also outlined.

Chapter Five to Eight inclusively present the findings and analysis of the study. The findings comprise four categories in four chapters, *'Making the leap from hospital to home', 'Seeing birth in a new light', 'Building trust'* and *'Recognising the benefits of publicly-funded homebirth'.*

Chapter Nine is the Discussion, which includes the substantive theory emerging from the study, '*The transformational power of exposure to homebirth*.'

Chapter Ten concludes the thesis, describing the implications for practice and further research.

Summary

This chapter has presented a wide range of topics relevant to this study. An overview of the Australian healthcare system set the context for the study, along with detail on the maternity care options available to Australian women. The political climate in relation to homebirth in Australia was briefly described, in order to give the reader a better understanding of why publicly-funded homebirth programs have been developed and the possible challenges they face.

To date, no national evaluation has been undertaken on midwives' experiences of working in this innovative model of care. It is hoped that the findings of this research will contribute to the maintenance and/or improvement of retention rates for publicly-funded homebirth and the expansion of both new and existing models in order to meet increasing consumer demand. The next chapter will review the literature on homebirth and midwifery practice.

CHAPTER TWO: LITERATURE REVIEW

Introduction

This review examines national and international literature relevant to the topic '*Midwives' experiences of providing publicly-funded homebirth in Australia'*. The literature reviewed primarily comes from the field of maternity care, however some work from broader health and social science fields is included, in particular in the section on organisational culture. The method of the literature review will now be discussed in relation to the chosen methodology.

Method of the literature review

This study employed a constructivist grounded theory methodology, primarily based on the work of Charmaz (2006). The methodology and methods of the study are described in more detail in Chapters Three and Four, however the chosen methodology is significant here because individual versions of grounded theory approach the literature review differently.

A traditional approach to grounded theory, also known as 'classic' grounded theory (e.g. Glaser & Strauss 1967; Strauss & Corbin 1990) proposed that the researcher should avoid conducting a literature review prior to data collection and analysis so as to avoid 'contaminating' the data (Birks & Mills 2015). Constructivist grounded theory, on the other hand, recognises that it is not possible for the

researcher to approach a topic with a completely impartial perspective, no matter how hard we might try (Charmaz 2006). As discussed in Chapter One: Introduction, I am both a midwife and homebirth mother who has a keen interest in homebirth, therefore I brought an existing level of knowledge to this topic even before conducting the literature review. This is fitting, however, for a constructivist approach to grounded theory as an understanding of the literature from the outset is thought to increase the level of theoretical sensitivity possessed by the researcher (Birks & Mills 2015).

The initial literature review was conducted and written up early in my candidature (2012 and revised in 2014). Although it is the practice of some researchers to later update the literature review before submission of the thesis, this approach has not been taken here. In this sense the literature review is a true reflection of the evidence available prior to data collection and analysis and an establishment of the gaps in the literature that drove the study. More recent literature pertinent to the topic has been included in Chapter Nine: Discussion.

Search strategy

A literature search was conducted using the terms: birthplace, homebirth, publicly-funded homebirth, midwives' experiences, and organisational culture. Inclusion criteria were that the paper was written in the English language or translated into English, was published in the last 20 years, was from a peer-reviewed journal or edited book, had an identifiable author and publication details and a relevant

focus to my research. Items such as editorials, conference proceedings and letters were excluded along with articles with a non-relevant research focus. This is a narrative review and as such research has been grouped into the topics of homebirth safety, birth environment, the role of the midwife, and organisational culture. The aim of the review was to establish any gaps in the literature in relation to midwives' experiences of providing publicly-funded homebirth. The literature from each of these subject areas will now be explored.

International evidence on the safety of homebirth

Randomised controlled trials (RCT) are generally considered the highest level of evidence for scientific research, however to date, it has not been feasible to conduct an RCT on the safety of homebirth. Given that women are unlikely to agree to the randomisation of their birthplace, there is some debate around whether an RCT comparing hospital and homebirth will ever be carried out (Keirse 2010; McLachlan & Forster 2009). Dowswell et al (1996) undertook a small feasibility study to assess whether women would accept being randomised to either home or hospital setting for birth. This study confirmed the low probability of an RCT ever being feasible as only 11 out of 500 women agreed to randomisation (Dowswell et al. 1996). Hendrix et al (2009) also found that women were reluctant to relinquish their control over where they gave birth.

Although no randomised controlled trial evidence on homebirth exists, extensive international evidence from cohort and observational studies has demonstrated

the safety of homebirth for women of low obstetric risk (Ackermann-Liebrich et al. 1996; de Jonge et al. 2009; Howe 1988; Janssen et al. 2002; Johnson & Daviss 2005; Olsen 1997; Olsen & Jewell 1998; Weigers et al. 1996). Low obstetric risk is generally defined as: a woman with no past family, gynaecologic or obstetric history that may increase her risk of an adverse outcome, no pre-existing or pregnancy related hypertension or diabetes, maternal age greater than 14 and less than 45 years, Body Mass Index greater than 17 and less than 35 and parity less than five (have previously given birth less than five times).

Studies undertaken in Australia have raised concerns about higher perinatal mortality rates at homebirths, however it is difficult to draw conclusions from these studies as they have often included high risk women such as those carrying twins or with medical complications (Bastian, Keirse & Lancaster 1998; Kennare et al. 2010).

A meta analysis conducted in the US by Wax et al. (2010), also showed poorer neonatal outcomes for babies born at home compared with hospital, demonstrating a tripling of the neonatal mortality rate for homebirths from 0.04% to 0.15%. This study, however, has been heavily critiqued as having a flawed analysis process due to numerical errors, improper inclusion and exclusion criteria, and a mischaracterisation of cited works (Gyte 2010). The study by Wax et al. (2010) has also been criticised for use of a software tool during the meta-analysis calculations that was found to contain significant errors. In addition to this, it is

significant that homebirth in the US occurs outside the mainstream maternity system and is often attended by certified midwives who have not undertaken university education. As such, homebirth operates as a fringe activity and the midwives providing it are not well networked into the hospital system for backup if required.

Whilst no RCTs on the safety of alternative birth settings currently exist, several countries have carried out meaningful research into the safety of alternative settings. Studies examining maternal and neonatal outcomes in alternative settings from England, The Netherlands, Canada and New Zealand and Australia are outlined below.

England

In 2007, the UK government commissioned the 'Birthplace in England' study: a large-scale prospective cohort study comparing perinatal outcomes, maternal outcomes and interventions in labour for women of low obstetric risk (Brocklehurst et al. 2011). The prospective cohort study compared women who planned to give birth at home being cared for by National Health Service (NHS) trust midwives (similar to Australian publicly-funded homebirth programs), freestanding midwifery units, midwife-led units on a hospital site (similar to Australian birth centres) and standard obstetric units (labour-wards). Neonatal health was the primary outcome with a composite measure used that included mortality and morbidity.

Overall, the study found that the incidence of adverse perinatal outcomes was low in all settings for healthy women with low-risk pregnancies (Brocklehurst et al. 2011). Healthy women planning to give birth at home or in a midwifery-led unit were more likely to achieve a vaginal birth and experience less intervention than women who planned to give birth in an obstetric unit (Brocklehurst et al. 2011). There was no statistically significant difference in the incidence of adverse perinatal outcomes overall for women who commenced labour planning a homebirth compared with women planning to give birth in labour-ward (Brocklehurst et al. 2011). For women having their first baby, however, the risk of adverse perinatal outcomes for planned homebirths was higher (9.3 per 1,000 births versus 5.3 per 1,000 births in labour-wards); no difference was found between labour-wards and midwifery-led units (Brocklehurst et al. 2011). Overall, Brocklehurst et al. (2011) concluded that women with low-risk pregnancies should be offered a choice of birth setting.

Several aspects of The Birthplace in England study have been criticised, namely for the study's short time frame and examination of adverse outcomes only at the time of birth with no long-term follow-up. The study was also criticised for employing the use of a composite outcome that included events considered to have minor clinical significance in terms of morbidity such as brachial plexus injury, fractured humerus or fractured clavicle (Hawkes 2012). Despite these issues, this is

the largest study of its kind and therefore provides a high level of evidence that is being used to guide policy and practice in the UK.

The Netherlands

In 2009, a large retrospective study was conducted in the Netherlands by de Jonge et al. comparing perinatal mortality and severe perinatal morbidity in planned home and hospital births. The study was undertaken over the course of seven years and included a nationwide cohort of 529,688 women in primary midwife-led care (de Jonge et al. 2009). The study compared perinatal outcomes of intrapartum and neonatal death up to 24 hours, intrapartum and neonatal death up to 7 days and admission to a neonatal intensive care unit (NICU) (de Jonge et al. 2009). Planned homebirth in low-risk women was found not to be associated with higher perinatal morbidity or mortality compared to hospital birth and homebirth was associated with fewer obstetric interventions (de Jonge et al. 2009). This result remained when adjustments were made for confounding factors of gestational age, maternal age, ethnicity, socio-economic status and number of previous children (de Jonge et al. 2009). The results showed no significant difference between planned home and planned hospital birth for intrapartum death 0.97 (95% CI, 0.69 to 1.37), intrapartum and neonatal death during the first 24 hours 1.02 (95% CI, 0.77 to 1.36), and intrapartum death and neonatal death up to 7 days 1.00 (95% CI, 0.86 to 1.16) (de Jonge et al. 2009).

The Dutch study is by far the largest study to date into the safety of homebirth. The authors acknowledged that some data was missing from the study, in particular paediatric data from non-academic (non-teaching) hospitals, though this is unlikely to have had a significant impact on results (de Jonge et al. 2009). It is also important to note that the Dutch health care system is very different to that of Australia. At the time of the study approximately 30% of women in the Netherlands gave birth at home (de Jonge et al. 2009; Euro-Peristat 2013) compared with 0.4% in Australia (AIHW 2012). This means that midwives in The Netherlands are likely to be much more experienced in homebirth and the systems for consultation and transfer to obstetric care far better developed than in Australia. The findings of this study are, therefore, not necessarily transferable to the Australian setting however they do provide insight into the results achievable in a well integrated system.

Canada

In Canada, Hutton et al (2009) compared intrapartum intervention rates and the maternal and perinatal/neonatal mortality and morbidity rates for women who planned a homebirth and similar low-risk women who planned a hospital birth. Midwives in Ontario, Canada regularly provide care in both the home and hospital and are required to submit data for all births to the Ontario Ministry of Health database (Hutton, Reitsma & Kaufman 2009). The database provided outcomes for all 6,692 women attended by Ontario midwives who were planning a homebirth at the onset of labour between 2003 and 2006 and for a cohort, stratified by parity,

of similar low-risk women planning a hospital birth (Hutton, Reitsma & Kaufman 2009).

The results of the study showed a very low rate of perinatal and neonatal mortality (1/1,000) for both groups, and no difference between the groups in perinatal and neonatal mortality or serious morbidity (2.4% vs 2.8%; relative risk [RR], 95% confidence intervals [CI]: 0.84 [0.68–1.03]) (Hutton, Reitsma & Kaufman 2009). No maternal deaths were reported. All measures of serious maternal morbidity were lower in the planned homebirth group as were rates for all interventions including caesarean section (Hutton, Reitsma & Kaufman 2009).

The authors concluded that midwives who were integrated into the health care system with good access to emergency services, consultation, and transfer of care provided high quality care, resulting in favourable outcomes for women planning both home or hospital births (Hutton, Reitsma & Kaufman 2009). It must be acknowledged that this is not always the case for homebirth midwives in Australia and therefore the results are not necessarily transferable to the Australian setting.

Like all studies comparing place of birth, it is possible that the results are influenced by the childbearing woman's desires and preferences, and by societal beliefs around acceptance of birth at home. Given that women in this study self-selected their planned place of birth, it is important to acknowledge that women who plan a homebirth are often more motivated to avoid interventions such as

use of pharmacological pain relief which then reduces the potential for further obstetric interventions which may contribute to the positive results seen for the homebirth cohort (Hutton, Reitsma & Kaufman 2009).

New Zealand

In recent years, several studies investigating the safety of alternative places of birth have been conducted in New Zealand. The maternity care system in New Zealand offers women the choice of a midwife, obstetrician or general practitioner as their lead maternity care provider who delivers continuity of care throughout their childbearing episode (Davis et al. 2011). Seventy five per cent of women in New Zealand choose a midwife as their lead care provider (Davis et al. 2011). Women are also able to choose from the following birth settings: home, primary units (designed for women of low obstetric risk, providing inpatient labour, birth and postnatal care without on-site obstetric, paediatric or anaesthesia services), secondary hospitals (where on-site obstetric, paediatric and anaesthesia services are available) or tertiary hospitals (with multidisciplinary specialist teams able to care for complex cases) (Davis et al. 2011).

A study by Davis et al. (2011) examined a retrospective cohort of 16,453 low-risk women in order to compare mode of birth and intrapartum intervention rates for women planning to give birth at home and in hospital. Data were extracted from the Midwifery Maternity Provider Organisation database for low-risk women who

gave birth between 2006 and 2007 and compared with results adjusted for age, parity, ethnicity and smoking (Davis et al. 2011). Despite all women included in the study being of low obstetric risk and cared for by midwives, a woman's planned place of birth appeared to affect the occurrence of obstetric interventions. Women who planned to give birth in secondary and tertiary hospitals had a higher risk of intrapartum interventions such as artificial rupture of membranes, augmentation of labour, use of pharmacological pain relief, episiotomy and neonatal admission to intensive care when compared with women planning to give birth in primary units or at home (Davis et al. 2011). The risk of emergency caesarean section for women planning to give birth in a tertiary unit was 4.62 times (95% CI: 3.66-5.84) that of a woman planning to give birth in a primary unit (Davis et al. 2011). Rates of instrumental birth were also higher for women who planned to give birth in a secondary or tertiary unit compared with women who planned to give birth at home or in a primary unit (Davis et al. 2011).

The authors concluded that planned place of birth had a significant influence on rates of intrapartum intervention and mode of birth (Davis et al. 2011). Davis et al. (2011), note that unlike other studies that combine caregiver, model of care and birthplace - all women in their study were cared for by midwives in a continuity model. The significant differences found in mode of birth for different settings are, therefore, more precisely associated with place rather than model of care or caregiver (Davis et al. 2011). The authors suggest that planned place of birth may influence decision making and behaviour of both caregivers and women, urging

that this line of inquiry may be fruitful for further studies (Davis et al. 2011). The use of a retrospective cohort for this study means that it was vulnerable to selection bias and again because women self-selected their planned place of birth, motivations and characteristics of women choosing to birth at home or in tertiary settings may have influenced the outcome (Davis et al. 2011).

Another New Zealand study by Miller and Skinner (2012) investigated whether women were more likely to receive evidence-based care in the hospital or home, when care was provided by the same midwives. Two groups of low-risk, first-time mothers were matched; the first group planning to give birth at home and the second in hospital (Miller & Skinner 2012). Midwives participating in the study supplied retrospective labour and birth outcome data for their ten most recent nulliparous women planning a homebirth at the onset of labour and the ten most recent nulliparous women planning a hospital birth at the onset of labour.

Like Davis et al's (2011) study, the results of this study showed that despite being cared for by the same midwives, women planning a hospital birth used more pharmacological pain relief, experienced more obstetric interventions, had a higher rate of postpartum haemorrhage and were less likely to achieve spontaneous vaginal birth (Miller & Skinner 2012). They also found that midwives practiced more evidence-informed midwifery when caring for women in a home setting, as opposed to a hospital setting (Miller & Skinner 2012). For example, the women were supported to achieve a physiological birth in the home setting when

midwives allowed time for events to unfold without unnecessary interference (Miller & Skinner 2012).

Though the number of participants in the study was relatively small (n=20) and purposively sampled, Miller and Skinner's (2012) research along with Davis et al's (2011) study are of particular relevance to my research as they both support the notion that birth place influences the way midwives practice.

Australia

The Birthplace in Australia study, of which this PhD forms a part, will be the first national cohort study of its kind in Australia to provide comprehensive evidence on the safety of childbirth in different settings in this country. The study, which commenced in 2012, is retrospectively examining neonatal morbidity and mortality associated with planned births at home, in birth centres and standard hospital labour wards, using routinely collected data. Intervention rates, maternal morbidity and mortality and intrapartum transfers will also be examined with a sample size of approximately one million women.

Although the results of the Birthplace in Australia study are not yet available, a population based cohort examining perinatal outcomes using routinely collected data from one state in Australia (New South Wales) has been published. This study by Homer, et.al (2014) had a sample size of 258,161 full-term, low-risk women and their infants with a primary composite outcome of neonatal mortality and

morbidity. The study results showed that low-risk women who planned to give birth in a birth centre or at home were significantly more likely to have a spontaneous vaginal birth (86% and 97% respectively), compared with women planning to give birth in a hospital labour ward (74%) (Homer et al. 2014). Additionally, there were no statistically significant differences in rates of stillbirth and early neonatal deaths between the three groups.

This study was limited in that there was insufficient statistical power to test reliability for differences in outcomes. However, it demonstrated that it is feasible to examine perinatal and maternal outcomes by planned place of birth in Australia using routinely collected data. Studies such as Birthplace in Australia and this smaller Birthplace in New South Wales (Homer et al. 2014) study provide evidence that will assist women in making decisions regarding their planned place of birth. Additionally, this information provides an evidence base from which the Australian government can make decisions regarding the funding and provision of alternative settings for birth.

Publicly-funded homebirth in Australia

There are multiple small-scale local evaluations of publicly-funded homebirth programs in Australia which indicate that the model is well accepted by both women and midwives (Hider 2011; McMurtrie et al. 2009; Nixon, Bryne & Church 2003; Thiele & Thorogood 1997). However, to date, there is only one national study reviewing the safety of this model. Catling-Paull et al. (2013) undertook a

retrospective analysis of maternal and neonatal outcomes for Australian women planning a publicly-funded homebirth between 2005 and 2010. Nine publicly-funded homebirth programs (out of the 12 in operation at the time of study), provided data on 1,807 women, accounting for 97% of births in the publicly-funded programs during the five year period being studied.

Whilst the sample size was not large enough to draw conclusions about the safety of publicly-funded homebirth, overall the outcomes were very positive. The study showed that 84% of women planning to give birth at home actually did so, with 17% being transferred to hospital during labour or within one week of giving birth (Catling-Paull et al. 2013). The rates for caesarean section, postpartum haemorrhage, third degree perineal tears, stillbirth and early neonatal death were low (Catling-Paull et al. 2013). Additionally, the normal vaginal birth rate was 90%, which is significantly higher than the vaginal birth rate for planned hospital birth (68.4% in Australia in 2010) (Catling-Paull et al. 2013). This study provides insight into this unique model of care in the Australian setting. My study will provide further insight into midwives' experiences of providing publicly-funded homebirth care and the feasibility of further expanding the model in order to increase access for women.

Midwives' experiences of caring for women at home

Although there is no significant research to date on midwives' experiences of providing publicly-funded homebirth in Australia, there is an existing body of international research on midwives' experiences of providing homebirth care in both public and private homebirth models. For the purpose of this study, literature on the impact of the home environment on midwives was reviewed along with research regarding the impact of exposure to homebirth on midwives' attitudes.

Impact of the home environment on midwives

Of particular interest to my study are midwives' experiences of providing care for women at home. One of the fundamental differences between a home and hospital setting is that the home is the domain of the woman and her family, whereas the hospital is the domain of the midwife. Bourgeault et al (2012) explored this notion in a study they carried out in Ontario, Canada. The research examined the experience of midwives providing maternity care both in hospitals and in women's homes (Bourgeault et al. 2012). Bourgeault et al (2012), suggest that midwives who work both in the hospital and home setting are a unique example of professionals inhabiting hybrid work-spaces. The authors were interested in how professional practice is shaped by space, referring not only to the built environment, but also the power relations the space represents and the meanings attributed to it (Bourgeault et al. 2012). This qualitative study used in-

depth, semi-structured interviews and then coded content thematically for analysis (Bourgeault et al. 2012).

The midwives in the study reported feeling like guests in the woman's home as they had been invited and welcomed into someone else's private space (Bourgeault et al. 2012). As each woman's home was a unique work-space for the midwife, at times there were extra challenges when working outside of the hospital environment. For example, in the woman's home the midwife faced the challenge of creating a predictable work-space so that she could effectively practice midwifery that was both woman-centred and safe and secure for the midwife (Bourgeault et al. 2012).

Midwives not only negotiate the physical environment, they must also negotiate the social environment where they work (Bourgeault et al. 2012). When Bourgeault et al's (2012) study took place in Ontario, an integration of maternity services had recently taken place that resulted in all midwives being required to offer women the choice of home or hospital for birth. This situation was challenging, both for the midwives who were primarily providing homebirth and the midwives who previously only worked in hospital. The community midwives who had little prior experience of working in hospital reported a level of discomfort when working in the hospital, both with the physical environment of the hospital and its bureaucratic nature (Bourgeault et al. 2012). These midwives

felt ‘painfully aware’ of the hospital not really being their work-space, but rather a space that was in a sense ‘borrowed’ (Bourgeault et al. 2012, p. 586).

This qualitative study provides interesting insight into the experience of midwives in Ontario, Canada. Whilst it is not directly applicable to the situation in Australia due to differences in the organisational structure of the provision of homebirth in both countries, it still provides valuable information regarding the experience of midwives providing homebirth. Interestingly, Bourgeault et al. (2012) identified that Ontario midwives tried to modify hospitals to be more like home, and modify the home to be a more standardised and professional work-space. Their inquiry found that there was a seemingly conscious or unconscious convergence of midwifery work-spaces to accommodate this unique model of practice and concluded that further research into the notion of professionals as guests in their work place is warranted (Bourgeault et al. 2012).

Earlier, an Australian study by Lock and Gibb (2003) explored the provision of midwifery care provided to women postnatally. This qualitative study examined the experiences of women electing for early postnatal discharge from hospital in Sydney, Australia. Data were obtained from audiotaped conversational interviews held with five women in their own homes which were then subject to thematic analysis (Lock & Gibb 2003). This work is relevant to my study because it examines women’s relationships with their midwives in the context of place.

The study found that when women referred to ‘place’, this encompassed more than just their physical location. The authors suggested that when women said they felt ‘more relaxed’ and ‘more comfortable’ at home they were making reference to not only their physical comfort but also their ‘psychic’ or mental and emotional comfort (Lock & Gibb 2003, p. 134). The authors referred to the hospital as ‘strange territory’ and a woman’s home as ‘familiar territory’, stating that wherever childbearing events occur, it is always someone’s territory (Lock & Gibb 2003, p. 132).

Women reported that in the hospital setting, the midwives care was fragmented by numerous other demands and that the midwife always had to ‘rush off and do something else’ (Lock & Gibb 2003, p. 138). At home, however the women felt that the midwife was there ‘just for me’ (Lock & Gibb 2003, p. 138). This research is relevant to my study because it explores the woman’s perception of the midwife’s care in both the home and hospital settings, as well as identifying a difference in midwifery practice in these respective settings.

This study was limited in that it only involved five women from a specific region in Australia. Whilst the number of participants is low, this is in keeping with the phenomenological approach taken by the authors. The study provides insight into the impact of organisational culture on midwifery practice with specific examples of hospital versus home settings.

Midwives' exposure to homebirth

Vedam et al. (2009) explored Canadian nurse-midwives attitudes towards, and experiences with, planned homebirth. This study of 1,893 nurse-midwives used the Provider Attitudes towards Planned Homebirth (PAPHB) scale in order to explore correlates and predictors of attitudes towards homebirth (Vedam et al. 2009). The authors found that increased clinical and educational experiences with planned homebirth lead to favourable attitudes towards planned homebirth, as did younger age of the nurse-midwife (Vedam et al. 2009). External barriers that predicted less favourable attitudes included financial and time constraints, an inability to access medical consultation and fear of peer censure (Vedam et al. 2009). Nurse-midwives' willingness to provide homebirth care was correlated with factors related to confidence in their abilities and their beliefs about the safety of planned homebirth (Vedam et al. 2009).

This research provides an interesting insight into the influence of exposure to homebirth on care provider's attitudes. My study also seeks to understand how exposure to homebirth and involvement in providing homebirth care influences midwives attitudes towards homebirth.

The role of the midwife

Midwives are the primary focus of this study, for it is midwives who are providing care for women in publicly-funded homebirth models. The International

Confederation of Midwives (ICM) international definition of a midwife suggests she or he is someone who 'works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period' (ICM 2017, p. 1). Further to this, the ICM (2017) define the midwife's role as being able to: conduct birth's under their own responsibility, provide care for the newborn and infant, detect complications in mother and child and access medical care where necessary. They also state that the midwife is responsible for the promotion of normal birth (ICM 2017).

The role of the midwife involves a combination of both clinical tasks and emotional support (Hunter et al. 2008; Nicholls & Webb 2006). The practice of midwifery is constantly evolving as new and better ways of meeting the needs of childbearing women and their families are developed (Bryar 2011). Midwives must maintain their skills in supporting women while keeping up to date with new technologies, protocols and practices. Several studies have been undertaken in order to identify the essential elements of midwifery practice and will be explored in the next section.

Nicholls and Webb (2006) undertook an integrative review of literature aimed at answering the question: What makes a good midwife? The authors used a four-stage systematic review process during which 33 research papers, using a range of approaches and methods, were identified as relevant (Nicholls & Webb 2006). Eight key concepts were derived, these being: education, research, what a midwife

does, care organisation, attributes of a midwife, other professionals, partners and an international perspective (Nicholls & Webb 2006). The authors found that the literature does not offer an operational definition of a 'good midwife' (Nicholls & Webb 2006). Nicholls and Webb (2006) suggest that different factors may influence various stakeholders' definitions of a good midwife. Their research did show, however, that having good communication skills was considered to make the greatest contribution to being a good midwife (Nicholls & Webb 2006). Being kind, compassionate and supportive, combined with being knowledgeable and skilful, appear to make a major contribution to the assessment of a good midwife (Nicholls & Webb 2006). This research adds weight to the importance of the midwife-woman relationship.

More recently, MacLellan (2011) published the results of a discourse analysis on the art of midwifery practice in order to uncover what facilitates quality outcomes in midwifery care and develop a theoretical framework for practice. An extensive literature search was undertaken resulting in 36 papers that related to the overarching theme of the 'art of midwifery practice' (MacLellan 2011). A critical appraisal tool was used to ensure academic rigour of the papers before review. MacLellan (2011) found that the literature referred to many attributes of the midwife in the practice of her art that were seen to be related with quality outcomes. For example, the practice of 'intangible skills' was widely referred to as an essential component of quality care during childbirth (MacLellan 2011, p. 27). Such skills ranged from support, comfort, intuition and presence through to

technical skills and advocacy for the woman (MacLellan 2011). Emotional characteristics were also frequently referred to in the literature for example, patience, trustworthiness, compassion, caring, gentleness and familiarity (MacLellan 2011). These characteristics represent the importance of human relationship. Table 1 demonstrates how MacLellan (2011) grouped her findings.

Table 1. MacLellan's findings on the art of midwifery practice.

PRESENCE	-Presence, therapeutic relationship, reassurance, guide -Facilitating the woman's confidence and her process -Watchful waiting
GUARDIANSHIP	-Security, safe-keeper, guardian, resisting urge to control labour, trustworthiness, familiar
INTUITION	-Subconscious knowing, intuition, insight, cluefulness, reflection, embodied knowledge
COURAGE AND CONFIDENCE	-Courage and confidence to make decisions, accept accountability -Belief the woman can do it, positivity, praise, encouragement -Acceptance of uncertainty, uniqueness
HUMAN RELATIONSHIP	-Human relationship, compassions, empathy, caring gentleness, communication, patience, quietness, calm -Hands-on high touch technique

These concepts are relevant to my study, which is interested in midwives' experiences of providing publicly-funded homebirth because they shed light on what facilitates quality outcomes. Midwives in my study will be in a unique

position to evaluate their capacity to provide good quality midwifery care in both the home and hospital environments, as they work across both settings concurrently.

Organisational culture

Organisational culture was included in this literature review because qualitative research addressing organisational culture from the Birthplace in England research programme (McCourt et al. 2012) partly provided the impetus for my research. The organisational culture that a midwife is immersed in has the potential to influence her assumptions and values, impacting the ritualised aspects of midwifery care. This is significant for my study of midwives' experiences of providing publicly-funded homebirth because moving midwives out of the hospital -based environment and into the domestic sphere has the potential to shift their perceptions regarding birth and the way they care for women.

It is important to distinguish between occupational culture and workplace or institutional culture. Midwives providing homebirth in Australia prior to the introduction of publicly-funded homebirth may have been more homogenous in their subscription to an occupational culture of privately practising midwives. However, with the introduction of publicly-funded homebirth, midwives who are primarily engaged in an institutional culture based in the hospital may find a breakdown of this culture as their work becomes de-centralised and moves into women's homes.

McCourt et al's (2012) qualitative study is the most significant research to date on organisational culture in maternity care, providing insight into organisational and professional issues that may have impacted the quality and safety of labour and birth care in different birth settings. Data for this research was drawn from 'The Birthplace Case Studies', ethnographic case studies of four different maternity services known as the 'better' or 'best' performing sites covering the range of National Health Service (NHS) Trust maternity configurations (McCourt et al. 2012). These included services that were Obstetrics only, Obstetric and Alongside Midwifery Units, Obstetric and Freestanding Midwifery Units, or all types of units. In accordance with NHS policy in the United Kingdom, each of these services are expected to provide for women who desire a homebirth. McCourt (2012) reviewed key documents such as guidelines and protocols and undertook interviews with service providers, key stakeholders, service users and birth partners (support people). They also observed 'key nodes' in the service such as meetings, case reviews and clinical hand overs in order to witness interactions between staff from different parts of the service, particularly different professional groups (McCourt et al., 2012).

Key findings of the research were that many community midwives and managers lacked confidence to provide care for women at home (McCourt et al. 2012). Midwives reported that they lacked homebirth experience and confidence and women who had used the homebirth service reiterated this notion. Those working

in midwifery units, however, expressed higher levels of support and confidence in their ability to provide quality care. The authors concluded that there was need for careful consideration and development of midwifery models of care where midwives are well educated and prepared to care for women in a variety of birth settings. It was also recommended that greater attention be paid to the integration of community midwives with the overall health service in order to ensure the effective and sustainable delivery of care for women in the community (McCourt et al. 2012).

The study conducted by McCourt et al (2012) was limited in that it only included the four 'better' or 'best' performing sites covering the range of NHS Trust maternity configurations. However, some very important findings were made in relation to a number of challenges faced by community midwives in providing good quality, safe maternity care. These insights are an important contributor to understanding the organisational factors that may have influenced the findings of the Birthplace in England Cohort Study.

The findings of the study are not directly applicable to the Australian setting because the National Health Service in England's organisational structure is very different to that of Australian maternity services. However, McCourt et al's (2012) research is relevant to my study in that it offers insight into midwives' experiences of providing homebirth via a public health service. It also addresses the significant

issue of midwives' confidence to provide homebirth care, a matter that will also be addressed in my study.

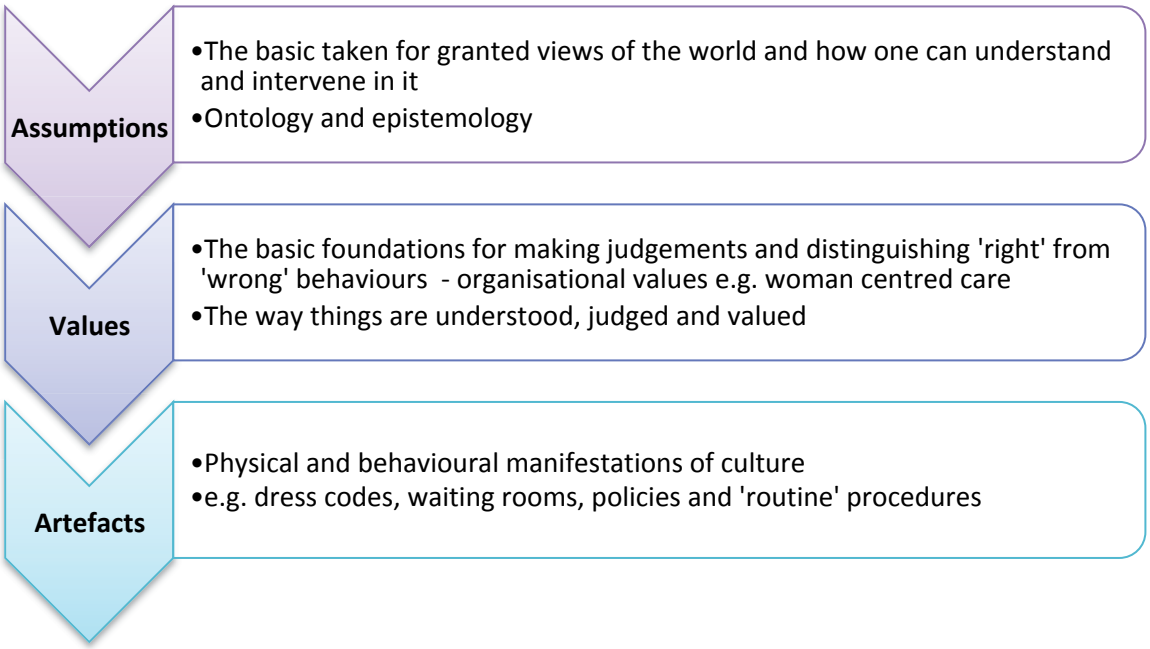
There is extensive literature on organisational culture, both in the field of healthcare and more broadly; the following serves as a brief introduction to the concepts of organisational culture. Defining organisational culture is a difficult task and there is considerable debate in the literature about what it constitutes (Davies, Nutley & Mannion 2000; Parmelli et al. 2011; Willcoxson & Millett 2000). Commonly, organisational culture describes the shared views, beliefs, attitudes and behavioural norms that exist within an organisation (Davies, Nutley & Mannion 2000; Tapp et al. 2008). It is summarised by some as 'the way things are done around here' (Scahill 2012, p. 79). Numerous authors have questioned whether an organisation's culture can ever be adequately described and whether organisational cultures can ever be effectively managed; given that they exist within the context of broader cultural frameworks and many elements of organisational culture are not overtly expressed (Davies, Nutley & Mannion 2000; Tapp et al. 2008; Willcoxson & Millett 2000).

Several relevant papers on the influence of organisational culture on the quality of health care were identified in my literature search (Davies, Nutley & Mannion 2000; Montgomery et al. 2011), on improving healthcare performance (Parmelli et al. 2011; Scott et al. 2003), policy development and implementation (Scahill 2012) and improving systems of care in general practice (Tapp et al. 2008).

Davies, Nutley and Mannion's (2000) paper offered several helpful insights on organisational culture and the quality of healthcare in relation to culture transformation. The authors suggest that to uncover the organisational culture of a workplace, the underlying assumptions representing unconscious and taken for granted beliefs must be identified as these structure the thinking and behaviour of individuals (Davies, Nutley & Mannion 2000). These assumptions give rise to organisational values that operate on a more conscious level. Organisational values represent the standards and goals to which individuals attribute worth – not just 'the way things are done around here' (Scahill 2012, p. 79) but the way things are understood, judged and valued (Davies, Nutley & Mannion 2000). This is particularly relevant to the introduction of publicly-funded homebirth programs which are likely to challenge accepted norms and assumptions regarding the safest place for a woman to give birth. Davies et al (2000) identify three levels of culture: the assumptions, values and artefacts present in an organisational culture. This concept is expressed in Figure 2.

Organisational culture encompasses not only policy and practice guidelines, it is also concerned with practices that are 'routine' or ritualised aspects of particular environments or, in the case of this study, birthplaces (Davies, Nutley & Mannion 2000). A woman's birthplace is also a midwife's work place and as such there are cultural dynamics taking place that will impact on the way a midwife cares for a woman at home (Bourgeault et al. 2012)

Figure 2. Levels of culture within an organisation



An understanding of organisational culture is relevant to my study because publicly-funded homebirth programs operate counter to the dominant medicalised model of childbirth in Australia. As such, on a macro level, the implementation and continuation of the model requires some level of cultural shift or transformation to occur. In addition, on a micro level, when midwives begin providing care to women in their own homes, it is possible that previously ritualised or routine aspects of midwifery care will shift and midwives will find a new way of working with women.

Conclusion

This chapter has described the literature in relation to the provision of midwifery care in the home environment. Multiple large-scale international studies have shown that, for the most part, homebirth is safe for healthy women who are experiencing a low-risk pregnancy when attended by a registered midwife who is networked into a local hospital for back up if required.

Literature about the importance of the midwife-mother relationship reveals that when midwives spend time with women in their home, the midwife-mother relationship is strengthened and women feel the midwife is able to offer better care.

CHAPTER THREE: METHODOLOGY

Introduction

This chapter serves to orient the reader to the history and philosophical underpinnings of grounded theory and provides the rationale for using this methodological approach. Furthermore, the use of constructivist grounded theory will be explained and justified. The chapter begins with an overview of the epistemological and historical foundations of the methodology.

Epistemology: ways of knowing

Throughout history, there have been long standing debates about the nature of reality and what actually constitutes knowledge (Bazeley 2013). Epistemology is a branch of philosophy concerned with the study of knowledge examining how we, as human beings, understand and learn about our world (Bazeley 2013; Birks & Mills 2015; Gerber & Moyle 2004; Maxwell 2012). Epistemology considers the criteria for determining what constitutes valid knowledge, studying our method of acquiring knowledge and providing a philosophical background for deciding what kinds of knowledge are considered adequate and legitimate (Gerber & Moyle 2004; Gray 2014).

It is important that researcher's identify their personal epistemological perspective as this will influence the methodology they choose, and the manner in which it is applied (Mills, Bonner & Francis 2006). There are three main epistemologies: objectivism, subjectivism and constructivism (Gray 2014). Objectivist epistemology is closely linked to positivism and argues that there is an independent, discoverable reality in life that we are able to measure with the right techniques (Bazeley 2013). Subjectivism, on the other hand, advocates that individuals impose meaning on objects or phenomenon; therefore there is no external objective truth (Grbich 2004). Finally, constructivists advocate that multiple realities exist and work from the premise that, in the context of individual histories and social interactions, knowledge is constructed through discourse (Bazeley 2013; Charmaz 2006).

Objectivist research is typically quantitative in nature as it is concerned with classifying features and constructing statistical models and figures in order to explain what the researcher believes to have objectively observed (Axford et al. 2004). In health care settings, this style of research typically involves randomised controlled trials, observational studies, case-control studies, and descriptive surveys. This form of research provides statistical data that may be useful in establishing a cause and effect, identifying probabilities and determining risk ratios. This objectivist style of research has historically been considered the 'gold standard' for health care research, providing the highest quality evidence. According to the Australian National Health and Medical Research Council's

(NHMRC) 2009 guidelines for assessing levels of evidence, the primary considerations for determining whether research offers a high level of evidence are: the risk of bias in study design, consistency of findings with other studies, clinical impact, generalisability of the results and applicability of the results to the local, national or international health care setting (National Health and Medical Research Council 2009).

Historically, subjectivist and constructivist research methodologies have not been valued in healthcare as providing a high level of evidence. However, many scholars and healthcare practitioners are beginning to question the singular objective of scientific research and the implication that higher-level research is intrinsically of more value (Axford et al. 2004). There is growing support for research that explores the meaning of health and illness in our lives, rather than solely the causes or cures for illness (Axford et al. 2004). For example, the International Confederation of Midwives (ICM) position statement regarding the role of the midwife in research states that research on the childbearing cycle should incorporate the physiological, psycho-social, cultural and spiritual aspects of health for women and babies (ICM 2014).

Constructivist and subjectivist research tends to be qualitative in nature with a primary focus on human attitudes, language and the making of meaning (Charmaz 2006). Qualitative research is interested in exploring an idea from the subjective standpoint of the participant; placing value on individual participants' lived

experience of the phenomena in question. Further to this, qualitative researchers actively recognise the influence that their personal philosophies and worldview will have on both the research process and final outcome. My research was exploratory in nature, carried out within an interpretive research framework in order to gain as much insight as possible into the experience of the participants.

The methodology of grounded theory was chosen as it allowed for a deep exploration of meaning and the examination of institutional and social practices and processes (Starks & Trinidad 2007). Since its establishment in the 1960s, grounded theory has grown in popularity and, over time, been adapted by a number of researchers resulting in different styles of grounded theory. Differing philosophical and methodological positions influence how the core methods associated with this approach are implemented (Birks & Mills 2015). An understanding of the history of grounded theory's development is, therefore, imperative for researchers to determine their own methodological positioning and its subsequent influence on their research methods. The following section provides a brief outline of the history of grounded theory.

The history of grounded theory

The technique of grounded theory was developed in the mid 1960s by sociologists Barney Glaser and Anselm Strauss. Glaser and Strauss were colleagues at the Department of Social and Behavioural Science at the University of California, San

Francisco (UCSF) (Birks & Mills 2011; Bryant & Charmaz 2007a). Whilst working together on a study examining the human experience of dying, Glaser and Strauss became interested in formulating a theory 'grounded' in the data (Birks & Mills 2011). Whilst constructing their analyses of dying, Glaser and Strauss developed a series of systematic methodological strategies that they subsequently realised could be adopted by other social scientists for numerous other topics (Charmaz 2006). Thus, grounded theory was born and subsequently shared with the research world in 1967 when their book 'The Discovery of Grounded Theory' (Glaser & Strauss 1967) was published, detailing the central tenets of this cutting-edge new methodology.

Following its initial inception, the concept of generating a new theory directly from the data appeared to resonate with other social scientists and over the next ten years grounded theory as a research design became increasingly popular (Birks & Mills 2011). As time went on, however, Glaser and Strauss evolved to have divergent perspectives on what grounded theory is and how it should be conducted. Glaser was influenced by positivist conceptions of scientific method and knowledge, which tend to stress the importance of research being objective, generalisable and replicable (Charmaz 2006). Strauss, on the other hand, worked from the theoretical perspective of symbolic interactionism, a sociological theory focused on the interactions between humans, creating meaning and actions based on language and communication (Bryant & Charmaz 2007a). Glaser and Strauss

both went on to work with other researchers in the field, further developing their different interpretations of grounded theory.

Glaser and Strauss are commonly considered ‘first generation’ grounded theorists with many of their students at UCSF going on to become so called ‘second generation’ grounded theorists (Birks & Mills 2011). These second generation theorists have in many cases used Glaser and Strauss' original work as a launching pad for their own iterations and interpretations of grounded theory (Birks & Mills 2011). In the years to come, Strauss teamed with Juliet Corbin producing several grounded theory texts (see Strauss & Corbin 1990, 1997, 1998). Strauss and Corbin’s version of grounded theory favoured technical procedures that emphasised verification whereas Glaser continued to promote his earlier interpretation of the method that relied on direct and often narrow empiricism, analysing a basic social process (Charmaz 2006).

Strauss and Corbin’s publications prompted a rebuttal from Glaser in the form of his 1992 text ‘Basics of Grounded Theory Analysis’, sparking debate amongst grounded theory scholars at the time. Whilst much has been made of the rift between Glaser and Strauss, their differences are thought to be purely intellectual with their friendship enduring until Strauss’ death in 1996 (Birks & Mills 2015). In the decade following Strauss’ death, several scholars such as Tony Bryant and Kathy Charmaz developed additional versions of grounded theory (Bryant &

Charmaz 2007b; Charmaz 2005) that moved even further away from Glaser, Strauss and Corbin's more positivist approach.

Grounded theory has now become one of the most commonly used qualitative methodologies for health research (Birks & Mills 2015; Starks & Trinidad 2007). The research presented in this thesis is based on a constructivist approach to grounded theory developed by Kathy Charmaz, which emphasises exploration of social interactions and processes within the area of inquiry. Constructivist grounded theory will be explained in greater detail later in this chapter. With each new iteration of grounded theory, several fundamental principles remain the same; these basic principles are outlined in the following section.

Principles of grounded theory

Since Glaser and Strauss (1967) developed the unique methodology of grounded theory, several founding principles have endured. The defining concepts of a grounded theory practice include; simultaneous data collection and analysis, the construction of analytic codes and categories directly from the data, use of constant comparative method, memo-writing, and theoretical sampling (Charmaz 2006). The chief purpose of a grounded theory study is not to perform research in order to verify facts, but rather to research certain phenomena and generate an explanation of them (Glaser & Strauss 1967). To this aim, a grounded theory is not logically deduced after the collection of data, it is formed simultaneously as data is

collected, analysed and 'ground truthed'. In practice, this means that data collection and analysis occur simultaneously, allowing the researcher to take their developing ideas back to participants in order to explore them more deeply.

Data generation

In order to differentiate from other qualitative approaches, the term 'data generation' is used in constructivist grounded theory to reflect the simultaneous nature of data collection and analysis. Initially, the researcher will start with a broad area of inquiry and determine an appropriate method of data collection. Traditionally, a grounded theory study would involve the observation of participants in an environment where the basic social processes of the group take place (Starks & Trinidad 2007). Given that observation in healthcare research is not always feasible, grounded theorists commonly use interviews as a secondary research tool. The interviewing strategy tends to involve the participant describing their experience while the interviewer probes for detail and clarity (Starks & Trinidad 2007).

As distinct from quantitative research methods that are deductive – i.e. they aim to prove or disprove a hypothesis - qualitative research usually employs an inductive approach, wherein no firm hypothesis is formed prior to the research commencing. Alternatively, constructivist grounded theory uses an abductive approach which involves testing all plausible hypothesis that emerge from the data

by performing rigorous testing of the findings from the inductive process via the techniques of constant comparison and theoretical sampling (Birks & Mills 2015; Charmaz 2006). In practice, this involves the researcher constantly revisiting the data to explore emergent theories that are then tested with subsequent participants.

Initially, an inductive approach is taken as the researcher develops analytic codes or categories directly from the data. During analysis, the grounded theory technique of coding allows the researcher to perform a type of content analysis which allows for the conceptualisation of important issues amongst the 'noise' of the data (Allan 2003). For example, during analysis of interview data the researcher will become aware of several words and phrases the participant is using that may highlight an issue of importance or interest to the research (Allan 2003). This is noted and described in a short phrase. The issue may be mentioned again by the same or subsequent participants and the short phrase used to describe the concept of interest becomes a code (Allan 2003).

Coding

Coding is a fundamental analysis technique in grounded theory. The first step in grounded theory analysis is called open coding. In this phase, the researcher is effectively playing with the data, trying to 'break it open' to see what is there. During this time, the researcher develops their own unique codes, derived directly from the data. To aid the process of coding, the use of gerunds (action words

ending in 'ing') has been suggested by both Glaser (1992) and Charmaz (2006). When using gerunds, the researcher questions the data in order to uncover what the participants main concern is and how they are resolving it. Coding the data in this way breaks it into smaller sections that can be compared to similar sections. This approach differs from thematically coding for content which merely labels data rather than seeking to understand the drivers behind a participants words or actions. Thematic analysis tends to be descriptive, whereas grounded theory analysis is looking for actions in order to develop an explanatory theory. When the researcher compares sections of data and examines their properties to determine if and how they relate to other pieces of data, the process related to the phenomena in question can be explained. This process of comparing sections of data with one another is known as the constant comparison technique (Birks & Mills 2015).

Memos

Memo writing is considered a fundamental practice when conducting grounded theory research. Memo writing (or memoing) is designed to capture early theories as they are developing and assists researchers to remain aware of how they might be affecting the data (McGhee, Marland & Atkinson 2007). Memoing can be used to monitor the researchers prejudices, interpretations and understandings of situations observed in fieldwork (Grbich 2004). More detail on memos is supplied in the Methods Chapter.

Purposive and theoretical sampling

Purposive sampling is a type of non-probability sampling technique used in grounded theory, where the sample numbers or data sources are unknown at the commencement of the study (Glaser & Strauss 1967). In accordance with the grounded theory methods endorsed by Glaser and Strauss (1967) and Strauss and Corbin (1990, 1998), the sampling process then becomes theoretical, i.e. sampling is then determined by the emerging theory. This step occurs after an initial sample has been selected and data has been collected and analysed. Theoretical sampling involves identifying and pursuing clues that arise during the analysis of data that lead the researcher to make a strategic decision about who or what will provide the most information-rich source of data to meet their analytical needs (Birks & Mills 2015).

Analytic approach

Constructivist grounded theory

There are several variations of grounded theory, all of which exist on a methodological spectrum reflecting the researchers epistemological underpinnings (Mills, Bonner & Francis 2006). Traditionally, the theoretical perspective of symbolic interactionism has underpinned grounded theory. Symbolic interactionism, developed by Blumer (1969), focused on the process of human interaction in the formation of meanings for individuals. First generation

grounded theorists, such as Glaser and Strauss paid little attention to their relationship with participants as they were primarily focused on obtaining data in an objective manner (Birks & Mills 2015). Over time, however Strauss and Corbin began to recognise that there was interplay between researcher and participant. The nature of the relationship between researcher and participant are thought to be central in identifying the researchers position (Mills, Bonner & Francis 2006). For this study, I employed a constructivist approach to grounded theory, based primarily on the work of American scholar Kathy Charmaz.

Constructivism is a research paradigm that recognises reality as being constructed by those who experience it; thus research is seen as a process of reconstructing that reality (Birks & Mills 2015). Constructivists reason that knowledge is co-constructed and emerges from a relationship that develops between the researcher/s and the researched; knowledge does not exist in a way that can simply be received or discovered. It emerges from the research process itself, from the telling of one's story and having one's experiences interpreted and represented by another. In this sense, our concepts, beliefs and theories about the experiences and objects with which we engage are continually altered in light of new experiences and new relationships. Constructivist analysis is contextually and relationally situated, examining how and why participants construct meanings and actions in specific situations (Bazeley 2013; Charmaz 2006).

Reflexivity

The act of acknowledging the impact of the researcher on their research is known as reflexivity. Reflexivity is considered an important component of all qualitative research, and is an essential component of constructivist grounded theory (Finlay 2003; Grbich 2004). Reflexivity involves the researcher actively engaging with their own self-awareness in order to identify the impact that their personal values and positions may have on the research process and type of data collected (Burns et al. 2012; Hunt & Symonds 1995; Reed 1995). Historically, health sciences research was predominantly quantitative in nature and strived to avoid the influence of the researchers bias in order to be deemed reliable. Initially, qualitative researchers aimed to emulate this method, however, it became obvious that this was not possible. Qualitative research is now considered to be a joint product of the participants, the researcher and their relationship (Finlay 2003). Indeed, the researcher is accepted as a central figure who actively constructs the collection, selection and interpretation of the data Finlay (2003, p. 6). Reflexivity, therefore, is an essential part of ensuring that the research process is trustworthy.

In this study, reflexivity was a continual, ongoing process. This involved a combination of memo writing and reflective journal writing, conversation with colleagues and supervisors and an awareness and willingness to challenge my own personal bias and move beyond political stances and assumptions. In addition,

consensus coding and triangulation with field notes and memos was undertaken in order to ensure rigor in my analysis and interpretation.

Reflexive writing - On being a midwife, mother and researcher

After reading about issues of insider/outsider conflict for midwifery researchers (Burns et al. 2012) I started to question my own positioning. For this study I spoke with midwives employed by the public health system about their experiences of providing homebirth care. As a registered midwife I am, to some extent, automatically granted status as an insider in the hospital environment – the primary place of work for midwives. I have an intimate understanding of the identity, language and cultural norms of midwives as a professional group. Yet having not practiced clinically in a hospital environment since late 2008 and indeed having never returned to clinical practice in the hospital setting since finishing my undergraduate midwifery studies, I also feel like an outsider.

I have chosen, for the time being, to pursue a career in midwifery research, and have also worked as a childbirth educator and birth attendant or doula. When I confess to other midwives that I am not practising clinically I feel my position shift to outsider. Midwives pride themselves on their dedication to being 'with woman' and, for the majority of midwives, this manifests as working in the hospital system. However, even though I have not focused on working clinically, I still identify as being a midwife and did so whilst carrying out this research.

Positioning myself as a midwife

I graduated from the Bachelor of Midwifery in December 2008, however since then have spent most of my time raising children and undertaking further studies. My first child was born only two months after I completed my undergraduate studies. I chose not to work in the first year or so of his life, a time when almost all of my graduating colleagues were undertaking their new graduate rotation year in hospital.

As time went on and I became engaged in further studies, first an honours degree and then a PhD, I realised I was purposefully avoiding working in the hospital setting. My mother was a midwife in the late 1970s and as such, my first exposure to midwifery literature was via reading the renowned text 'Spiritual Midwifery' by Ina May Gaskin (1978) during my teenage years. This early exposure to woman-centred midwifery care and homebirth captured not only my interest but also my heart.

In my first 10 years of being a midwife, instead of working clinically I opted to teach antenatal education, develop my skills as a researcher and tutor at university. These were all ways for me to stay engaged with my passion for working with childbearing women, without having to work in the hospital system. After being asked by several friends to support them during their births, I also began offering my services as a professional support person, providing physical and emotional support for women giving birth both in hospital and at home.

I have also actively worked as a consumer representative for the past six years in an effort to improve local women's access to quality maternity services. This volunteer role has put me in touch with many committed homebirth mothers and deepened my understanding of why women choose homebirth. For all too many women their story involves finding their way to homebirth after a traumatic hospital birth that set them on a path of questioning the status quo of maternity care. A recurring theme here is the invisibility of midwifery in Australia and the lack alternative options available to women.

Since early 2017, I began providing care as a second midwife at private homebirths with an experienced PPM. This has brought about unexpected learning opportunities. Not only has it significantly deepened my knowledge of birth and the way it unfolds if undisturbed, I also now more thoroughly understand what it is like to care women at home. Whilst many of the births we attend are beautiful, joyful events, at times they also require a vast amount of patience, stamina and dedication to the role.

When caring for women at home I am constantly reminded of Nicky Leap's refrain "the less we do, the more we give" (2000, p. 1). I have seen stark examples of the dynamic interplay between the woman and her environment and have seen first hand how sensitive the labouring woman is to what's going on around her. This resonates with the experiences of many midwives I interviewed who spoke about

gaining a deeper understanding of normal physiological birth after attending homebirths.

My relationship with publicly-funded homebirth

Prior to commencing this study I had never met a midwife who worked in this model. I do have several friends who have engaged our local publicly-funded homebirth service during pregnancy and am aware of some of the challenges they faced, particularly in regards to meeting the eligibility criteria.

At the beginning of the study I was aware of a sentiment amongst some homebirth advocates (both women and midwives) that positioned the publicly-funded model as not 'real' homebirth. For many years a woman's decision to homebirth (in Australia at least) has represented a rejection of the hospital system and as such it seems incongruent for the hospital to be providing homebirth. Admittedly I have puzzled over this concept myself and throughout my PhD studies this was the topic of many reflexive journal entries.

Anecdotally, several colleagues and friends who have shown interest in my research topic have added their voice, telling me that the publicly-funded homebirth model is "not woman-centred" or "too restrictive" – referring to the strict eligibility criteria women must meet to be included in the homebirth program. In some ways I feel this is the infiltration of the medical model and something about women requiring obstetric "approval" for a homebirth certainly

challenges the feminist within me. Eventually these concepts were investigated during my data generation, as the topic was also one that some of my research participants were grappling with.

My own homebirths

Another interesting aspect of my insider/outsider positioning is in regards to my own births. As a woman who has twice given birth at home I am an insider in the homebirth context. I know what it's like to be a woman planning to give birth at home. When I was pregnant with my first child in 2008 I was in my third year of the Bachelor of Midwifery and had attended increasing levels of clinical placement throughout the final year. I was well aware of what was on offer in tertiary maternity hospitals and was troubled by what I saw. My overall impression was that a woman's experience was highly dependent upon the care providers who were present at her birth. I saw how open to suggestion women were when they were in labour, unable to make decisions whilst in the depths of labour, just wanting "what's best for their baby". Whilst there was always joy at the births I attended, I experienced much trauma and heartache over the amount of seemingly unnecessary intervention that I saw.

My own two homebirths were excellent experiences and I am very grateful to have had the opportunity to give birth in my own home, surrounded by loved ones. I had private midwives for my care and although both births were challenging events that required me to call on more strength than I knew I possessed, they

were straightforward and I felt well supported and trusted my midwives implicitly. Undoubtedly these experiences have shaped my perspective on birth and maternity care.

My research experience

My honours thesis (undertaken in 2009-2011) was a discourse analysis of 11 key maternity care stakeholders submissions to the Australian Government's 2008 National Maternity Services Review. It was during this course of study that I came to fully comprehend the concept of the 'birth wars' described by a multitude of authors. I now understood academically what I had felt on a gut level. That is, the reason that people approached birth differently was because of the philosophical differences between those who see birth as a normal biological function of human life, as opposed to those who fear what can go wrong, only willing to consider birth normal in retrospect. This knowledge helped me gain compassion for those who had a different perspective to my own.

Justification for the research

The focus of my study was on midwives' experiences of providing publicly-funded homebirth in Australia. Whilst there is some existing research on Australian midwives' experiences of working in the hospital environment and a small amount of research on Australian midwives' experience of providing private homebirth, very little is known about midwives working in publicly-funded homebirth models. As I was interested in midwives' personal experiences of working in such models,

including an analysis of how macro-level structures such as the organisational culture of the hospital impacts on their lived experience, the qualitative methodology of constructivist grounded theory was an appropriate choice.

Qualitative research is focused on the investigation of human social behaviour through the collection and analysis of non-numerical data, allowing for the development of theories that may not be apparent from quantitative findings (Andrews, Sullivan & Minichiello 2004). Whilst quantitative methods allow researchers to measure and mathematically model a particular phenomena, qualitative methods allow researchers to undertake comprehensive investigations assisting them to ascertain the reasons for the success or failure of interventions or identify specific barriers and facilitators to behavioural or cultural change (Andrews, Sullivan & Minichiello 2004; Starks & Trinidad 2007).

The underpinning philosophy and methodological framework of a study influence how the researcher works with participants (Birks & Mills 2011). As a methodological approach, constructivist grounded theory emphasises the conceptualisation of social interactions and processes in human experiences with the intent of formulating theory that is grounded directly in the data. It is now one of the most widely used qualitative research method across a range of disciplines and subject areas (Bryant & Charmaz 2007a) and has been used by several authors to explore interactions and processes in maternity care (e.g. Barry et al. 2013, Catling-Paull 2010, Sheehan et al. 2010, Fenwick et al. 2008 and Dahlen et al.

2008). For this study, constructivist grounded theory was used to describe, analyse and theorise the experiences of midwives providing publicly-funded homebirth in Australia.

Conclusion

This chapter has detailed the philosophical underpinnings of the chosen methodology and justified the use of constructivism. The next chapter will describe how the data collection and analysis techniques described here were applied using this approach in order to generate a substantive theory that describes the experiences of midwives' providing publicly-funded homebirth in Australia. The design reflects the research aims, questions, and epistemological understandings appropriate to this study.

CHAPTER FOUR: METHODS

Introduction

The previous chapter explained the methodological approach for this study. This chapter details the study methods beginning with a description of the study context, setting and participants. Ethical considerations for the research are outlined, including details of data storage methods. In keeping with a grounded theory methodology, both purposive and theoretical sampling approaches were employed for this research. These techniques are explained, along with the process of recruitment and simultaneous data collection and analysis.

Study context

The setting for the research can essentially be described as publicly-funded homebirth models in Australia. However, publicly-funded homebirth models are not a homogenous entity. As most of the publicly-funded homebirth programs have been developed in isolation from one another, there are a number of differences in the way programs were established and currently operate (Catling-Paull, Foureur & Homer 2012). Each service collects data differently and uses different definitions and guidelines for reporting, making them each somewhat unique. This makes publishing outcomes for the combined services quite challenging and until recently there was a distinct lack of publicly available

information about the characteristics, development and outcomes for publicly-funded homebirth programs in Australia (Catling-Paull, Foureur & Homer 2012).

In order to remedy this, as described earlier, The National Publicly-funded Homebirth Consortium (hereafter, 'The Consortium') was established in 2010 by Catling-Paull, Foureur and Homer (2012). The Consortium is a network of publicly-funded homebirth programs in Australia designed to facilitate the sharing of resources and collation of national data. The Consortium website[1] provides resources such as papers and policies relevant to publicly-funded homebirth. Quarterly teleconference calls maintain networks between midwives and assist with the sharing of information and resources between publicly-funded homebirth programs operating nationally.

Prior to this study, the establishment of The Consortium facilitated the description and comparison of different programs resulting in a publication by Catling-Paull, Homer and Foureur (2012) about the development of the model in Australia. Subsequently, a review of maternal and neonatal outcomes for publicly-funded homebirth over 6 years was written by Catling-Paull, et al (2012). The Consortium also proved to be a valuable resource for my study as it offered an effective means of communication between the homebirth service managers, midwives and myself. This was the primary means of recruitment for my study. As many of the

[1] http://www.uts.edu.au/research-and-teaching/our-research/midwifery-child-family-health/research/national-publicly-funded

services were developed in isolation from one another, no two services operate in exactly the same manner. At present, there are no national standards for the determination of midwives' competence to provide publicly-funded homebirth. However, all services require midwives to undergo a rigorous credentialing process.

Credentialing commonly involves attendance at an Advanced Life Support in Obstetrics (ALSO) course, completion of the Australian College of Midwives Midwifery Practice Review (MPR) and competence in the skills of cannulation, perineal suturing and neonatal resuscitation (Catling-Paull, Foureur & Homer 2012; Homer & Caplice 2007). For all services that participated in this study, designation as the primary midwife for a homebirth required the midwife to have witnessed a number of homebirths (commonly five births) before acting as the second midwife for several births. Once this process was complete and the appropriate 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. Although many midwives' discussed this aspect of their experience during interviews, data were not collected specifically pertaining to this aspect of their training.

Participants

Participation in the study was open to all English-speaking midwives who had experience providing publicly-funded homebirth in Australia within the past five

years. In order to capture 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 who supported or managed such services.

Ethical considerations and data storage

All human interaction has ethical dimensions, including the interaction involved in human research. Ethical conduct, however, is more than simply doing the right thing; it involves acting in the right spirit out of a principal respect and concern for fellow humans. (The National Health and Medical Research Council 2007). This philosophical approach guided the study and every effort was made to maintain a high standard of ethical conduct throughout. 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. Recruitment and data collection activities commenced following approval for the study, which was granted in July 2014.

Confidentiality and anonymity of the midwives participating was considered to be of utmost importance. In order to achieve this, participants were advised that pseudonyms would be used to conceal their identity and that of anyone else mentioned during the interview and the site at which they worked. Participants were assured that the name of their workplace and any identifying geographical

information would also be protected. To achieve this, all data was de-identified following transcription with names being replaced by codes and names of locations replaced with 'XX'.

It is important to consider the feasibility of maintaining confidentiality when speaking to participants who work in such visible roles in their communities - providing publicly-funded homebirth care. There was a large range in the number of midwives providing this type of care at each site, from just one midwife at one site to more than 30 at others. I have been careful to avoid connecting participant's geographical location with their pseudonym in order to reduce the possibility of identification. The provision of robust confidentiality practices encourages participants to speak more openly about their experiences. Whilst most midwives in my study spoke positively about their experiences, several described negative experiences or challenges faced which indicates they felt safe to share their true thoughts and feelings.

During data collection, interviews were recorded on my password protected smart phone, using the Rev application[2]. Rev.com is an online transcription service and the Rev app allows users to audio record and then upload files directly to the company for immediate transcription. Audio files are securely stored and transmitted using high level security encryption. Files are visible only to the professional transcriptionists at Rev who have signed strict confidentiality

[2] https://www.rev.com

agreements. Once completed transcripts were received, they were stored on my password protected laptop and desktop computer, along with the UTS Oxygen Enterprise cloud storage system. All data on Oxygen are stored and transmitted in an encrypted format. UTS recommends the use of the Oxygen cloud storage system for research students and staff. Upon completion of the study, all data were stored in a secure area at the University, as per the data storage policy.

The recruitment process

Potential participants were located in five different states and territories of Australia where publicly-funded homebirth models were in operation at the time of the study's commencement. In order to capture such a diverse pool of participants, ethical approval was granted to email a flyer (Appendix B) advertising the study via The Consortium and the e-bulletin of the Australian College of Midwives (ACM). The Consortium provided an ideal mode of communication for this study, allowing for initial purposive sampling of midwives and managers involved with publicly-funded homebirth programs in Australia.

Following an initial group email to The Consortium members with the study flyer attached, several responses were received from midwives and managers interested in participating. The study was also publicised at three of The Consortium's quarterly teleconferences during which I briefly described the study and midwives were invited to contact me via email if they were interested in

participating. The email and teleconference announcements attracted a significant portion of participants to the study (approximately 14).

Following initial contact made by the participant, a recruitment pack was emailed to them with an Information Sheet (Appendix C), Consent Form (Appendix D) and demographics survey (Appendix E). The study was explained to potential participants in plain English via the Information Sheet. My contact details along with my principal supervisor's contact details were provided, should participants have required any further information about the study. Written informed consent was obtained prior to the commencement of data collection activities. Those who agreed to participate were asked to return the completed demographic survey with their signed consent form.

Interview times were arranged via email correspondence and every effort was made to ensure that they took place at a time and location most convenient to the participant. Participants were encouraged to arrange an occasion when they were away from their workplace or in a private space so that they could speak freely and maintain confidentiality. Similarly, I worked from my home office in a private space.

Verbal consent to being audio recorded was obtained at the commencement of phone interviews. Participants were fully informed that the interview would be audio recorded, transcribed and then de-identified and that they could choose to

withdraw at any time, if desired. Following interviews with the respondents to the initial email and teleconference announcements via The Consortium, a theoretical sampling approach was employed. This will now be described in further detail.

The sampling process

As described in Chapter Four: Methodology, purposive sampling (also known as theoretical sampling) is a type of non-probability sampling technique used in grounded theory where the sample numbers or data sources are unknown at the commencement of the study (Glaser & Strauss 1967). Purposive sampling was used in the initial stages of this study to recruit a diversity of midwives and managers who had recent experience working in publicly-funded homebirth models in Australia. After the first 12 interviews were completed, it became apparent that participants had, to this point, been recruited from New South Wales, Victoria, South Australia and the Northern Territory, with no participants from Western Australia where the first publicly-funded homebirth program had started. It also become apparent, following initial analysis of the first 12 interviews, that participants who had experience working as privately practising midwives (PPMs) as well as in a publicly-funded homebirth model offered a particularly interesting perspective and unique insights relevant to the emergent findings. Theoretical sampling was then employed to access these two types of participants; those located in Western Australia and those with prior or current experience as a PPM as well as in the public model.

In order to recruit midwives from Western Australia, an email was sent to the manager of the service in this region asking her to distribute the study flyer (Appendix B) to potential participants. In this same email, a request was made for midwives who had experience working both as a PPM and providing publicly-funded homebirth. This sampling technique was very effective as following my email, contact was made by several potential participants. The study flyer (Appendix B) was also placed on social media, which attracted the final participants to the study. Snowball sampling took place throughout the recruitment process as midwives began forwarding the study flyer to colleagues who were suitable for participation, several of whom had experience as PPMs.

Data collection

Data were collected via semi-structured interviews that were audio-recorded and later transcribed. As it was not practical for me to travel to the diverse geographical locations where participants were situated, interviews were conducted via telephone. Telephone interviews are often depicted as a less than ideal mode of data collection (Cachia & Millward 2011; Novick 2008). This is because, when compared with face-to-face interviews, 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 (Novick 2008). Evidence is lacking, however, that phone interviews actually

produce poorer quality data (Carr & Worth 2001; Novick 2008) and the textual transcripts obtained from telephone interviews provide a rich data source for qualitative analysis (Cachia & Millward 2011).

Whilst the loss of non-verbal cues cannot be refuted, the development of rapport is not necessarily hindered by lack of face-to-face contact. There are also potential benefits to the distance offered by phone interviews as the anonymity afforded by this mode of interview may encourage respondents to feel more relaxed and better able to disclose sensitive information (Novick 2008). In addition to this, telephone interviews offer a greater level of flexibility in scheduling, reduce costs for the research project, are a faster method of collecting data and afford access to a larger population seeing as geographical location is not an issue when compared with face-to-face interviews (Shuy 2002).

In this study, I was able to build rapport easily with most participants over the phone. I typically spent the first few minutes of the call chatting with the participant helping them to feel at ease and making sure they had put aside enough time for the interview. I experimented with the way I introduced myself and noted that when I began the phone call by introducing myself as a midwife and a mother to two children born at home, a conversation naturally began to open up.

Homebirth is a controversial topic in Australia and I sensed that some of the midwives were skeptical about my intentions for the research project. Positioning myself as a 'homebirther' located me politically as someone supportive of homebirth and with lived experience of what is an infrequent event in Australia (0.3% of all births in 2015) (AIHW 2017). When I identified myself as a midwife, it indicated to the midwives participating that they could use technical language and talk about clinical scenarios without need for detailed explanation as there was a level of assumed shared knowledge and experience. It was made clear to participants that I had no personal or professional experience with the publicly-funded homebirth model and that the aim of the study was simply to explore midwives' experiences of working in this relatively uncommon model of care. Locating myself in this way is related to the concept of being an insider or outsider in research, which will now be further explored.

Researcher positioning: insider versus outsider

In qualitative research, the researcher plays a direct and intimate role in the process of data collection and analysis (Birks & Mills 2015; Dwyer & Buckle 2009; Finlay 2003). Constructivist grounded theorists openly acknowledge that the researcher influences the data, both in the collection and analysis phases; hence the research is considered a joint product of the participants, the researcher and their relationship (Birks & Mills 2011; Charmaz 2006; Finlay 2003).

According to Dwyer and Buckle (2009), the positioning of the researcher is an essential and ever-present aspect of the investigation being undertaken. Positioning refers to the researcher's own lived experience and where this fits with the phenomenon being studied. Researchers who have prior or current membership to the group they are studying are recognised as having 'insider' knowledge or status (Burns et al. 2012). Being an insider might mean sharing the characteristics, role or experience under study with the participants (Dwyer & Buckle 2009). On the other hand, the researcher may be an 'outsider' to the commonality shared by participants (Dwyer & Buckle 2009).

Whilst it is acknowledged in qualitative research that the investigator needs to be aware of their positioning, several authors have argued that the dichotomy of insider/outsider is too simplistic and that most of us tend to occupy a space somewhere in between these two extremes (Burns et al. 2012; Dwyer & Buckle 2009). Further to this, although the researcher may identify as being a part of the group under investigation, it is important that they avoid making assumptions about the culture they are studying, as they may not be aware of subcultures that exist within it (Asselin 2003; Dwyer & Buckle 2009). For this reason, it is advised that the researcher enters the field assuming they know nothing about the phenomenon being studied (Asselin 2003).

Having little knowledge of the phenomena you are studying is considered an advantage in grounded theory as the methodology emphasises discovering theory

directly from the data (Glaser & Strauss 1967). It is intrinsic to grounded theory practice that the researcher approaches the phenomena in question without preconceived ideas (Birks & Mills 2015; Charmaz 2006; Glaser & Strauss 1967). Though this approach is ideal, realistically most researchers have some knowledge of the field they are studying.

In order to identify and mediate any bias created by ones personal positioning, it is imperative that the researcher practices reflexivity. Reflexivity involves the researcher actively engaging with their own self-awareness in order to identify the impact that their personal values and positions may have on the research process and type of data collected (Burns et al. 2012; Hunt & Symonds 1995; Reed 1995). As described in the Methodology Chapter, I used journal and memo writing to develop reflexivity in an attempt to prevent my prior knowledge of the field of midwifery and homebirth from distorting my perception of the data (McGhee, Marland & Atkinson 2007). Greater detail on my position in relation to the area of inquiry has been provided in the previous Chapter.

Telephone interview technique

A semi-structured interview technique was used with a general opening question of 'Can you tell me about your work?' This allowed midwives to describe details of their current position and they commonly gave an overview of how the model operated at their particular site. Care was taken to use open-ended questions and a funnelling interview technique was used, beginning with more general questions

and then narrowing down to specific topics of interest (Charmaz 2006; Minichiello et al. 2004).

Initially an interview guide was developed with 25 possible interview questions. However when I attempted to use this guide, it became obvious after the first interview that 25 questions was far too many for a one-hour interview. I also noticed that working from the guide interrupted my ability to listen attentively and follow the flow of the interviewee's discourse. Endeavouring to gather more nuanced data, I discarded the majority of questions on the interview guide and conducted the next interview using a semi-structured approach. This yielded much richer data and allowed the interview to flow more freely. Keeping the overall aims of the study in mind, several more interviews were conducted in this semi-structured manner until initial codes were developed and themes started to emerge.

During approximately the first six interviews, participants tended to give great detail on how their particular publicly-funded homebirth program operated. Although time-consuming, the gathering of this information was necessary as it gave me a clearer picture of the variety of ways in which the different publicly-funded homebirth models in Australia function. Once my understanding of the operational aspects of the model was established and my interview technique improved, I was able to focus the next set of interviews predominantly on the emerging concepts.

A new series of guiding questions were then developed and continued to be refined after each interview. They included questions such as:

- How did publicly-funded homebirth become established in your hospital?
- What was your personal experience with homebirth before starting with the program?
- How do you feel about working in a Community Midwifery Program (CMP) or Midwifery Group Practice (MGP) team?
- How do you find working within the hospital policies and guidelines?
- What has been your experience of homebirth transfers?
- How does being in a woman's home affect the way you practice?

Following initial analysis of each interview, new ideas or recurrent themes were recorded in memos. Verification of concepts was then sought with subsequent interviews and the interview guide was refined. This is in keeping with a grounded theory approach where there is a close interplay between sampling, data collection and data analysis, referred to as data generation. Using this approach meant that my interview questions became progressively more structured in later interviews as a result of theoretical sampling and the need to ascertain specific data in the final interviews. The techniques used for analysis of data are now outlined.

Data analysis

The qualitative, interpretive methodology of grounded theory was employed for this study. In keeping with this approach, the process of data collection and analysis occurred simultaneously and were ongoing and interrelated processes (Charmaz 2006; Strauss & Corbin 1998). Grounded theory techniques were described in detail in Chapter Four: Methodology, hence this chapter offers a description of how such methods were engaged for this study rather than a justification for their use.

Coding

As outlined in Chapter Four: Methodology, the use of coding is a fundamental aspect of grounded theory practice. Coding involves categorising segments of data with a short name that both summarises and interprets each piece of data (Charmaz 2006). Codes were used repeatedly to identify conceptual similarities and reoccurrences in the patterns of participant's experiences (Birks & Mills 2015). Coding processes in grounded theory tend to have a natural progression that reflects the level of conceptual analysis the researcher has attained (Birks & Mills 2015). Coding was roughly separated into two phases: initial coding and focussed coding. However, the process was not completely linear and at times I moved backwards and forwards between different types of coding. Throughout the analysis phase, I remained theoretically sensitive by continually questioning the data and staying open to new codes and categories forming.

Initial coding

During initial coding, the researcher remains open to exploring whatever theoretical possibilities are perceived in the data (Charmaz 2006). The first step in my analysis process was to listen to the audio recording of an interview in detail whilst proofreading the transcript in order to check for transcription errors. This intensive listening allowed for a deep immersion in the data. Line-by-line coding was then undertaken wherein codes were attached to each line of data so that ideas were not restrained by sentence and paragraph structures. Line-by-line coding fragmented the data in a way that encouraged me to probe the data intensely in order to develop analytic ideas and identify the meaning behind participant's words.

Although I underwent training in the use of NVivo 10 Software at UTS in 2014, I found it was not helpful as an analytical tool for grounded theory. As an abductive approach, grounded theory requires the researcher to 'break open' the data, rather than identify pre-determined themes or concepts. For this reason, I found the NVivo software to be limiting. I needed to generate codes directly from the data, which happened slowly, over time. In order to achieve this I printed hardcopy versions of de-identified transcripts and coded them by hand using coloured highlighters and handwritten notes in the margins. Each transcript was revisited multiple times during data generation, in keeping with the grounded theory technique of constant comparison.

In order to clearly track coding procedures and assist with the management and organisation of data, an audit trail table was used (see Appendix F). This allowed me to arrange data under preliminary codes and then develop categories to 'house' those codes. Using an audit trail table was an integral part of my analysis as the table was a visual tool that facilitated the organisation of ideas and allowed me to constantly compare and rearrange codes as needed.

During initial coding, I asked the following questions of the data: What does the data suggest or pronounce? What is the data a study of? From whose point of view is it speaking and what theoretical category does it indicate? (Charmaz 2006; Glaser & Strauss 1967).

Gerunds

After sharing an early audit trail table with my supervisors, the use of gerunds for category names was suggested as a tool to further my analysis. Charmaz (2006) encourages the use of gerunds, which are the noun form of a verb, during the initial coding phase of analysis as it emphasises the actions and processes involved in the data. Gerunds are essentially 'doing' or action words ending in the letters 'ing' and their use is intended to encourage the researcher to deviate from simply identifying topics or themes and instead seek out the connections between structures apparent in the data (Charmaz 2006). I found this technique incredibly useful and, although challenging at first, the use of gerunds helped develop my

critical thinking around the drivers behind participant's words or actions presented in the data.

Focussed coding

During the process of focussed coding, initial codes were evaluated critically to determine their analytic strength. As opposed to initial coding which breaks the data into hundreds of small pieces, the aim of focussed coding is to bring together multiple codes that may be related in terms of the participants main concern and how they are resolving it. Constant comparison was used throughout the analysis phase of the research, comparing data with data, data with codes and codes with codes. During focussed coding I examined the most significant or most frequently used initial codes in order to ascertain those that should be rejected and those that should be promoted as over-arching concepts. At times, one piece of data illuminated another and new meaning was made. This process was not linear and occurred continually throughout the analysis phase, even whilst writing up the findings.

Memo writing

Memo writing or memoing is considered to be a fundamental component of developing a grounded theory (Birks & Mills 2015; Charmaz 2006; Corbin & Strauss 2008). Theoretical memos are reflective records that exist separately from the data, assisting the researcher to identify what is actually 'happening' in the data as well as document the decision making process involved in coding and category

development (Corbin & Strauss 2008; Hall, McKenna & Griffiths 2012). According to Charmaz (2006), memoing is the pivotal step between data collection and writing drafts of papers as it prompts the researcher to analyse codes and data very early in the research process.

I found memoing incredibly useful and used this technique consistently throughout the duration of the research project. Before I began conducting interviews I wrote a lot in my reflexive journal in an attempt to identify and acknowledge my biases. This got me in the habit of writing reflexively and many of the memos written during data generation included reflexive writing. Once interviewing commenced, my usual practice was to write a memo immediately following an interview and again when coding interview transcripts. During phone interviews I took down hand-written notes in order to record initial ideas and any possible 'in vivo' codes (i.e. direct quotes suitable as codes) that emerged from the data. These hand-written notes were then further developed in memos (see Appendix G for an example) and used in conjunction with the transcription of the audio recordings during analysis and the generation of findings.

Initially I commenced writing memos by hand and quickly moved to typing in a word document so that a word search could be performed on key terms. Reading back over my memos was an essential element in the process of developing codes and categories that later turned into findings and formed part of the constant comparison process. According to Charmaz (2006), memos are able to catch your

thoughts, capture comparisons and connections as well as crystalize questions and directions for you to pursue. I found memoing to be a valuable tool, as sometimes my initial response to an interview or the gut feeling I had after speaking to the interviewee would provide a lead towards a more sophisticated idea. Interviews commonly brought up many opinions and feelings for me, and writing memos assisted me to capture fleeting thoughts or impressions that might have otherwise been forgotten.

Theoretical saturation

Theoretical saturation is the phase of analysis when the researcher has continued sampling and analysing data until no new data appear and all concepts in the theory are well developed (Morse 2004). At this point, no additional data are needed as concepts and relationships between the concepts that form the theory have been verified (Charmaz 2006; Morse 2004). In contrast to saturation of data in some other qualitative methods, theoretical saturation occurs when data no longer reveals any new theoretical understandings (Charmaz 2006). I reached theoretical saturation after conducting 18 interviews, with a further three interviews conducted to confirm findings.

Identifying a core category

In earlier versions of grounded theory developed by Strauss and Corbin (1990), researchers aimed to develop a core category from the data. This complex process

involved bringing together all sub-categories to form one core category. The core category is a concept that encapsulates the phenomenon apparent in all categories and sub-categories, as well as the relationship between them (Birks & Mills 2015). Constructivist grounded theorists, on the other hand, advocate the integration of categories into theoretical concepts that are then woven into a substantive theory, rather than limiting the analysis to a singular core category. According to Thornberg and Charmaz (2014), seeking one core category potentially limits the analytic rendering of the data and subsequently reduces the theoretical usefulness of the final report. The method of the analysis used in this thesis is aligned with Charmaz' view of theoretical concepts, resulting in four major categories which are overlapping and interlinked.

Synthesis of findings with extant literature

Initial codes and focused codes that formed categories and sub-categories were all driven by the data. Following the formulation of theoretical concepts and categories, extant literature was synthesised with the findings in order to develop a substantive grounded theory. In this study, Mezirow's (1978) theory of transformation was used to enrich the understanding and analysis of the theoretical concept *'Seeing birth in a new light'* that emerged from the data. Additionally, anthropological perspectives regarding homebirth as a systems-challenging praxis by Cheyney (2008) were synthesised with the theoretical concept of '*Normalising homebirth'*. More detail on the integration of extant literature is given in the Discussion Chapter.

Summary

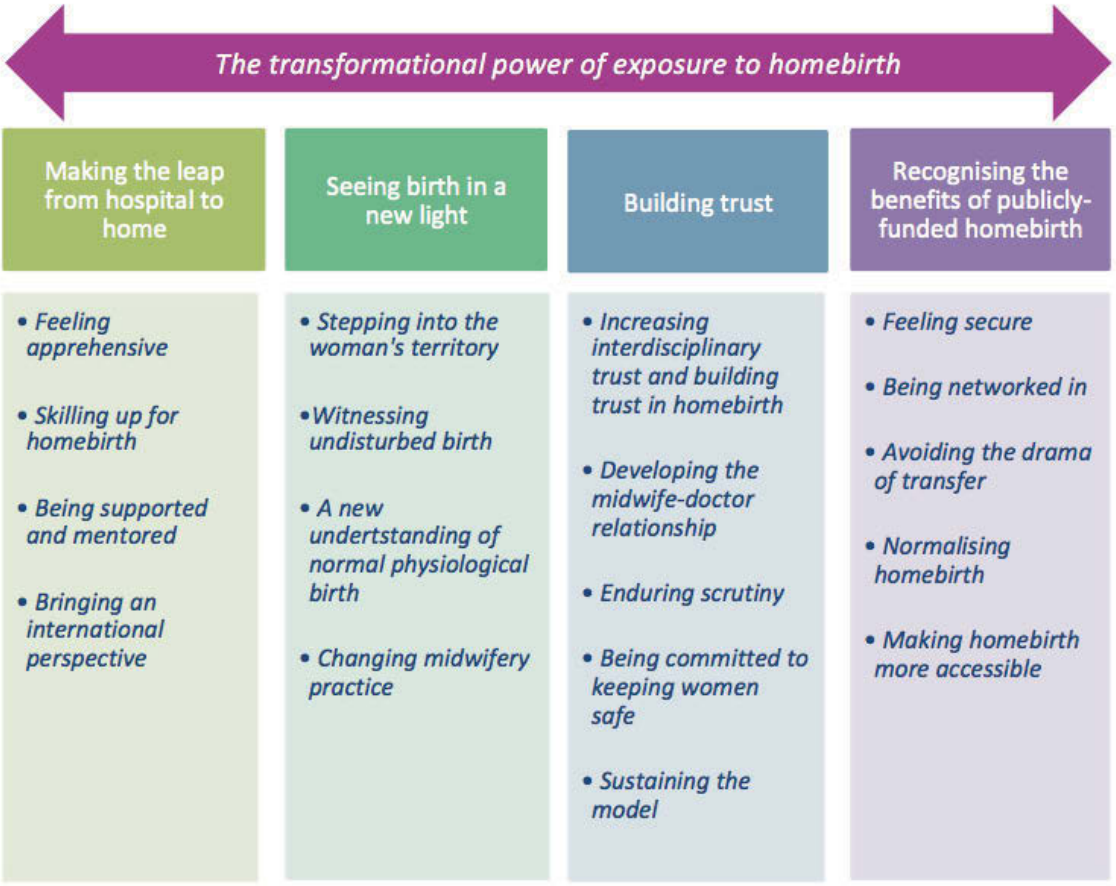
This chapter has described the setting, context and participants involved in this research project. An explanation of sampling techniques and the methods of data collection and analysis has been given. Through the application of these methods four major categories emerged from the data. They were; *'Making the leap from hospital to home', 'Seeing birth in a new light', 'Building trust'* and *'Recognising the benefits of publicly-funded homebirth'.* Each of these categories and their respective sub-categories will be described in the following four Findings Chapters.

PREAMBLE TO FINDINGS

This grounded theory study explored the social interactions and processes experienced by midwives working in publicly-funded homebirth programs in Australia. Four main categories were constructed from analysis of the data. They were: *'Making the leap from hospital to home'*, '*Seeing birth in a new light'*, '*Building Trust'* and '*Recognising the benefits of publicly-funded homebirth'* (Figure 3). Each category is explained in turn, in chapters five to eight. The substantive grounded theory *'The transformational power of exposure to homebirth'* underpins the findings and is explained in detail in the Discussion Chapter. Figure 3 is a visual representation of the findings, showing each of the categories and their related sub-categories.

Each findings chapter illuminates one major category and related sub-categories using excerpts of data from interviews conducted with midwives and midwifery managers to help illustrate the concepts. In order to protect their confidentiality, the names of participants have been replaced with pseudonyms. Where quotes are used throughout Chapters five to eight, a pseudonym is provided in brackets followed by a description of the participant's role as either 'midwife' or 'manager'.

Figure 3. Findings categories: *'Midwives' experiences of providing publicly-funded homebirth in Australia'.*



Outline of Findings Chapters

Chapter Five: *'Making the leap from hospital to home'* details midwives' experiences of transitioning into the publicly-funded homebirth model and includes discussion of the steps midwives took in order to prepare for the provision of homebirth care. These steps included both practical and emotional processes that varied depending on the participant's previous level of exposure to homebirth. This category is comprised of four sub-categories, which are '*Feeling apprehensive', 'Skilling up for homebirth', 'Being supported and mentored'* and *'Bringing an international perspective'.*

Chapter Six: *'Seeing birth in a new light'* describes midwives' feelings about working in the home environment, a place that was recognised as being the woman's territory. This category also addresses how witnessing homebirth lead to a change in midwives understanding of normal physiological birth, which often subsequently lead to a change in the way they practiced midwifery in both the home and hospital environment. This category is comprised of four sub-category, they are: '*Stepping into the woman's territory', 'Witnessing undisturbed birth', A new understanding of normal physiological birth'* and *'Changing midwifery practice'.*

Chapter Seven: '*Building trust'* describes the ongoing challenges faced by midwives in their endeavour to build trust in homebirth and sustain the model in the long term. It outlines the strategies used by midwives to develop strong relationships with doctors in order to ensure the success of the publicly-funded homebirth

program. In addition, this category addresses the scrutiny endured by midwives working in this model of care along with the scrutiny applied to women planning a homebirth. '*Building trust*' is comprised of five sub-category's, they are: '*Increasing interdisciplinary trust and building trust in homebirth', 'Developing the midwife-doctor relationship', 'Enduring scrutiny', 'Being committed to keeping women safe'* and *'Sustaining the model*'.

Chapter Eight: '*Recognising the benefits of publicly-funded homebirth'* portrays the perceived benefits of the publicly-funded homebirth model for midwives, for women and for homebirth in Australia. This category describes the advantages of being part of the public health system when providing homebirth care including a sense of job-security for midwives, the ability to collaborate with midwifery and obstetric colleagues when complications arose and the ease of transfer from planned homebirth to hospital when required. This category explores the way in which the publicly-funded homebirth model has opened up the option of homebirth to a wider range of women and served to normalise homebirth in Australia. It contains the following four sub-categories: '*Being networked in', 'Feeling secure', 'Avoiding the drama of transfer'* and *'Normalising homebirth'.*

Participant characteristics

Interviews were conducted with 21 midwives and midwifery managers from 8 different public hospitals. Participants came from five different states or territories of Australia where publicly-funded homebirth services were operating at the time of

recruitment. These included New South Wales (NSW), Victoria (VIC), Western Australia (WA), South Australia (SA) and the Northern Territory (NT). At the time of data collection there were no publicly-funded homebirth services operating in the states of Tasmania, Queensland or the Australian Capital Territory. The majority of participants in this study (nine out of 21) came from NSW, which was also the state that contained the highest number of publicly-funded homebirth services.

Each of the participants had recent experience of working in or managing a publicly-funded homebirth model. Eight of the 21 participants also had previous or current experience of working as a Private Practice Midwife (PPM) providing homebirth. Sixteen participants were midwives who had provided homebirth services through a public hospital continuity of care program known as either Midwifery Group Practice (MGP) or the Community Midwifery Program (CMP). The remaining five participants were managers of MGP and CMP services that offered homebirth, and all were midwives themselves. Some of these managers still cared for a small caseload of women whilst simultaneously holding the position of midwifery manager. The midwives' ages ranged from 26 to 70 years old. The number of years qualified as a midwife ranged from five to 40. Table 2 displays the demographic details of participants grouped by state. Age is shown in ranges and years qualified is given in five-year blocks in order to provide anonymity. A dash is shown where the data was not available.

Table 2. Demographic details of participants.

State or Territory*	Age	Years qualified to be a midwife	Years working in PFHB*	Position in PFHB service	Employment status when providing PFHB*	Private Practice Midwifery experience
NSW	61-65	>25	7	Midwife	Full time	Yes
NSW	36-40	>10	4	Midwife	Full time	Yes
NSW	46-50	>20	7	Midwife	Full time	Yes
NSW	-	-	-	Midwife	-	No
NSW	56-50	>30	7	Midwife	Full time	Yes
NSW	66-70	>40	2	Manager	Full time	Yes
NSW	56-60	>15	6	Midwife	Full time	No
NSW	-	-	-	Midwife	-	No
NSW	51-55	>25	4	Midwife	Part time	Yes
VIC	41-45	>10	2	Manager	Full time	No
VIC	41-45	>5	4	Midwife	Full time	No
SA	26-30	>5	4	Midwife	Full time	No
SA	46-50	>20	4	Midwife	Part time	Yes
SA	46-50	>20	5	Manager	Part time	No
WA	56-60	>30	3	Midwife	Part time	No
WA	46-50	>10	4	Manager	Full time	No
WA	-	-	-	Midwife	-	Yes
NT	26-30	>5	2	Midwife	Full time	No
NT	-	-	-	Midwife	-	No
NT	41-45	>15	6	Manager	Full time	No
NT	26-30	>5	1	Midwife	Full time	No

*VIC (Victoria), NT (Northern Territory), SA (South Australia), NSW (New South Wales), WA (Western Australia). * - Denotes 'data not available'
* > Denotes 'greater than' *PFHB stands for 'Publicly-funded homebirth'

CHAPTER FIVE: FINDINGS 'MAKING THE LEAP FROM HOSPITAL TO HOME'

Introduction

This chapter outlines the first category that describes the processes that midwives underwent while '*Making the leap from hospital to home*'. '*Making the leap'* portrays midwives' experiences of not only physically moving their practice from the hospital to the home setting, but also refers to the shift in mindset and attitude required. The phrase 'Making the leap' alludes to taking a leap of faith; doing something despite not being certain that it is correct, or that there will be success. This speaks to the level of uncertainty some participants felt about transitioning into providing publicly-funded homebirth, particularly those who had never been involved with homebirth before.

A woman's home was seen as a place that was distant from the hospital both physically and politically. Participants were aware that, in Australia, planning a homebirth was generally not accepted as a normal or safe choice for women to make: '*It's still seen by society as this crazy, unsafe, "why would you do that?" type of thing'* (Bianca, midwife). However, participants did not tend to agree with this judgement and many believed that women should have the right to choose their place of birth – including the home; '*It should just be a normal choice for women'* (Annie, manager); '*Everyone has their own home. So why shouldn't they be able to*

choose to birth at home where we've been doing that for many, many years before we all moved into the hospital system' (Rachel, midwife).

Despite their support for a woman's right to choose where to give birth, some participants still felt a sense of apprehension when it came to them personally providing homebirth services for women. Participants recounted that, at times, it was hard to shake the notion that homebirth was associated with greater risks for mother and baby, as is often portrayed in the media; '*You get the media stories about the ones that aren't so good, and that's what's pushed in people's faces all the time'* (Vicky, midwife); *'…the media love a botched homebirth story'* (Pam, midwife).

Participants were acutely aware that caring for a woman at home would involve a change in not just the physical space they work in, but also the way in which they work. Participants perceived that providing homebirth required greater skills from the midwife, and some midwives doubted whether they personally possessed the skills required. For some of the participants these factors provoked anxiety and feelings of apprehension as they made the transition from hospital to home. The category '*Making the leap from hospital to home'* is made up of four sub-categories: '*Feeling apprehensive*', '*Skilling up for homebirth', 'Being supported and mentored'* and '*Bringing an international perspective'* which provide greater insight into the concepts just outlined.

Sub-category: Feeling apprehensive

Midwives providing publicly-funded homebirth in Australia come from a variety of different backgrounds in terms of previous exposure to homebirth. Many of the participants had no prior exposure to homebirth before practising in the publicly-funded homebirth model; '*I had no experience with homebirth at all'* (Jenny, midwife); '*I'd never done homebirth before'* (Vicky, midwife). The transition to providing homebirth services was often daunting for midwives who were accustomed to practising in the hospital environment. This apprehension stemmed from a fear of the unknown and anxiety around whether they were 'up to the task'. Providing publicly-funded homebirth allowed midwives to work to the full scope of their practice and involved spending time on-call and out in the community. Josephine described how she felt when she first joined her hospital's MGP team:

> *[I was] a bit apprehensive, yeah, I must admit. [MGP] was a huge leap anyway, from working at the [hospital] in structured shifts (Josephine, midwife).*

Midwives who had not been exposed to homebirth before commonly felt unsure about the practice of homebirth, and initially some were even actively opposed to the idea. When providing publicly-funded homebirth, midwives had to adapt to a new way of working which, at the time, made them feel nervous. Josephine went on to say:

> *When I first started... there was a lot of births still happening at the [hospital], which I still feel comfortable in, as opposed to the homebirths, because I hadn't experienced it. It was something that I wanted to do, but on one hand I was keen to, and on the other hand it was, "Oh wow! This is out of my league" type of thing. The more and more that I do homebirths, I think, "It's just wonderful" (Josephine, midwife).*

Participants talked about their first exposure to homebirth as being a highly significant event. During interviews, midwives commonly retold the story of the first homebirth they ever attended with many describing the acute anxiety they felt around practising in an environment so different to their usual place of practice, which was the hospital. Some midwives even described feeling physically ill with anxiety during their first homebirth, as Jenny recounts:

> *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 (Jenny, midwife).*

In part, the apprehension described by participants was a result of their concern about the safety of out of hospital birth. As homebirth is a contentious issue in

Australia, midwives regularly encountered negative attitudes about homebirth from the media, medical community and general public. This influenced their attitudes and contributed to their apprehension about providing homebirth, as midwifery manager Lori explained:

> *To be honest, in my midwifery career when I first started I really didn't think much of homebirthing. You get trained in the medical model… You get it all drummed out of you and you get basically brainwashed that homebirthing is terrible, bad, shouldn't happen, dangerous. Over the years I managed to get over that and realised that actually this is a really good way for women to go (Lori, manager).*

Another midwifery manager, Gwen, described how at times she had difficulty recruiting midwives to work in the publicly-funded homebirth model. However, over time as employees got used to the idea of publicly-funded homebirth they became less apprehensive. She explained:

> *…A lot of people are a bit funny about it. Given the [political] climate at the time, there's a lot of focus on homebirth and stuff in the media. 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 [crazy] or different (Gwen, manager).

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

Sub-category: Skilling up for homebirth

Providing care to women at home meant that midwives were able to work to the full scope of their practice. Participants described the process of '*Skilling up for homebirth'*, which referred to developing competence in the range of midwifery skills necessary for attending women at home. Whilst the basic midwifery skills required for homebirth were the same as the midwifery skills required in hospital, midwives needed to learn to work more autonomously. For some, this was described as a 'learning curve', for example Carla said:

I was very much keen to start practising homebirth. I'd never done it before, but wanted a more woman-centred and midwife-centred model of working so I chased the job. I got the job and I loved it! The first few months, obviously, were a huge learning curve (Carla, midwife).

Midwives and their managers took the responsibility of providing homebirth very seriously. In order to provide homebirth care, midwives needed to be proficient in intravenous cannulation, perineal suturing and maternal and neonatal resuscitation. Once competent in these skills, they were proud of their ability to work as autonomous practitioners and provide a complete service for the women in their care, as Jenny describes:

> *I'm able to facilitate a complete experience almost so we don't have to involve other health care professionals to help facilitate a birth at home, which is fantastic. We can keep it completely, kind of, in-house so to speak. That's a very satisfying experience for me, as well, 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 (Jenny, midwife).*

Designation as the primary midwife for a homebirth required each midwife to have witnessed several births 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 and then later act as a mentor to other midwives. Jessica described the accreditation process in her program:

> *The process is that you go through that transition of being a third midwife, second midwife, then you're a primary with some support from the mentor. I think once you've done ten as a primary midwife, I think then you become a mentor (Jessica, midwife).*

All services required a second midwife to be present at every homebirth. Along with being a safety measure in case of an emergency situation, this supervision model was seen as an excellent way to introduce new midwives to homebirth in a supportive environment: *'I was there really in an observational role and it was a fantastic experience'* (Jenny, midwife). The supervision model was also available for more experienced midwives. Even after being deemed competent to provide homebirth, midwives were encouraged to engage the support of their colleagues whenever they felt unsure, as Annie conveyed:

> *….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! (Annie, manager).*

Although there was commonly an initial apprehension around whether they had the capacity to provide homebirth and a focus on 'skilling up', ultimately midwives identified practising in the home environment as being 'the same, but different' to hospital. Cultural conditioning that resulted in fear of homebirth was dispelled after witnessing several homebirths and seeing how 'normal' the event can be. As

participants became more familiar with working in the home environment, their confidence grew as they realised that the midwifery skills they had developed in hospital were still effective in a woman's home. Bianca explained her realisation, saying:

> *'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 . . . ' (Bianca, midwife).*

In a similar vein, Margot described being informed by her colleagues (who had already begun attending homebirths) that there was no difference in terms of the midwifery skills required. She said:

> *I was really pre-prepared by my colleagues… by saying, "It's no different than the care that we provide in terms of clinical care [in hospital], its just about providing that in the home" (Margot, midwife).*

Although the basic midwifery skills required remained the same in the event of a normal birth, participants were acutely aware of the importance of being prepared for an emergency situation that may arise at home. As such, midwives regularly participated in emergency drills in order to maintain up to date skills in neonatal and

maternal resuscitation as well as the management of obstetric emergencies. These training days were usually conducted in collaboration with obstetricians, anaesthetists, ambulance workers and other allied health staff. Vicky explained her teams 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] (Vicky, midwife).*

Along with providing the opportunity to refresh essential skills, these training days were also viewed as an occasion when team-building and interdisciplinary collaboration could take place. The notion of belonging to a team was very important for midwives' sense of job satisfaction and safe practice and several participants cited this as one of the primary reasons they felt publicly-funded homebirth was a 'better' model than private practice. The importance of mentoring and support are described in the following sub-category.

Sub-category: Being supported and mentored

The third sub-category under '*Making the leap from hospital to home'* is about '*Being supported and mentored'*. 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 often two, or sometimes three, midwives present for the labour and birth. This was different to when midwives cared for women in the hospital labour-ward environment where a second midwife would only be called into the room if a complication arose or when the birth was imminent. Many participants described how much they enjoyed the support offered by colleagues as Rachel 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 (Rachel, midwife).*

Midwives also described the benefits of working side by side with 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, as Vicky expressed:

> *So from my perspective that has been huge, that learning and being able to adapt my practice watching other people participate… You know when you do [antenatal] clinics, you are on your own. When you are doing postnatal care usually you are on your own. Everything as a midwife is one-to-one care, which is great… and I know we are good*

> *at collaboration and we are good at talking to people and saying: "Oh, I'm not sure what does anyone else think?" so getting advice that way. But actually watching other people is something that we don't get to do (Vicky, midwife).*

Observing the practice of others provided an opportunity for participants to reflect on their own midwifery practice and to build confidence in their clinical and communication skills. Many participants felt that this aspect of working in the publicly-funded homebirth model contributed to an improvement in their midwifery practice. In addition to the benefits of observing others practice, participants enjoyed being offered support from colleagues and mentors whom they respected and with whom they felt safe enough to ask questions or discuss problems. As a less experienced midwife, Bianca particularly appreciated opportunities to reflect on her practice and consider whether there might be a better way of doing things. She stated:

> *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 (Bianca, midwife).*

Midwives valued the notion of belonging to a team very highly. In particular, the opportunity to debrief and discuss clinical scenarios with other health professionals who had worked in the same model was seen as extremely important. Other midwives working in MGP or CMP were able to offer a level of understanding and empathy not available from the midwife's friends or partner. Bianca described the closeness of her team and the importance of debriefing with them:

> *We all became really close, because you need each other. You need that debrief time, you need someone to talk to that totally understands and can feed off you. Just like your partner and your other friends want to care for you and want to understand, and they do to a certain degree, but no one knows the ins and outs like your colleagues do (Bianca, midwife).*

Working as part of a team provided an opportunity for peer mentoring in a safe and supportive environment. Midwives felt that this facilitated an improvement in their practice based on observing others, debriefing, consulting and reflecting on their own practice. The trusting relationship that developed between midwifery colleagues was central to this, as the following quotes detail:

> *I think a big part of this job is debriefing and talking, consulting with your other staff members about particular issues… having someone*

who's been there and done that at the other end of the phone at whatever time of day… (Jenny, midwife).

I'm sure if I hadn't felt that I was working with someone that I trusted as a midwife, that worked in a similar way to me, then it would have been much harder (Helen, midwife).

I definitely learned from, you know, little secret tricks of the trade… you learn about yourself as well, and you are able to reflect on your practice with your colleagues and to change your practice for the better (Bianca, midwife).

Not all midwives felt well supported, however. Some described challenging interactions with core midwifery staff and felt they were heavily scrutinised by hospital management and other health professionals who were not supportive of homebirth (this issue will be described in detail in Chapter Seven '*Building Trust'*). Whether a practitioner was supportive of homebirth or not appeared to be influenced by whether their previous exposure to homebirth, either through their personal or professional life. One factor that influenced the likelihood of prior homebirth exposure was the country in which the midwife or doctor was born, the country in which their own children had been born and the country in which they had completed their midwifery or medical education. This concept is explained in the next sub-category '*Bringing an international perspective'*.

Sub-category: Bringing an international perspective

Several participants were '*Bringing an international perspective'* to homebirth as they discussed their experience of living outside Australia and how this impacted their attitudes towards maternity care. Some participants were born and educated overseas, while others had given birth to their own children in a country other than Australia that routinely offered homebirth as an option for women. These midwives felt they didn't have to 'make the leap' when transitioning into the publicly-funded homebirth model because, in their lived experience, homebirth was constructed as a normal occurrence. Participants described how their experience of living in countries where homebirth was accepted as normal practice influenced their own philosophy around birth, Vicky said:

> *My philosophy, I guess had developed over years with from where I've come from. [I had] one birth in Holland and one in England. That was where I had my babies… And the idea of midwives being primary carers and birth being normal, that's sort of where I come from (Vicky, midwife).*

One midwifery manager described how in the United Kingdom (UK) homebirth is more widely accepted: *'I trained in the UK. As a student we were involved in homebirth because it's considered a perfectly normal thing in the UK*' (Annemarie, manager). She went on to describe the differences between midwifery education in Australia and the UK stating:

> *It's integrated into your training so in the UK when you train, 50% of the training is actually implemented in the community environment and therefore that incorporates anything that goes with that. The difference is that women have the right to choose a homebirth regardless of the level of risk (Annemarie, manager).*

Taryn had also witnessed homebirths whilst training in the UK: *I'd seen homebirths in England as a midwife. We worked with a community midwife for three months there* (Taryn, midwife). Participants observed that obstetricians and other medical professionals who were supportive of the publicly-funded homebirth model were commonly from international rather than Australian backgrounds. Many of the obstetricians who were involved in getting a publicly-funded homebirth service established were noted by participants to have been educated or worked overseas. This was thought to impact their attitude towards homebirth, for example, Annie said:

> *A lot of our doctors worked in the UK where it [homebirth] was not a big deal. You know, they'd had a history of homebirths and stuff where they were. Some of them were from The Netherlands so, you know, they were just pretty cruisey [relaxed] about it… (Annie, manager).*

In particular, maternity care providers who were born or educated in the UK, New Zealand, or The Netherlands were automatically assumed to be supportive of

homebirth: '*[Our obstetrician's] training was over in New Zealand, so he was ok with it [homebirth]. It was just the rest surrounding him that weren't* (Lori, manager). These obstetricians were seen to be great allies in the effort to establish homebirth as an acceptable practice in Australia. Participants believed that obstetricians who had been educated in these locations tended to not only be more open to homebirth, but they were also thought to have a better understanding of how to work in partnership with midwives. Lori made this link when describing the obstetrician who worked in the publicly-funded homebirth service with her, saying:

> *He was very pro midwifery because he had trained in a New Zealand model so it [homebirth] wasn't so far out there for him. He actually worked with the midwives (Lori, manager).*

Participants felt that when maternity care providers were educated and/or had worked overseas, particularly in countries where homebirth was routinely offered, they tended to have a different mindset around place of birth: *'I was born and trained in England where the mindset is very different'* (Pam, midwife). Homebirth was not a matter of controversy for care providers who were *'Bringing an international perspective'* because homebirth had been a normal aspect of their education and work life prior to their arrival in Australia. In comparison, none of the participants in this study who undertook their midwifery education in Australia described being exposed to homebirth during their midwifery education, as this is not a standard part of the midwifery or obstetric curriculum here. Indeed, it was

quite the opposite, as homebirth remains a controversial matter in Australia. Participants observed that some Australian obstetricians felt conflicted about supporting the publicly-funded homebirth program because it directly went against their professional college (RANZCOG's) stance on homebirth. This matter is described in detail later in Chapter Seven '*Building Trust*'. With acknowledgment of the initial apprehension felt by many maternity care providers in regards to their provision of homebirth care, the following major category '*Seeing birth in a new light*' describes the change of heart experienced by many midwives following their first exposure to homebirth.

Summary

This chapter described the applied and social processes midwives underwent when transitioning from providing hospital-based to homebirth care. This included a description of the practical steps midwives took in order to prepare to work to the full scope of their practice, as well as an exploration of the apprehension some participants felt about providing homebirth. Mentoring and support from colleagues was an important component of a successful transition from providing hospital-based to homebirth care. Midwives apprehension and fears around homebirth were allayed once they witnessed their first few homebirths. The following chapter describes participants experiences of '*Seeing birth in a new light*' following exposure to homebirth via the publicly-funded model.

CHAPTER SIX FINDINGS: 'SEEING BIRTH IN A NEW LIGHT'

Introduction

The second major category, '*Seeing birth in a new light*', describes the process of transformation that midwives underwent in regards to their understanding of, and appreciation for, normal birth. In maternity care, the term 'normal birth' refers to a birth with minimal or no medical intervention. Whilst participants had witnessed and supported women through normal birth on many occasions in hospital labour-ward environments, they reported that once they began providing homebirth care they experienced an unanticipated change in what they had come to understand as normal birth. In a sense, their definition of what constituted 'normal' was altered. For midwives, often this transformation in understanding was met with a sense of shock that then lead to a re-evaluation of what they currently knew about birth. One participant summed up her experience of seeing a homebirth for the first time, simply stating: '*It blew my mind*' (Jenny, midwife).

For some participants, despite having many years experience as a midwives, they began to see birth 'in a new light' as they observed the process of birth unfolding differently when it took place in the woman's home. They noticed a difference not only in the woman's behaviour in the home environment, but also in their own behaviour and how they practised midwifery. Participants reported a process of reflecting upon their previous experiences of birth and questioning the impact that the birth environment and subsequent power dynamics might have on the woman's

birth. Midwives who had not been exposed to homebirth prior to working in the publicly-funded homebirth model reported the greatest shift in their perspective. As described in the previous category, some participants reported initially *'Feeling apprehensive'* about providing homebirth. However, typically after witnessing several homebirths, their confidence grew not only in regards to the safety of homebirth but in regards to their own ability to facilitate birth at home with their existing midwifery skills. The major category '*Seeing birth in a new light'* has four sub-categories: '*Stepping into the woman's territory'*, '*Witnessing undisturbed birth*', '*A new understanding of normal physiological birth'* and *'Changing midwifery practice'*. Each of these sub-categories will now be explored in more detail.

Sub-category: Stepping into the woman's territory

Midwives noticed several differences between the hospital and home as a setting for birth. Not only was the domestic sphere of a woman's home different in terms of the physical environment, but also caring for women at home significantly shifted the power dynamic in the midwife-woman relationship. Home as the woman's territory, whereas the hospital was perceived as the midwife's territory. Use of the term 'territory' signifies the notion of power associated with each place. Participants described how the processes and interactions between midwives and women were different when women were giving birth at home due to this shift in power. At home, the woman and her partner were noted to be '…*Masters in their own domain'* (Gwen, manager), meaning that the space was under their control. Participants

repeatedly described themselves as being a visitor in the woman's home, with the inference that this altered the power dynamic between midwife and woman. Being in the woman's home was perceived to place the woman truly at the centre of the care being delivered, as detailed in the following quotes:

> *It's a very different experience birthing women, I guess in a hospital, to birthing them at home. It feels, I don't know… I think the sense for me is that you… 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 it's... you're there as an invited guest in somebody else's labour when you're in the home environment, which is lovely (Vicky, midwife).*

> *It's got something to do with the space, the woman's own space, and we are visitors in that space. Immediately, you are in a different paradigm as a health professional, and the way you move about that space, and the way you use that space is entirely different. The woman, she's the centre, she's the absolute centre, whereas it's not that clear often in the hospital situation (Taryn, midwife).*

When the midwife was a visitor in the woman's home, social processes and interactions played out differently to how they would play out in hospital due to the

altered power dynamic. Participants described how, at a homebirth, women and their partners did not need to ask for permission or directions for simple actions, such as, making a cup of tea or using the bathroom. Instead it was the midwife who was a guest in the woman's home and she was required to ask permission for such tasks. While these matters may seem trivial, midwives felt that they were symbolic of the shift in power dynamic that occurred in the woman's home. When women and their partners were in charge of the space they could set it up to suit them, and the midwife would adapt to what the couple wanted rather than the couple adapting to what was provided in the hospital environment. Ruth described what she saw as the advantages of being in the home environment:

> *For the woman it's a no-brainer, they just can get on with what they have to do. The men, they're just at home. They can offer us a cup of tea. We don't have to tell them where the tea is…. It's wonderful from a sociological point of view, I think. The power is totally with the couple. We're guests in their homes. We have to behave ourselves. We can't just go around acting like we own everything 'cause we don't. I think all that ownership, and sense of power and familiarity… Yeah, I think that's really, really important in that choice to birth at home (Ruth, manager).*

Midwives reflected on how a different power dynamic was set up from the commencement of labour, as with a homebirth the onus was on the woman to call

and invite the midwife to attend when she felt it was time. This was noted as a significant shift from a planned hospital birth where the woman needed to phone the hospital in order to arrange to attend. Helen surmised this notion, saying:

> *It is different because they're in their environment. It's their territory, not ours. We've been invited in really. We don't invite them in like we do in hospitals. If they want us there, we go (Helen, midwife).*

Many participants noticed that in the home environment women appeared better able to relax, which assisted the progress of labour. In addition, women's partners often appeared less anxious at home as they felt useful and able to participate in the birth, rather than just observe as they often did in the hospital environment. Taryn described the difference she noticed in partners between the home and hospital and felt that their experience of birth impacted their transition to parenthood:

> *'[I've noticed] how different men are able to be in their own domain… they busy themselves with things. They busy themselves with the pool when the temperature is not quite right they've got the hot water going with this tap and that tap… Then I can remember [one] guy, there was not enough privacy for her so he was getting sheets and banging them in with a hammer [to make curtains]… How often do you see [partners], they sit at [The Hospital], they sit under that freezing cold air conditioner, which is against the wall, so they're cold,*

they're frightened, they're tired. They don't have a role, they don't know what to do, they keep leaping up and down if they think they're in your way. They're just out of their comfort zone completely. Whereas you walk into their space in the home situation… I feel very satisfied about that for the men, because I think if they have that positive experience and the positive experience also of being the man, the alpha male, he's in charge of his domain. That's what that does for him going into being a father (Taryn, midwife).

Participants noted that being on the woman's territory not only altered the power dynamics at play, they also observed that in the home setting women were able to give birth in a truly undisturbed environment. The following sub-category '*Witnessing undisturbed birth*' follows on from the notion of home being the woman's territory to describe the difference midwives noticed in the way women experienced labour and birth at home.

Sub-category: Witnessing undisturbed birth

Several participants 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 practiced as midwives for many years. Participants portrayed a powerful shift in the pregnant woman's behaviour during labour as a result of being in the home environment. At home, midwives' described witnessing women give

birth in a truly undisturbed way, and they noticed how different the experience of facilitating a homebirth was to facilitating a birth in hospital. Participants felt that the experience of *'Witnessing undisturbed birth'* opened their minds to a new level of understanding of the process of labour and birth, and led them to question their previous understanding of birth. Jenny recounted:

> *I had facilitated almost a thousand births when I started working in MGP, but I had never seen a woman [give] birth so calmly and physiologically as I did when I saw that woman birth at home… It was a completely new experience for me (Jenny, midwife).*

Participants described a transformation in their understanding of the physiological process of birth, and how the surrounding environment might impact this. Midwives noticed that women giving birth at home were able to do so in a truly undisturbed way. Being undisturbed encompassed the woman's familiarity and sense of safety within the home environment along with a lack of interference from noises, smells and unfamiliar staff: *'They're not worried that someone is going to burst through the door in a minute… You don't have the bells outside and the different smells'* (Gwen, midwife). Home provided an exceptional level of privacy for the woman as the only people present were the homebirth midwives and the woman's partner or whomever she had invited as her support team, sometimes including her other children. There was a notable lack of interference with the woman during the birth process and midwives' were conscious of giving the woman privacy and space. Jenny described how she behaves at a homebirth in order to avoid disturbing the labour:

I think I'm more kind of just watching the labour, always from a distance. I never like getting up in women's faces. I think that's really quite invasive for lots of women... I mean, apart from doing the mountains of paperwork that come with homebirth, I think I just sit and I just watch women, and I watch them labour, and I watch their body go through that physiological process, which is just amazing. I mean, I love it. I could sit there and watch women labour all day really, quite happily (Jenny, midwife).

Participants were aware that creating a private space where women felt safe would encourage optimal levels of oxytocin, the hormone responsible for contractions and continued progress of labour. Helen explains the difference between the home and hospital environment and how this impacts women, stating:

I think the level of fear. I think it [impacts] so much. [At home] the women are much more able to be in their zone and just do their thing and their hormones can work in the way that they're meant to. We're not meant to move [relocate] during labour. We're not meant to have bright lights and people staring at us the whole time. None of that helps. The level of anxiety that happens in a hospital is incredible. That's something I've really noticed going back into a big tertiary hospital labour word. There's so much fear. I even get fear. I'm

continually worried that something is going to go wrong, and it so often does (Helen, midwife).

Midwives felt that allowing the woman to labour undisturbed was a key component in facilitating normal birth. Many participants felt this was easier to achieve in the home environment compared with hospital. Vicky reflected on the home environment, saying:

… It's amazing. It's how it should be in any environment for all women. They should have that ability to [give] birth in that sort of environment whether they're in a hospital or whatever, to actually not have loads of people running into a room and things like that. And having things quiet and uninterrupted (Vicky, midwife).

In addition to a lack of unnecessary interference, participants felt that a major advantage to homebirth was that women were able to stay at home for their entire labour, consequently avoiding the stress of deciding when it was time to attend hospital and the often uncomfortable car-ride. Disturbance to the labouring woman was minimised by the midwife travelling to the woman, rather than the other way around. Some MGP and CMP services offered home visits in early labour for all women in the continuity of care program, while others only offered this for women planning to give birth at home. Avoiding the need for the woman to get in the car

and travel to hospital in early or established labour was seen to be extremely beneficial for the progress of labour, for example Gwen describes:

> *I think the main thing is when someone is in labour and they've got to make the decision to go into hospital ... Because you don't want them to go in too early because otherwise [labour] will stop. Even just thinking from my own [birth] experience, I don't know... I could never have got in a car. One of the women I was talking about earlier, she said that not having to get in a car and drive to the hospital when you're 6, 7, 8 [centimetres dilated], in transition, whatever, was a big difference. It's just seamless. The women tend to labour better at home, as we all know; but you really see it (Gwen, midwife).*

Being in the home environment, which was physically distant from the hospital, allowed women and midwives to remain uninterrupted by the surveillance of the hospital. Rather than needing to constantly report what was happening to the midwife in charge, midwives could concentrate on just being with the labouring woman: '*At home you don't have to keep running and telling the person who's in charge what's going on'* (Ruth, manager). Midwives felt confident knowing that the women they were caring for had been screened to ensure they were at low-risk of complications. Further to this, in the event that a labour did not progress normally, midwives felt reassured that they could seek assistance from the hospital when they needed it, consulting with hospital obstetricians over the phone or organising for the

woman to transfer to hospital. In the event that all was well, however, being at home facilitated a reduction in unnecessary interruptions and intrusions, allowing both the woman and midwife to feel more relaxed. These factors helped facilitate an undisturbed birth. Rachel talked about the different way of working in the home environment:

> *There is absolutely a different way of working with women in homebirth. Absolutely, you can barely compare it sometimes… just because in a hospital, you know... You're watched as a midwife. Your paperwork is watched; Doctors want to know exactly what's going on. You don't have the breadth of normal that you can apply to a homebirth. Women when they're birthing at home often call you a little bit later too or are happy for you to come and go, you know… It's just different (Rachel, midwife).*

A sense of being watched was perceived to have a negative impact on both women and midwives. Participants felt that in the home setting they were able to practice what they referred to as 'real midwifery'. This concept referred to midwives using their clinical judgment to assess whether a woman's labour was progressing normally without the fear of unnecessary interference. Participants clearly appreciated the support offered by the hospital system in the event of an emergency or when a woman required extra medical support during a planned homebirth. What was evident, however, was that the midwives felt the option to actively seek medical support in the home environment - rather than having it imposed - was a clear

benefit of homebirth. In this sense, being at home alleviated the perceived need for the midwife to protect the woman's birth space, as Vicky described:

> *Actually being away from that setting where there isn't somebody wandering in or out or, you know, feeling that you actually are having to stop people from entering a room. Trying to, you know, be that caregiver that has to try and keep things normal. Where in the home environment you're there just to facilitate. You're there just ensuring that there isn't anything that changes. That the risk stays as, you know, that everything stays normal and then if there is a risk that you're there to facilitate the need to transfer or whatever if that has to happen (Vicky, midwife).*

In addition to the difference in the birth environment, Midwives described how their understanding of normal was transformed after attending homebirths. This will be explored in the following sub-category '*A new understanding of normal physiological birth'.*

Sub-category: A new understanding of normal physiological birth

Participants described the way their understanding of normal birth changed after being exposed to homebirth. Many reflected that outside of the hospital environment, they witnessed patterns of labour that stretched the boundaries of what would have been considered normal in hospital. This lead to a process of re-

evaluation by midwives, in regards to what 'normal' is and, in particular, a questioning of the medical model's timeframe for labour progress. As midwives began to witness undisturbed birth more frequently, their threshold for when they felt intervention was needed began to extend. Margot described this by simply stating: *[Homebirth] broadens your knowledge in terms of what is normal and your line in the sand of when you would actually do something'* (Margot, midwife).

Although midwives worked to the same safety criteria and guidelines when caring for women at home as they did in hospital, some participants said they began to feel more confident in their midwifery skills and judgement when providing care for women at home. This confidence was based on their relationship with the woman and ability to provide one-to-one care. When providing publicly-funded homebirth, midwives had the opportunity to develop a well-established relationship with the woman and her family throughout the course of the pregnancy. In addition to this, during labour the midwife was focused solely on one woman, without any of the distractions that can occur in hospital. Sometimes in the hospital environment, midwives were not able to provide continuous one-to-one care for women in labour: '*We do leave women. We walk out the room and go and get our tea and we're not there all the time if they need us'* (Vicky, midwife).

At a homebirth, however, midwives were able to be fully present at all times which allowed them to be more aware of subtle changes in the labour that might indicate a potential complication developing. Jenny explains the significance of this, saying:

That's 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. So, yeah. I think in that sense, I think that's almost why homebirth can be safer than hospital birth for low-risk women (Jenny, midwife).

Strict notions of progress in terms of cervical dilation were also brought under question as midwives began to shift their perspective and broaden their understanding of normal. Some described caring for women whose labour deviated from the current medical model's definition of adequate progress of one centimetre dilation per hour, yet they recognised that this did not necessarily indicate an obstructed labour. For example, Rachel said:

You can recognise the ranges of normal more. I think that once you work in homebirth you understand a lot more about what is normal and what isn't normal. I suppose progress is a good example. In a hospital, you've got that "you must be a centimetre every hour" … [But at home] you see things that are different and you're able to understand a lot more about birth, I suppose, and how powerful and strong women are (Rachel, midwife).

Participants felt that being present at homebirths had helped them to truly understand normal physiological birth. Georgia talked about how important it is for midwives' to really '*know birth'*, something she felt was challenging for midwives working in the current hospital system. She said:

> *…You need to know birth. Physiological birth, you need to know it. You need to know it personally, experientially, and you need to know it as a midwife being with a woman. Unless you're exposed to that... It's not about believing in it, unless you've witnessed it over and over again and not been responsible for the outcome, just being there. I think it's very hard to have faith in the physiology of birth in our culture. The hospital system we're trained in is indoctrinated to [make you] think otherwise (Georgia, midwife).*

In the same vein, midwifery manager Annemarie also spoke about the challenge she saw midwifery students facing in regards to their understanding of normal birth. She felt that it was not until they undertook a placement within the CMP that they were exposed to 'real midwifery':

> *We allocate these student midwives a placement with us on the community midwifery program, they love it. But they are able to actually see midwifery as it really should be. Unfortunately for*

everybody else, all they end up doing is seeing is hospital births. They have no exposure to the real… how a midwife should work. I'm afraid to say it but they absolutely are obstetric nurses here [in Australia]. Generally, they're afraid of [homebirth]. They're actually afraid of… I get it all the time from them, so many trainees, "You're so brave, you're so brave". I'm so brave to be with a completely healthy, normal woman who needs hardly any input in labour, yet they see that as frightening (Annemarie, manager).

Many participants felt their understanding of birth was vastly improved after attending homebirths. Caring for women at home required midwives to work to the full scope of their practice and some even described feeling as if they were practising 'real' midwifery for the first time. They enjoyed using their midwifery skills and knowledge, and working as autonomous practitioners. Whilst midwives felt confident they could safely allow women the time they needed in labour, they were careful to follow the strict safety guidelines regarding indication for transfer. Rachel described how they manage this balance:

It's not that you get away with more at homebirth. I don't want to say that, but it's that you can just be more confident that, you know if an OP [Occiput Posterior] baby is being born at home, you know it's going to take longer and you use your midwifery skills and knowledge to say: "Look, she might not be doing two centimetres every four hours but…

the labour is progressing." If she was in hospital, they're looking at that chart. Someone else is observing that. You know that they're going to start Synto[cinon] and you're going to have a battle on your hands. So it's just little things like that, trusting in that normal process. But having said that, the threshold for risk is much lower at a homebirth. You don't take risks at a homebirth. If anything stops to be normal you transfer. We don't do heaps of transfers because things obviously normally stay normal, but we do do quite a few. You know, mec[onium] stained liquor, that kind of thing. (Rachel, midwife).

Many of the participants spoke about the way their midwifery practice changed once they had become accustomed to attending women at home. Several participants also discussed how their experience at homebirths had prompted them to change their midwifery practice in the hospital environment. This concept will now be explained in the final sub-category of *'Seeing birth in a new light',* titled '*Changing midwifery practice*'.

Sub-category: Changing midwifery practice

Participants reported that their experience with publicly-funded homebirth had prompted a change in their midwifery practice. Once they had overcome the initial anxiety of attending homebirths, midwives described feeling more relaxed in the home environment: *'It just is so much more relaxed and so much more social'* (Ruth, manager). Midwives working in the publicly-funded homebirth model are in a unique

position as their work environment crosses two distinct areas of practice; the institutional setting of public hospital maternity wards and the domestic setting of women's homes. Midwives in the study who provided publicly-funded homebirth did so as part of their hospital's MGP or CMP program wherein they were concurrently providing care for women planning homebirths and women planning hospital births. Many midwives perceived a vast difference between the two environments and noted how this impacted not only on the woman and her partner, but also on the midwife herself and subsequently how she practiced midwifery: *'…Going right back to that very first homebirth experience. I think that woman's experience influenced and changed my practice a lot'* (Jenny, midwife). Lori also described the change in her practice while attending homebirths:

> *The whole atmosphere is a lot more relaxed. You as a clinician and midwife can, you know you're always on the ball but in a much more… in a setting where it's not so clinical. You can do things within the home; fetal heart, blood pressures, or whatever, but it's all about working with the woman and what she wants and negotiating. It's about being respectful in her environment… As a midwife, it's just a totally different experience in a way, it's much more relaxed. Even though people say "Oh gosh, 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. You know you're not going to be*

worried about who's going to be knocking on the door, who's going to be wanting a VE [vaginal examination] every four hours, all that sort of stuff.

As previously discussed, the domestic setting of the woman's home set the tone for power dynamics to shift in the woman's favour. At home, the woman was the centre of the care being provided and the onus was on the midwife to adapt to the woman's environment, rather than the other way around. A tangible example of this shift was the way a midwife's equipment was setup at a birth. Participants described making a conscious effort to avoid bringing *'the hospital into the home*' (Gwen, manager) which meant minimising the amount of medical equipment that was visible to the woman. It was acknowledged that having to adapt to the woman's environment may make some midwives feel uneasy *'…[some] people feel out of control because it's not their space'* (Gwen, manager). Whilst having the equipment required for the birth was a responsibility that midwives took seriously, they were mindful of not 'taking over' the space. Gwen spoke at length about how she sets her equipment up at a homebirth:

You don't need to have it setup like you're going to do an appendectomy... There's hardly anything you need before [the baby] comes out. You want to make sure everything is nice and clean in case you need to do stitching or something like that. So, you know, you use their things. I don't know. We don't want to come in and be like,

"Right, now. I need to have all my instruments lined up. I want this and that"... I mean I feel in control if everything's OK. What unsettles me is if I haven't got everything that's working. I like to check all my equipment and make sure that's all there. Well, I've already done that [antenatally] because I've brought the kit out and done all that. If I know that everything's working, if I need that resuscitation or anything, I know that's going to work for me, I'm fine (Gwen, manager).

As detailed in the previous sub-categories, participants described how attending homebirths transformed their perspective of birth and lead to a re-evaluation of what they considered normal. In addition to this, midwives noticed that they acted differently in the home environment and felt this lead to subtle, yet powerful changes in their midwifery practice. Midwives commonly compared their experience with homebirth to the care they had previously, and were still currently providing women in hospital. For some midwives, facilitating homebirths dramatically changed their perspective of hospital birth, as Bianca 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. It just felt like that was so normal… it made hospital birth seem so

abnormal. I was so upset and frustrated for the amount of women that miss out on experiences like that (Bianca, midwife).

Once midwives became aware of the supportive qualities that the home environment contained, they attempted to bring this knowledge into the hospital environment. Subsequently, the way they practiced in hospital began to shift as they tried to emulate the positive aspects of homebirth when caring for women in hospital. Robbie described her awareness of treating the birth environment as the woman's '*Sacred space' (Robbie, midwife)*, whether that space is located in the hospital or the woman's home:

When you park outside the house and you step over that threshold into that family's space, it's just so evident that we're entering your space and I'm going to respect that… but you can also take away that I'm going to bring that into any space… whatever birth we're going to we have to imagine that we're stepping into the door of their home (Robbie, midwife).

Although the hospital was recognised as the midwife's territory, many participants acknowledged that the midwife could transform this power dynamic by making a conscious effort to change the physical space in hospital and be more aware of their own behaviour. Jenny described how she altered the hospital birth environment in order to make it more friendly and home-like for the woman:

I mean, just simple things like turning down the lights, burning essential oils, having nice calming music playing. Just things that they would have at home and just keeping out of the room a bit as well and letting the woman and her support people get on with it a bit on their own. I think that makes a big difference (Jenny, midwife).

Summary

This category '*Seeing birth in a new light*' explored midwives' experiences of caring for women in the home environment, often for the first time in their midwifery career. The opportunity to step into the woman's territory during homebirths allowed midwives to experience a different power dynamic, where the woman was truly at the centre of care and the midwife was a guest in the woman's space. This alternative social process caused midwives to question the practices they had been part of in the hospital environment.

Participants felt that their experience of providing publicly-funded homebirth had resulted in positive changes to their midwifery practice. They cultivated a new appreciation for, and understanding of, normal physiological birth. In addition to this, providing homebirth allowed midwives to work to the full scope of their practice and encouraged them to develop new clinical and decision-making skills. Ultimately, exposure to homebirth lead to a process of reflection and, combined with an increased understanding of the physiology of birth, resulted in a

transformation in midwives' attitudes towards homebirth and their willingness and capacity to facilitate birth at home.

The next chapter examines the challenges faced by midwives in '*Building trust*' in homebirth and working to improve the midwife-doctor relationship in order to assist in the success of the model and support its long-term sustainability.

CHAPTER SEVEN: FINDINGS 'BUILDING TRUST'

Introduction

The previous chapter detailed the transformation in midwives' understanding of normal physiological birth, along with the change in midwifery practice that often resulted from exposure to homebirth. This findings chapter outlines the third major findings category **'***Building trust'.* Participants described the political climate surrounding homebirth in Australia as one of fear and mistrust: *'[Women] don't even contemplate homebirth because it's all fear-driven in the community'* (Lori, manager). This fear was fuelled by negative homebirth stories regularly being published in the mainstream media. In addition, participants felt there was a lack of agreement as to whether homebirth was a safe option for women and their babies amongst doctors and midwives and that these differencing stances played out in social interactions and processes in the workplace. Commonly doctors were skeptical of homebirth and midwives were more supportive or open to the idea. However, some midwives were unsure about homebirth and doubted whether they possessed the necessary skills to care for women at home and keep them safe. As described in the previous chapter, maternity care providers who had lived and worked overseas tended to be more accepting of homebirth and the notion that midwives were well-placed to be the lead-carer for women experiencing low-risk pregnancies.

In Australia, the establishment of publicly-funded homebirth programs was usually a hard-won fight with many years of campaigning from key supporters. Even once the

program was established, participants strived to encourage trust in homebirth and trust in the midwives working in the service. The process of '*Building trust'* was multi-faceted for participants. They described the challenges faced in their interactions with doctors and allied health workers who were dubious about homebirth. Participants spoke in detail about the process of developing relationships with these individuals who held powerful positions that would determine whether the publicly-funded homebirth program would run at their hospital, and whether individual women would be approved for a homebirth. Midwives and midwifery managers went to great lengths to cultivate working relationships with doctors at their hospital. Without the support of a lead obstetrician, hospitals could not establish or maintain a publicly-funded homebirth service, making this relationship critical to the program's success or failure.

Midwives also worked hard to keep women safe and ensure they were practising within the hospital guidelines. They felt that the existence of the publicly-funded homebirth program was particularly tenuous and that just one adverse outcome could lead to its closure. As a result, participants needed to carefully balance the needs of the institution with the needs of the women in their care, in order to sustain the model. These concepts will be further discussed in the following five sub-categories: '*Increasing interdisciplinary trust and building trust in homebirth', 'Developing the midwife-doctor relationship, 'Enduring scrutiny', 'Being committed to keeping women safe'* and *'Sustaining the model'.*

Sub-category: Increasing interdisciplinary trust and building trust in homebirth

There was a sense that, for publicly-funded homebirth programs to be successful, maternity care providers needed to learn to trust each other and learn to trust homebirth. Participants in this study felt that, in Australia, homebirth was largely misunderstood and met with a sense of mistrust: *'I think in society, in general, [homebirth] is very much frowned upon'* (Bianca, midwife). Poor public perception of homebirth was thought to be perpetuated by the media publishing primarily negative homebirth stories: '*You get the stories, the media stories about the ones that aren't so good, and that's what's pushed in people's faces all the time'* (Vicky, midwife). For maternity care providers, previous exposure to homebirth seemed to influence whether or not they were supportive of homebirth. Given that homebirth is so uncommon in Australia, very few maternity care providers had personal or professional experience with homebirth, which often contributed to a sense of mistrust and misunderstanding.

Participants spoke about the challenges of working with doctors who did not trust homebirth. There was a perception that midwives and doctors generally possessed different philosophies regarding birth: *'…Birth is a risky thing, according to the medical perspective'* (Jemima, midwife). These divergent philosophies tended to mean midwives were more open to the idea of homebirth than doctors. Participants felt that doctors were best at managing emergency situations and midwives were best at managing normal births: '*My philosophy is that an obstetrician is there for risks and emergencies, and that's what they're trained in anyway. They have no real*

need to deal with normal birth' (Vicky, midwife). Whilst they were very grateful for the expertise of an obstetrician when complications arose, most midwives felt that providing care for low-risk women at home was well within the scope of their practice. Some of the doctors they worked with, however, needed to be convinced of this.

Participants described engaging with doctors during the planning phase of a publicly-funded homebirth program being established, in an attempt to gain their support. At times, it was necessary for midwives and midwifery managers to address the concerns of doctors who had serious misconceptions about how the model would work. Midwifery manager Annie offered the following advice on how to go about establishing a publicly-funded homebirth program:

> *Include everybody. Make sure you get everybody's opinions and fears, because 90% of them will be from what they've read or heard… We had our paediatricians and our ED [Emergency Department] consultants and our anaesthetists and things like that… We said, "What's your biggest fear?" Well you know, I think at one point in time we had an anaesthetist who said "Well, I'm not doing Epidurals for women in the home" (Annie, manager).*

Annie's story about the anaesthetist who misunderstood homebirth, suggesting he would be asked to offer epidurals to women at home indicates a substantial lack of

understanding about homebirth on the doctor's part. This misunderstanding, and others like it, drove many of the fears doctors had around homebirth. Rachel had a similar experience of addressing a doctor's misunderstandings about homebirth. She described a confrontation she had experienced with a locum obstetrician who did not appear to understand what was involved in homebirth midwifery care:

> *He was very aggressive. He bailed me up in the corridor one day… He was like "Are you part of MGP? You guys are irresponsible." He saw us as irresponsible, unsafe. Basically I think he thinks we were coercing the women into having homebirths. Then he came out with, "You don't even provide proper care at home". He just actually had no understanding of the equipment we brought into the home. He had no idea that we listened to the fetal heart at home. It was embarrassing for him… He was a private obstetrician at a private hospital… A lot of our locums are people who are retired. They're practising how we practiced 50 years ago, not how we practice today (Rachel, midwife).*

During the initial planning phase, it was common for numerous stakeholders to attend meetings about the publicly-funded homebirth service in order to express their apprehension about the program. Midwives used this forum to address any concerns about homebirth and gain the support of key stakeholders, as revealed in the following quotes from midwifery managers:

We had, you know, the old adage 'you catch more flies with honey' … We involved anaesthetists, paediatricians, emergency department clinicians, both nursing and medical. There wasn't anyone that wasn't involved in starting to develop our guidelines and transfer criteria. So we had everyone's line in the sand drawn and we came somewhere in between and I think that was pivotal in getting wide support (Annie, manager).

When we first started, there would have been 15 [doctors] around the table, I reckon, putting policy through and all the rest of it. So they were very concerned that they wanted to make sure that everything was as safe as possible and that we weren't going to be 'rogue' midwives and doing all sorts of weird and wonderful stuff (Gwen, manager).

The notion that midwives might be going *'rogue'* speaks to the lack of trust between doctors and midwives and a desire for some doctors to maintain a sense of control. Participants knew that most Australian doctors had never been exposed to homebirth before and were aware that many were deeply opposed to the idea. At times, there was friction between midwives and doctors about the level of autonomy midwives should have in caring for women and whether homebirth should be supported by the hospital: '*When you're working with doctors who don't trust midwives, it's really hard to even get a [midwifery] group practice happening,*

let alone homebirth' (Helen, midwife). For some participants, this was a source of ongoing frustration, yet others were sympathetic towards doctors who were unsure about the publicly-funded homebirth model because they understood the origin of their concerns. Lori spoke about a frank discussion she had with the obstetrician at her hospital, and the obstetrician's reasons for being cautious about supporting the publicly-funded homebirth model. Lori said:

> *We've been drummed into us that it's okay for homebirthing, they've been drummed in "No". Their college [RANZCOG] doesn't support [homebirth]. That was one of the arguments that [the obstetrician] always came up with. She said: "You know you've always got to look at where I come from. My college doesn't support homebirthing. If I go out on a limb here, and that's exactly what I'm doing by supporting homebirthing, then I'm automatically this little rebel in my own group" (Lori, manager).*

As discussed in the previous chapter under the sub-category '*Feeling apprehensive'*, some midwives initially felt unsure about homebirth, but once exposed to it their fears diminished. Several participants had a desire for all doctors to witness homebirth so that they could understand it more fully and be less fearful: '*I think all doctors should see it'* (Helen, midwife). Bianca spoke about wanting the obstetrician at her hospital to see a homebirth so much, that she had considered inviting her to her own birth:

> *I've actually always said if I fell pregnant I'd want our head obstetrician to come to the homebirth so she can see it, because she supports it but she never gets the buzz that we get from it. She's never been to one and I think that's really sad. I think she should be part of what she's helping to support. Not to do anything, just to sit in the corner and watch, I think it would be good for her to do that (Bianca, midwife).*

Numerous participants described how the obstetrician at their hospital learnt to trust homebirth after seeing the positive results achieved once the publicly-funded homebirth program began operating. Although obstetricians did not have the opportunity to see homebirths first hand, they were aware of the positive outcomes being achieved in the homebirth program as it was common practice for data on all homebirths to be collected and forwarded to key stakeholders. Rachel described how midwives and doctors at her hospital learnt to trust homebirth:

> *When we first started doing the homebirth service… all the obstetricians were very against it - very, very against it. When they brought it in, some of the midwives working in the service were too… Then, people started to do it and they saw it was safe and they saw how lovely it was. They saw how the women just flourished in that environment and how outcomes were so good. And they all slowly, slowly changed their minds (Rachel, midwife).*

This second-hand exposure to homebirth even had the capacity to transform some obstetricians from being homebirth skeptics to homebirth champions, such as the obstetrician overseeing Lori's service:

> *… For [the obstetrician] to start out as totally opposing everything and now she's our biggest advocate. She wants to extend the service for every woman, particularly the remote women in the [region]. It's a really great thing (Lori, manager).*

For Helen, this was one of the reasons she strongly supported publicly-funded homebirth: '*I felt… we could make a difference to the way doctors perceived homebirth and the public generally' (Helen, midwife).* Providing publicly-funded homebirth offered an opportunity for midwives and doctors to increase interdisciplinary trust and also helped to build trust in homebirth. Another aspect of 'Building trust' was the development of a strong, collaborative relationship between midwives and doctors. The following sub-category details the process participants underwent to intentionally strengthen their relationships with doctors, in order to allow the publicly-funded homebirth program to operate effectively.

Sub-category: Developing the midwife-doctor relationship

'Developing the midwife-doctor relationship' was crucial to the success of a publicly-funded homebirth service. Participants described the importance of the midwife-doctor relationship, explaining that the operation of each publicly-funded homebirth program relied on the support of an obstetric sponsor or lead; one or more obstetricians who agreed to take responsibility for the obstetric aspect of care. The obstetric lead worked alongside the midwifery lead (also the midwifery manager) to oversee the operation of the program. Having the support of an obstetric lead was a crucial step for the establishment of a new publicly-funded homebirth service and helped to foster an acceptance of the program in other stakeholders: *'Even though it's hard… when you get obstetric buy-in for a publicly-funded homebirth [service] it makes your job a lot easier'* (Pam, midwife).

Participants who worked in hospitals where there were existing positive working relationships between midwives and doctors felt this was a great advantage when working to establish a publicly-funded homebirth program: *I don't think we would have even got it off the ground if we hadn't had good relationships with the obstetricians* (Helen, midwife). However, others had to work hard to build positive relationships with the doctors at their hospital. There was a sense that, in some hospitals, relationships between doctors and midwives had historically been challenging and an 'us' and 'them' dynamic existed. This usually stemmed from midwives and doctors having different philosophies around birth, differing opinions on how care should be carried out and tension over who the lead maternity carer

should be. Pam spoke about how the strength of the midwife-doctor relationship significantly impacted their interactions:

> *…You see the very best midwives, they are fantastic in that consultation process and they do develop that networking so the doctor doesn't come in the [birth] room. He doesn't need to come in the room because he trusts the midwife, that she can tell him everything… [With] some doctors, you are protecting the woman because you know they're going to come in and they're going to do some intervention, no matter what you say (Pam, midwife).*

The establishment of a publicly-funded homebirth program tended to illuminate any existing challenges in midwife-doctor relations, as providing homebirth care involved an increased level of autonomy for midwives which challenged some doctors. In order to overcome the 'us' and 'them' dynamics, participants engaged in a number of techniques with the aim of *'Developing strong relationships'.* One technique that midwifery manager Lori described involved connecting with the doctor on a personal level, in order to improve their professional relationship:

> *We've just pulled down those barriers. We've made each other human. We've made each other have a good relationship with [the obstetrician]. And you know, she's just wonderful. She's amazing now. But you know I think if we hadn't done that and hadn't worked at*

> *that… because that's what we did. We just basically worked out our relationship with her. And once you start coming down on a human level rather than a doctor/midwife level, it actually works very well (Lori, manager).*

Midwifery manager Lori's description of *'coming down on a human level'* suggests that some of the conflict between midwives and doctors stemmed from their allegiance to a particular professional identity. Once they connected on a human or personal level, conflicts tended to diminish and mutual trust and respect developed. Similarly, in order to achieve this aim, several participants described inviting the obstetricians to team dinners and other social activities. Another commonly used technique was to invite doctors to attend emergency training days or drills alongside midwives. Vicky noticed a change in the attitude of doctors who were *'difficult'* after attending homebirth drills together:

> *In the last few homebirth drills that we've done we've actually invited some of the registrars… the most difficult registrars that we've got, have been invited. For the ones that struggle with midwives. We've got a very strong team of midwives at the hospital that we work at. [They're] experienced and, well, ballsy [assertive] I guess. And some of the registrars that we get do struggle with that. Because they come from places where they're unquestioned and so they find being questioned, I guess, and being told "No" quite difficult. So one of the*

things that we try to do is include them in some of the homebirth drills. So it's not that they, it's more of a learning [experience] for them. So they can sit back and watch, but they don't actually get involved in them… One of the registrars that came, he was a really difficult person. And he came in September, I think, to the homebirth drill and [after that] his actions to us… changed dramatically (Vicky, midwife).

Inviting doctors to attend emergency training days was a technique used not only to break down barriers between midwives and doctors, it also demonstrated that midwives working in the publicly-funded homebirth service took women's safety seriously and were well trained in how to manage emergency situations. This appeared to put doctors at ease and, in turn, improved their relationship.

Communication was seen as a key aspect of '*Developing the midwife-doctor relationship'.* Midwifery manager Annie spoke about the importance of good communication and how she and her team worked hard each day to maintain good relationships with the doctors. She said:

We work at it every day. Every day. It's like any relationship that you [have]. If you don't work on it, if you don't use good communication and if you don't constantly sort of promote it and, I guess, work on the relationship, it will become difficult (Annie, manager).

In addition to good communication skills, participants identified several other key qualities that assisted them to develop positive relationships with doctors. These were; being a competent practitioner; being open to feedback; consulting when necessary and transferring in a timely manner. When midwives demonstrated these qualities, it tended to promote mutual trust and respect between midwives and doctors as demonstrated by the following excerpts:

> *The other important aspect of having a team is having those good relationships with our obstetric colleagues. Where we're working in a trusting relationship… demonstrating competence and providing appropriate feedback, referring in a timely manner and supporting women through that journey… (Carla, midwife).*

> *It's actually about the relationships that you build, across your team and into the hospital system. So if you demonstrate competence and if you have good, clear communication and you're open to being challenged or being scrutinised or having things suggested about your practice... I think if you've got that openness and if you're willing to go "Yep, I can adjust my practice in this way or that way" and have it kind of move both ways as well. Because, once you have a good trusting relationship them, the consultant [obstetricians] go, "Oh they're going to call me if there's something out of the ordinary." Then they're much*

more likely to let you push the boundaries. They'll know that you're going to call when you need and that it's going to be okay (Robbie, midwife).

Whilst participants acknowledged that it was important for midwives and doctors to have strong collaborative relationships, some expressed frustration at how much power the obstetrician overseeing the model held. Furthermore, participants felt their practice was heavily scrutinised when working in the publicly-funded homebirth model. These concepts will be described in the next sub-category, *'Enduring scrutiny'.*

Sub-category: Enduring scrutiny

Midwives working in the publicly-funded homebirth model felt they endured a higher level of scrutiny than midwives working in other models of care. This issue was perceived to stem from a general mistrust of homebirth and apprehension from hospital management and doctors about midwives having an increased level of autonomy when caring for women at home. Participants described being required to complete additional paperwork when providing publicly-funded homebirth: '*Mountains of paperwork… comes with homebirth'* (Jenny, midwife). Some also reported their service being evaluated more frequently than other models of care: '*…Of course we're scrutinised… Our publicly-funded homebirth service is the only one*

that's evaluated annually. And those stats and that evaluation goes all the way to the clinical council, so we know we're watched' (Pam, midwife).

At times, there was tension between doctors and midwives regarding who the lead-carer should be. Jenny worked in an all-risk model where midwives collaborated with doctors to provide continuity of care for women of low, medium and high risk. Low risk women were eligible for publicly-funded homebirth and higher risk women would be cared for in hospital. It was intended that midwifery care was the overarching coordinating component of care, however in practice this was difficult to achieve due to tensions between doctors and midwives. This resulted in midwives feeling '*under the microscope'*, as Jenny explained:

> *Unfortunately, at the moment there's a bit of a feeling that we are hijacking the women so to speak in that I think the doctors want to keep control of the higher risk women. I don't know if that's because they feel like they need to justify their positions or what, because there certainly hasn't been any reports of insufficient care or inappropriate care because the midwives are doing that supervision role. I think it's more the doctors feeling a bit insecure that they're not the ones that are in charge anymore, so to speak. As a result of that, there's lots of ... You feel like you're under the microscope all the time. You feel like the doctors are always double checking your work or going behind your back and organising things for these women that*

perhaps aren't necessary or should be organised in consultation with their primary care giver, which is us (Jenny, midwife).

Whilst some participants felt being so highly scrutinised was unfair, others accepted it as something they had to endure until homebirth became more accepted by the hospital and society in general. As previously explained, homebirth is an uncommon event in Australia and many maternity care providers do not have personal or professional experience with homebirth. Lack of exposure, combined with the dissemination of negative homebirth stories in the media and lack of support from peak professional bodies representing obstetricians in Australia, make homebirth a controversial choice for women and the midwives caring for them. Carla described the challenge of working in this model of care given the political climate surrounding homebirth:

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 homebirth. 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 (Carla, midwife).

In a similar vein, midwifery manager Ruth described homebirth as being highly visible. She felt that when it came to adverse events, people were quick to blame the place of birth, rather than look at all of the factors potentially involved:

> *There's a real issue around homebirthing being so out there, standing on a pedestal. I don't mean that pedestal as in always good, but standing out there so damn obvious. Stuff in hospital is kind of glossed over. Not seen, not viewable. People think what happens at homebirth, particularly if it's a negative thing, is all about homebirth rather than being about a birth, the care they've gotten, or a particular situation. [They think it's] something to do with the place, not the actual process or the care providers, or whatever (Ruth, manager).*

Some midwives experienced a negative response from doctors and hospital midwives when transferring women to hospital from a planned homebirth: *'…You were under scrutiny and suspicion and criticism, merely by setting your foot over the threshold. There was immediate suspicion and assumption'* (Carla, midwife). Pam accepted that, for a midwife providing homebirth, there would always be a certain level of scrutiny that had to be endured. However, her experience of working in the publicly-funded homebirth model involved less scrutiny than her experience as a private practising midwife:

> *There's always that [issue] of acceptance being a private practitioner... That issue of always proving yourself and selling yourself. I find with the publicly-funded homebirth it's very different. Because we worked really, really, really hard to sell it and to set up the safety nets that we needed and to make sure all the key stakeholders were involved in that, there seems to be more trust. There's always people that won't support homebirth no matter what, whether it's public or private, but I feel there's more trust of the practitioners [in publicly-funded homebirth] (Pam, midwife).*

In addition to the scrutiny midwives faced regarding their practice, some participants expressed concern over the level of scrutiny women who were planning a publicly-funded homebirth faced. Each publicly-funded homebirth program had a lead obstetrician overseeing the model. In accordance with the maternity services hierarchy in Australia, this obstetrician had the final say on whether individual women were eligible for a publicly-funded homebirth. The majority of services required women to attend a routine antenatal visit with the obstetrician between 34 and 37 weeks gestation and whilst they tried not to frame it as such, this antenatal visit was the final step a woman had to take in order to be approved for publicly-funded homebirth: *'…[Women] get approved, I don't really want to use that word, but they get accepted into the homebirth program by the obstetrician at about 37 weeks'* (Bianca, midwife). The notion of women being 'approved' by the obstetrician made some participants feel uncomfortable because, at times, they did not agree

with the obstetrician's assessment. Furthermore, some participants questioned the relevance of the guidelines being used to assess women's eligibility for homebirth: *Those guidelines, they're set up I guess to protect us and to protect women… The whole thing is based on who knows what – it's not research based* (Vicky, midwife). The issue of eligibility criteria will be thoroughly explored in the next sub-category '*Being committed to keeping women safe'.*

In services where the lead obstetrician was generally supportive of homebirth, it was believed that this system of obstetric approval worked well. In such cases, the woman's antenatal visit with the obstetrician was framed as an opportunity for her to meet the whole team and be reassured that they were supportive of her choice to give birth at home, rather than being a *'final tick-off'* of her eligibility (Annie, manager):

> *Women also have at least one visit at around about 34 weeks with one of our consultant obstetricians. And, as I said, they're all pretty positive around homebirth, but it's also to, I guess… debunk any myths that, you know, it's doctors against midwives or doctors not liking homebirth. It's really about "We're here to support you. I might be a face you that might see if you need to be transferred in" (Annie, manager).*

However, other participants expressed frustration that when obstetricians were not

supportive of homebirth, they had the power to restrict women's access based on their personal conviction, rather than an evidence-based decision: *You'd be amazed the things the [obstetricians] don't clear for homebirth… Whichever way you look at it, it's about the power and control the doctors have over the women* (Annemarie, manager).

The matter of individual obstetricians having the final say regarding whether women could access publicly-funded homebirth was particularly problematic when there was a change in staffing and a new obstetric lead was appointed who was not supportive of homebirth. This was a potentially disastrous situation for women wanting a homebirth who were refused despite meeting the eligibility criteria. Vicky spoke about the disappointment of losing their obstetric lead who worked collaboratively with the midwives and made the 34 week antenatal appointment a really positive experience. Unfortunately, the obstetricians who replaced her did not take the same approach: *It has been quite difficult… we are trying very hard to sort of say "Look this is not the way it's supposed to be. It's supposed to be a collaboration. It's not that you're looking for something that we've missed". We haven't actually missed anything* (Vicky, midwife).

This was a particularly pertinent issue for midwives working in rural areas where there was a high turnover of locum obstetricians. Rachel described the difficulty of working with a locum obstetrician who declined women access to a publicly-funded homebirth because he was not personally supportive of homebirth:

> *We get locums from Sydney who are outraged that we have a homebirth service… We had a locum obstetrician a couple of months ago who had a six month term and he got fired. He kept declining normal women with no risk factors homebirth for no reason, other than he didn't believe in it. What does that even mean you don't 'believe' in homebirth!? This is what I get concerned about. If we have people like this in positions of power… (Rachel, midwife).*

This scenario demonstrates how heavily the publicly-funded homebirth model relies on the support of individual care providers to succeed. Without the support of these powerful individuals, the service has the potential to be significantly compromised, as Lori also disclosed: *Our lovely [obstetrician] is on extended sick leave now and it's all fallen into a heap. So it was very obstetrician-dependent. That's mostly the story everywhere* (Lori, manager). These issues are interlinked with concerns some participants had over the struggle for power and control in maternity care and the politics involved in midwife-doctor relations. Whilst the majority of midwives accepted the level of scrutiny they faced in the publicly-funded homebirth model, some felt it was too great and left the public model either to work in private practice or in a different model of maternity care.

Related to their experience of '*Enduring scrutiny'* was the requirement that midwives providing publicly-funded homebirth practice within strict guidelines developed by the hospital. Their experiences of working within these guidelines are

explored in the following sub-category, '*Being committed to keeping women safe'.*

Sub-category: Being committed to keeping women safe

Participants were very mindful of their responsibility to care for women in a manner that was safe and provided the best possible outcomes for mother and baby. They worked within strict guidelines that were usually developed by a committee of key stakeholders during the establishment of the publicly-funded homebirth service. Women were required to meet eligibility criteria to be accepted onto the publicly-funded homebirth program and then continue meeting the criteria as their pregnancy progressed, as Bianca explained:

> *…Only well women are able to choose publicly-funded homebirth and they plan it from 37 weeks gestation… It's based on strict guidelines of, you know, they have to meet a certain criteria and then if any complications arise during their labour, birth or even in the early postnatal period then they're transferred to a hospital (Bianca, midwife).*

Jenny gave more detail regarding the screening process midwives went through with women who were interested in homebirth, outlining what was considered a low risk pregnancy:

> *As part of our screening process when women indicate that they might like to plan to birth at home, we require them to meet a certain set of criteria for safety reasons. They include things like having an uncomplicated obstetric history, so no caesarean sections in the past, no major postpartum haemorrhage over 1000 mls, their current pregnancy has to be uncomplicated and normal, so no preeclampsia or hypertension. They can have gestational diabetes if they're well diet controlled, but not if they're on any form of medication for the gestational diabetes. Yeah, virtually anything, a cephalic presentation as well. They do have to meet pretty firm criteria (Jenny, midwife).*

There were mixed feelings from participants regarding the guidelines. For the most part, midwives were willing to work within the guidelines and advise women whose pregnancy deviated from low risk status that they were not eligible for a publicly-funded homebirth: *I believe that you need guidelines and I think the guidelines that we have set are set for a reason* (Bianca, midwife). The majority of participants agreed that not all women were suitable for homebirth: *I do think there needs to be guidelines because, like I say, I don't actually personally believe that it is safe for everybody to birth at home* (Helen, midwife). However, tension existed around elements of the guidelines that some midwives felt were too restrictive: *It can be really frustrating working under really… They're not limiting policies but they can be a little strict sometimes* (Jenny, midwife). There was a general consensus that participants would still be able to keep women and babies safe, if the guidelines

were less strict: *I think there's a lot of policies that could be relaxed and still be just as safe* (Helen, midwife).

Each publicly-funded homebirth service operated slightly differently when it came to working with the guidelines. As previously described, women were usually required to undergo a number of tests in the antenatal period to assess their risk status which determined their eligibility for a publicly-funded homebirth. In some services, if women declined particular tests, then they were automatically excluded from the program. Midwifery manager Annie referred to this as '*withdrawing the offer*' of publicly-funded homebirth care, she said:

> *Well obviously depending on what they were declining… We would then say "Yeah, we're withdrawing the offer to provide [homebirth care] because we're not obliged" We're not obliged, we're a publicly-funded service and we're actually not obliged to put our midwives in a situation that would be, you know, difficult (Annie, manager).*

Annie's emphasis here was on the midwife being put in a difficult situation, rather than the woman being able to make an informed decision regarding her care. In other services, however, there was more flexibility in the way the guidelines were enacted, in order to allow women greater choice regarding their pregnancy and birth. Rachel described how it worked in her service:

When I say we have strict guidelines, that's my perception because I've been talking to other midwives who work in publicly funded homebirth… [Women] don't have to have GTTs [Glucose Tolerance Test] up here if they don't want them… and this is the thing I'm getting used to, but I just think it's not a problem and the doctors aren't going to deny you [a homebirth] for that (Rachel, midwife).

In some services, the lead obstetrician was willing to negotiate with women on a case-by-case basis as to whether they were still able to plan a publicly-funded homebirth despite not meeting all of the eligibility criteria. For example, although all services excluded women who had a previous caesarean section, Bianca described how women in her service were able to negotiate with the lead obstetrician to plan a vaginal birth after caesarean (VBAC) at home:

We have provided homebirths for I think four women who have had a VBAC, but they had to provide a case, and it had to be approved by the principal midwifery advisor... I guess sometimes the policies do restrict you, but I think if there's flexibility to be able to review the case individually as well... I actually do think that flexibility's important, because those four women did have homebirths, and they wouldn't have been able to… if the criteria was that strict (Bianca, midwife).

A few services offered women an opportunity, in some cases, to make an informed decision to birth at home, despite not meeting all of the criteria. Midwifery manager Lori described the system they had in place that allowed women to negotiate directly with the lead obstetrician:

> *So we really wanted to have a more flexible guideline and our obstetrician was really willing to do that. We have this really unique set up here that the women, if they have requested to birth outside the guideline, then they will go and see [the obstetrician]…. And have a chat with them. If she was happy for them to birth at home, she would just pass it and we would go ahead and we would all be covered. It's all legal. If not, then she would extend the case on to our co-director. He would look at the whole scenario. We'd give him the case, and then he would talk to us and talk to the woman. Then he would decide, then, if he was willing for the service to support the woman to birth at home (Lori, manager).*

This system was only possible when there was an obstetric lead who was supportive of homebirth and confident in assisting women to make informed decisions, something that not all services had available. Midwives appreciated being able to apply the guidelines with some flexibility. When this was possible, participants experienced a great sense of satisfaction in being able to provide woman-centred care:

> *I think that we have a certain scope to stretch the policy in certain ways which still works under the policy but we're actually just adapting areas to provide women-centred care without actually breaking the rules. Being able to do that I think is really quite fantastic, but at the same time obviously still practising within the boundaries of the guidelines and policies (Jenny, midwife).*

In services where there was no flexibility in the application of the guidelines, some participants found it difficult to withdraw the option of publicly-funded homebirth from women in their care when pregnancy complications arose. This was particularly hard when midwives felt the women was not actually at any higher risk or when the woman was deeply committed to the idea of having a homebirth. Midwifery manager Annemarie felt concerned that turning women away from the publicly-funded model forced them to consider a freebirth (unassisted homebirth) or seek out, and personally fund, a private homebirth instead:

> *They have no option. The women then either have to go with what the doctor says or they have to say: "I'm sorry but I'm actually going to go and either freebirth or I'm going to go and pay an independent midwife $5000." How fair is that? It's just not fair and it's awful for all the women (Annemarie, manager).*

This problem was minimised in services where the women were cared for in an all-

risk model, meaning they were still able to access continuity of care with the same midwife, even if their plans to give birth at home changed. Midwives worked hard to keep women and babies safe, whilst ensuring they had access to the birthplace they wanted. At times, this lead to an internal conflict for participants because despite their commitment to supporting individual women's choices, they felt that the publicly-funded homebirth program was in such a tenuous position that it would take just one adverse event to close the service down. This concept is described in the following sub-category, '*Sustaining the model'.*

Sub-category: Sustaining the model

'*Sustaining the model'* is the final sub-category under the major category '*Building trust'. 'Sustaining the model'* refers to the social processes and actions consciously engaged in by midwives in order to ensure the publicly-funded homebirth program was able to continue operating into the future, amidst sometimes difficult political circumstances. As described in the first sub-category presented in this chapter '*Increasing interdisciplinary trust and building trust in homebirth*', participants felt that there was a general mistrust and fear of homebirth in Australia. As a result, there was a sense that, for the publicly-funded homebirth model to be sustained in the long term, it had to first prove itself as safe. Bianca stated:

> *…It's got to be a more than safe, it's got to be an extremely safe model. Because it would just take one incident to stop that kind of*

> *care. It's too fragile at the moment in Australia. What, we've only got like 12 models across Australia that do it? It's way too fragile. We've got to build up the research, and build up the strength, and it's got to prove itself first (Bianca, midwife).*

Almost all of the participants expressed the same sentiment as Bianca, fearing that it would take only one adverse event to result in a closure of the service altogether: This was typically an issue of great concern for participants and it impacted on the way they practiced: *I did tend to stick to our policies closely because what I didn't want was to lose the whole thing because if we stepped outside those guidelines and something went wrong, then it would all come crashing down* (Helen, midwife). At times this meant sacrificing individual women's birth experiences, for the sake of protecting the program: *It's an unfortunate balance because sometimes you have to compromise what women want with protecting it for the women who are going to come after. And that's just how it is (Rachel, midwife).*

This caused distress for some midwives who felt they had to impose unnecessarily strict guidelines on women who could have safely given birth at home. Midwifery manager Annie, however, felt that the strict safety criteria in place were justified and she was willing to enact them in order to sustain the program in the long term. She said:

> *You want to make sure that your staff are safe and you want to make sure that the woman is safe… You can actually go a little bit*

overboard in saying "Well just do whatever you want and you can birth at home… it doesn't really matter". But if your program gets shut down, how many hundreds of women miss out? There is that responsibility. You're looking to make sure that women in the next five or ten years have the option of birthing at home" (Annie, manager).

'Sustaining the model' meant that participants had to balance the needs of the woman with the needs of the institution (the hospital), particularly regarding decisions about whether it was safe for the woman to give birth at home. Vicky spoke about a difficult situation that arose with a woman in her care who very narrowly missed out on having a homebirth. In order to be eligible for a publicly-funded homebirth women need to be at least 37 weeks pregnant. When this particular woman went into labour one day short of the cut-off, Vicky felt she had to withdraw the option of homebirth in order to protect the program:

So I had a thirty-six week and six day lady who rang me in labour and I had to tell her she had to come in to the hospital. I'm on the phone telling her, "I can't come to you. You will damage the program. You need to come into the hospital"… To keep the program, we have to play by the rules. You want to stretch those rules sometimes, which we can stretch them in hospital a little bit, but we can't play with the program because otherwise we will lose it (Vicky, midwife).

The notion of playing by the rules in order to prevent losing the program infers that there would be punitive action for midwives who contravened the guidelines, potentially jeopardising the whole publicly-funded homebirth program. As described in the previous sub-category, some services were willing to negotiate with women on a case-by-case basis so that they could still be supported in a homebirth, despite not meeting every aspect of the eligibility criteria. This negotiation, however, could only take place with the obstetrician; midwives were not afforded this power.

Given the fraught nature of determining whether a woman was suitable for a publicly-funded homebirth, some midwives were very happy to defer the decision to an obstetrician. Several participants felt they would not be confident in negotiating with women on a one-to-one basis regarding their eligibility for homebirth. Instead of feeling restricted, these participants described feeling protected by the guidelines. Maleah spoke about how she did not want the responsibility of making a 'final call' and at the same time found it difficult to tell women they could not have a homebirth:

> *I think, having someone to make that final call and for it to not be my responsibility, so that when the women say, "Well, why can't I?" and "I wish that that would happen" and "I'm devastated, this won't happen". It's very hard taking that on as a midwife and not wanting to just be like, "It's okay. Let's just make it work" (Maleah, midwife).*

Maleah's comment exemplifies the way many participants felt; torn between offering women the birth experience and environment that they wanted and the need to provide clinically conservative care that stayed within the hospital guidelines in order to sustain the model. In this matter, Maleah was relieved to pass the responsibility on to someone else.

In the same vein, when participants compared their experience of providing publicly-funded homebirth with their perception of what it was like to work in private practice, some concluded that they preferred the perceived protection offered by the hospital guidelines. There was a perception that, without the same strict guidelines governing their practice, privately practising midwives were vulnerable to being put in a compromising position by women in their care who might want to stretch the boundaries of what was considered safe for homebirth: *If you're an independent midwife, you haven't got that backup of "This is what we have to do". I wouldn't want to be in that position* (Annemarie, manager). There was a sense that, because homebirth is scrutinised so heavily in Australia, participants needed to protect themselves as practitioners:

> *…Even though I do work under those policies and procedures and know I have to protect the service, I know midwives don't like to talk about this, but there is a bit of me protecting myself as well. I know lots of homebirth midwives who get put in compromising situations with clients or take risks like doing VBAC's at home, which… I mean*

they're not… It's riskier. They're slightly more riskier, but I'm just not ready to go there. Some people will be for sure, but I do like being protected by the policies and procedures of the service as well (Rachel, midwife).

Participants believed that, in order to sustain the model, the criteria to access a publicly-funded homebirth needed to be strict:

We don't apologise for probably having more stringent guidelines than probably what you might have if you had a private midwife... But, you know, we try and look at best practice and what we think is going to be safe and what we think long-term is going to make sure that we have a sustainable program (Annie, manager).

Despite the challenges midwives faced in balancing the needs of the women in their care with the guidelines set by the hospital, on the whole participants considered the publicly-funded homebirth program to be an overwhelming success:

We considered it a great risk to bring homebirthing under the acute service public umbrella. But you know, after we first implemented it, we just haven't looked back. It's been amazing. It's been fantastic. It's been the best thing we've ever done (Lori, manager).

Many participants felt hopeful that the positive results being achieved in the publicly-funded homebirth program would help to continue '*Building trust*' in homebirth, ultimately contributing to the sustainability of the model moving forward.

Summary

This chapter presented the third major findings category '*Building trust'.* This category explored the challenges faced by midwives in establishing and working in publicly-funded homebirth models in the context of the political climate surrounding homebirth in Australia. Midwives employed a number of techniques to develop strong relationships with doctors and gain their trust and respect. The midwife-doctor relationship was critical to the success of the publicly-funded homebirth program as doctors held powerful positions that could determine whether the service would be offered and which women were eligible for homebirth. As a result of fear and mistrust surrounding homebirth in Australia, the practice of midwives working in the publicly-funded homebirth model was highly scrutinised. In order to sustain the model in the long term, midwives employed a clinically conservative approach that, at times, left them feeling torn between the needs of the woman and the needs of the institution.

The final findings chapter, '*Recognising the benefits of publicly-funded homebirth',* will describe the perceived benefits of working in the publicly-funded homebirth model and it's impact on the normalisation of homebirth in Australia.

CHAPTER EIGHT FINDINGS: RECOGNISING THE BENEFITS OF PUBLICLY-FUNDED HOMEBIRTH

Introduction

The previous chapter described the challenges midwives faced when working in the publicly-funded homebirth model and the techniques they employed to ensure the model was successful and sustainable in the long term. This final findings Chapter portrays the benefits midwives perceived to be associated with publicly-funded homebirth – for midwives themselves, for women and to assist in the acceptance of homebirth in Australia.

When describing the benefits of the publicly-funded homebirth model, participants discussed issues that impacted on them personally as well as professionally. Commonly, participants compared their experience of providing homebirth in the public model to that of Privately Practising Midwives (PPMs) providing homebirth. Although only eight of the 21 participants had direct experience of working as a PPM, other midwives who had no direct experience still commented on the differences between the publicly-funded and private models of homebirth. These participants spoke from their perception of what private practice might be like based on the experiences of friends or colleagues who worked in private practice or based on their interactions with PPMs during homebirth transfer situations.

Participants described feeling secure in their employment with the public health system and highly valued working as part of a team. One of the primary advantages of publicly-funded homebirth was thought to be the ease with which midwives could transfer women into hospital if complications arose during labour. Participants also expressed a strong belief that all low risk women in Australia should have the opportunity to access a homebirth if they desire, and felt the publicly-funded model improved the equity of access by eliminating the barrier of cost.

The four sub-categories presented in this chapter are: '*Feeling secure', 'Being part of a team'*, '*Avoiding the drama of transfer*', and '*Making homebirth more accessible'.* Each of these sub-categories will now we described in detail.

Sub-category: Feeling secure

Participants commonly described a sense of '*Feeling secure'* in their employment as a benefit of working in the publicly-funded homebirth model. This sense of security related to midwives being employed by the public health system as opposed to working in private practice and needing to run their own small business in order to provide homebirth care. Matters such as receiving a regular income, being covered by the hospital's indemnity insurance and having rostered days off were important to midwives sense of security in their employment and capacity to sustain working in their position.

Other considerations related to their midwifery practice such as having access to obstetric support, ease of transfer from homebirth to hospital and a concept of shared responsibility between midwifery and obstetric colleagues. For many midwives working in the model, the interactions and processes involved in providing homebirth via a publicly-funded program were seen as preferable to their personal or imagined experience of providing homebirth via private practice. Jemima had previous experience working as a PPM, and was able to directly compare this with working in the public model. Although she enjoyed private practice, she found it was not practical once she had children of her own, she explains:

> *…I got a lot of joy from [working as a Private Practice Midwife] but that also wasn't doable with my kids, new babies and all that kind of stuff. I could only do a tiny bit of it, and it wasn't sustainable. I couldn't easily do casual shifts at hospitals, or part time roles as well as that, because my commitment to the hospital shift suffered because, you know, someone would go into labour. So I stopped doing the private stuff. And indemnity [insurance] is an issue. I think that was the straw that broke it, because my husband didn't feel safe without the indemnity stuff. And so I've stopped doing the private stuff and am just sticking with the public sector (Jemima, midwife).*

The matter of professional indemnity insurance (PII) was a common concern for participants and many were not prepared to practice as a PPM without it. As

described in the Introduction chapter, midwives have not been able to access PII to cover labour and birth care since 2002. In the following quote, Helen describes working in private practice without insurance as taking a personal risk:

> *I'd done a few [homebirths] as an independent midwife… I sort of just dabbled to see if I wanted to go down that path but in the end, I had a mortgage so I stayed working in the public system and gave up private practice. It was also around the time that the insurance dropped out. So I wasn't prepared to take that sort of risk (Helen, midwife).*

Similarly, midwifery manager Lori discussed why she preferred working in a publicly-funded model of homebirth and why she felt it was a more sustainable way for her to work. Needing regular income in order to pay the mortgage and provide for their families was a common concern. There was a perception that private midwives had unpredictable incomes, as they relied directly on the woman for payment. Lori describes why working in the publicly-funded homebirth model provides everything she wants:

> *I've looked into doing [private practice] midwifery and I've talked to many people. At the end of the day, for me personally, public - I've got everything I want here. I also have the support of a team, support of the obstetric team. Also, we have days off so it's sustainable and we're getting a pay packet. I didn't have to do anything book [keeping] wise. I've spoken to many midwives who've been on their last brink of*

> *money because women haven't paid them. All that sort of stuff and you say, "I don't want that." I need that security myself, for my family, to be able to provide. No, I don't want to deal with that. I know I'm getting this income (Lori, manager).*

Many midwives had given consideration to whether they could work in private practice and had decided that working in a publicly-funded homebirth was more suitable. For some, this wasn't their first preference but rather a purely pragmatic decision. For others, however, the benefits of being employed by the hospital outweighed any potential drawbacks. The next section portrays the benefits of '*Being networked in'.*

Sub-category: Being networked in

Numerous participants described how much they valued *'Being networked in'* when providing publicly-funded homebirth care. The notion of '*Being networked in'* encompassed the support and connection available from colleagues within their midwifery team, as well as having access to clinical support and expertise from hospital-based doctors and midwives. One of the primary benefits of '*Being networked in'* was ease of transfer from a planned homebirth to the hospital during labour, if complications arose. This concept will be described in detail in the next sub-category '*Avoiding the drama of transfer'*.

Publicly-funded homebirth is usually provided as an extension of continuity of care services offered by a Midwifery Group Practice (MGP) or Community Midwifery Program (CMP), where midwives provide care as a primary midwife and are backed up by a small team. Participant's appreciated the support offered by colleagues in their team, and enjoyed working with others who had a similar philosophy around birth: *'All the other midwives I work with, we all have the same philosophy. We're all different but we're all very similar as well'* (Bianca, midwife). In addition, participants felt it was beneficial to work closely with other midwives who understood the unique challenges of working in a continuity of care model. Bianca described the support she gave and received from colleagues as 'being a midwife to the midwives':

> *You're a midwife to women, but you're a midwife to midwives too. You're constantly caring and looking out for each other, and we need it and we need to provide it because I think we learn from it, and we need to give it as well. I think that's the biggest thing, just that communication and respect* (Bianca, midwife).

For some midwives, the notion of belonging to a team extended beyond their own group practice and included the core midwifery and obstetric staff at their hospital. Midwifery manger, Annie described her positive experience of working collaboratively with both midwifery and medical staff:

> *So, my experience has been fantastic. We work well with our medical staff, our midwifery staff are amazing, not just the midwives who provide the homebirth service, but the midwives who work on the floor who are also their teammates. 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. So that's what I've found so rewarding about it (Annie, manager).*

Support from colleagues and management was a benefit participants felt would not be available to them in private practice. More inexperienced midwives were particularly grateful for the opportunity to seek advice from experienced practitioners: *Our manager's door was always open and we were always in there, just [asking]: "Is this right? Can I do this? Should I be doing that? How do I go about that?"* (Bianca, midwife). Because the majority of participants had never provided homebirth care before working in the publicly-funded model, being able to seek advice was seen as particularly important.

'Being networked in' was most highly valued when complications arose during a woman's labour. Participants felt safe, knowing they had the backup of the hospital system if needed. As Helen described:

> *For me, as a midwife, it was good having that backup of the hospital system. Knowing the doctors and, it's like, if you transfer in the reception was fantastic. You know, they just say: "All right, you need to come. We know you…" You know the women and the doctors are great (Helen, midwife).*

Being well received during a homebirth transfer situation was seen as a key benefit of the publicly-funded homebirth model, as depicted in the following sub-category, *'Avoiding the drama of transfer'*.

Sub-category: Avoiding the drama of transfer

Many of the participants discussed the issue of transferring from a planned homebirth to hospital if complications arose during labour. This is known as an intrapartum transfer – being a transfer that occurs during labour. The process of transfer was seen as a key point of difference between the private and publicly-funded models of homebirth. Participants described how *'Avoiding the drama of transfer'* was possible in the publicly-funded homebirth model, primarily because they were known by hospital staff which improved trust and allowed for more constructive interactions. The 'drama' surrounding intrapartum transfer did not usually relate to the clinical scenario, as many transfers were for non-urgent reasons such as prolonged labour, meconium stained-liqour or maternal request for pain

relief. Instead, the drama referred to hostile interactions between hospital midwives and doctors and non-hospital midwives, that is Private Practice Midwives (PPMs).

PPMs and the women in their care were viewed as *'external'* to *'the system'* (Annie, manager), whereas publicly-funded homebirth midwives and women were viewed as *'internal'* (Annie, manager). The significance of a midwife being either 'internal' or 'external' seemed to be centred on trust. Some hospital-based midwives and doctors tended to have a sense of mistrust in 'external' midwives, which lead to hostile interactions and made the process of transfer uncomfortable and difficult for PPMs: *'It's just a horrible reception that they get, usually* (Helen, midwife).

Some of the participants had personal experience of being a PPM and transferring women to hospital, whilst others had experience of being the hospital-based midwife receiving a homebirth transfer. All participants depicted the ability to easily transfer to hospital as a significant area of concern. Jemima felt that homebirth transfers were often full of angst because doctors felt it was their role to rescue women who transferred in to hospital and admonish them for making a bad choice:

> *I think there's a perception from medical people, a very big generalisation, that they see their role as rescuing people when they transfer in because they've made this really bad choice in trying to birth at home and things have gone all pear-shaped... (Jemima, midwife).*

Whilst participants could understand the anxiety that hospital-based midwives and doctors felt about receiving intrapartum transfers, they also reflected on the challenges faced by PPMs during transfer and felt that although these midwives were 'external' to the hospital, they still deserved to be treated with respect:

> *This whole "Oh, no we must know the midwife and we must trust them and we must…" Really, we should already have that respect and trust that they're actually doing [the right thing]… They're in the same role, they're just providing it in the home. The whole mutual respect, it goes AWOL [Absent Without Leave] (Lori, Manager).*

As opposed to the angst and drama of intrapartum transfers for PPMs, the majority of participants reported positive experiences of intrapartum transfer when providing publicly-funded homebirth and this was seen as a major benefit of the model: '*…The actual transfer of women from the homebirth setting into the hospital is so much better and so much smoother'* (Lori, manager). Publicly-funded homebirth programs were described as having robust transfer protocols where midwives felt welcomed by '*team mates'* (Annie, manager) at the hospital they were transferring to. For example, Annie said:

> *When [midwives] 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 team mate' (Annie, manager).

Being familiar with hospital staff when transferring was seen as a crucial advantage of the publicly-funded model: *'…People know you and they trust you because [you've] worked there for a long time'* (Gwen, manager). In addition, participants thought that the strict eligibility criteria for women to access publicly-funded homebirth was reassuring for the hospital doctors and midwives receiving intrapartum transfers, because they knew women were low risk to start with. This tended to result in a reduction in hostility, as Jemima described:

I reckon it's a trust thing. And because protocols are so strict and so vigorous and the scrutiny is so vigorous afterwards as well… I think there's a greater trust in the system. Whereas I think that the hospital people think that's lacking in the private system. I don't think it is, but that's what the perception is… (Jemima, midwife).

The majority of participants felt they were treated respectfully during transfer scenarios and appreciated that they were not subjected to intimidation and suspicion from hospital doctors:

We're not getting dragged over the coals for anything. Everything is considered, "Oh, you're transferring your woman? No problem. I'll see

you when you get here." It's all smooth sailing. The doctors are on board. It's not a question of "Oh, this woman's a homebirth. She's coming from a homebirth, what dodgy stuff have they done?" (Lori, Manager).

On the other hand, Carla described a very different experience when transferring into hospital from publicly-funded homebirths where the friendliness of the reception she received was heavily dependent on who happened to be working at the time. Her account depicts many of the challenges midwives face when transferring a woman into hospital from home, such as needing to provide emotional care for the woman who may feel distressed about her homebirth plans changing whilst trying to advocate for the woman despite facing negativity and resistance from staff receiving the transfer. She explains:

Sometimes you were lucky and you had good people who didn't make immediate judgements and who just went with you, and that was fine. Other times you'd walk into a wall of negativity and resistance, and that was incredibly difficult because you were changing the woman's plan, so you were needing to advocate for her as much as possible. Trying to overcome her disappointment and do whatever was necessary, but at the same time you were under scrutiny and suspicion and criticism, merely by setting your foot over the threshold (Carla, midwife).

Although the majority of midwives in this study had very positive transfer experiences, it is evident that there is still work to be done to improve women and midwives' experiences of intrapartum homebirth transfers for both PPMs and some publicly-funded homebirth services.

Sub-category: Normalising homebirth

Another benefit of the publicly-funded homebirth program reported by participants was the impact it had on '*Normalising homebirth'*. In addition to the impact that being exposed to homebirth had on midwives personally, the operation of a publicly-funded homebirth program was seen to reduce apprehension about homebirth amongst doctors and allied healthcare workers. It was thought that the provision of homebirth through the publicly-funded model gave more weight to the notion of homebirth being a safe and acceptable choice for women, as Robbie described:

> *I think the fact that it is publicly-funded actually gives it more power and because hospitals are backing this, it's like: "Wow! They [homebirths] must be a bit safe because if the local health service supports this initiative, you know, they don't generally do things that are dangerous..." I think that's a really interesting thing that people kind of notice. Ok well, if the hospital supports it, then there might be something to it (Robbie, midwife).*

Participants felt that once the program had been established for some time and positive stories started being shared amongst hospital employees, homebirth became more accepted. Some midwives and managers were aware of this process of '*Normalising homebirth'* and went out of their way to share information relating to the positive outcomes they were achieving. This was a strategy designed to reduce fear about homebirth, something Annie referred to as getting people '…*sensitised to the positive'* (Annie, manager).

Sharing positive homebirth stories was an aspect of the publicly-funded homebirth model that participants were particularly proud of as it was seen to promote the safety of homebirth not just to other midwives, but to all maternity care providers. Helen described how she could understand why homebirth was thought of as unsafe because prior to the publicly-funded homebirth model, many hospital midwives and obstetricians had only ever seen a homebirth woman and midwife when they were transferring into hospital due to complications, she said:

> *If they only ever see you when you've got a problem, they don't see all the beautiful births that you do when everything goes well. And that was one of the beautiful things about our homebirth service, you know, they'd know that we were out there at a birth and they'd know how many homebirths we'd done and how many went well and how few we had problems with (Helen, midwife).*

Similarly, when her local publicly-funded homebirth program was initially set up, midwifery manager Annie made an effort to share their homebirth outcomes with the hospital's obstetric and midwifery team members, along with their local ambulance service, in order to improve their perception of homebirth. She describes this practice in the following quote:

> *When we had our first few homebirths we made sure that we sent an email around to everybody saying: "We've actually had one, it's all good." Because we knew that these people would only see us in an adverse event. It was the same with our local ambulance service. I gave them, I can't remember how often it was, it might have been three monthly or six monthly or something. I just shot the team leader an email: "We've had four homebirths, everything's gone great. Thanks for your ongoing support". You know, because they're only going to transport [women] when there's a problem (Annie, manager).*

These techniques were employed to reduce the level of apprehension around homebirth and promote the model as being safe for women and babies. In addition to reducing maternity care provider's fear around homebirth, the publicly-funded model was thought to promote the normalisation of homebirth amongst the community, as Lori explained:

They [women] don't even contemplate homebirth because it's all fear driven in the community. Then, when they start talking here, a lot of women end up having a homebirth who never initially thought they would (Lori, manager).

Ruth felt that there had been a change in attitudes towards homebirth in the last ten years and that slowly homebirth was becoming more accepted:

Overall, I think there's pockets of resistance and pockets of fear. Pockets of thinking it's fabulous. I think we are a varying, mixed culture in terms of how we perceive [homebirth]. Certainly there's been a change in the last ten years, particularly with all the evidence coming out. I think it's gone from being a strange activity to being something that people are seeing. Starting to understand why its' not only just okay, but a really good idea… (Ruth, manager).

Gwen described how she felt the publicly-funded homebirth model helped to challenge stereotyping of homebirth women as alternative types or 'hippies' and instead promoted it as an option for all women:

... You know people think it's a bit more hippy, that sort of thing. Someone even said that to me the other day about, "Oh, I thought your women would have all worn long skirts and sandals." I thought we'd got rid of that. So I think it's in the public domain and people

can't say, "Oh homebirth is unsafe. A homebirth is this, it's only nutcases that want to do it", or whatever, because there's a lot of people who are from all walks of life that want to have a baby at home (Gwen, manager).

There was a sense that many women had never considered homebirth before, because it was not framed as a normal choice in Australia. However having access to homebirth via their local public hospital normalised this choice for women and made them more open to the idea, as Bianca stated:

A lot of women are coming to us that don't have friends that have homebirthed, that have never thought about it before and it's not until you provide them with the evidence that they go: "Oh hang on a second." You know, homebirth isn't something you learn about when you go to school. You learn about having a baby, but you see it in hospitals. It's not until you are provided with that option and the safety of that option, and the experiences that you might have, and you put those women in touch with other women, and you reassure the partners… (Bianca, midwife).

In addition to normalizing homebirth, the publicly-funded model was thought to increase women's access to the option of giving birth at home. This is described in the final sub-category '*Making homebirth more accessible'.*

Sub-category: Making homebirth more accessible

The final sub-category in this chapter is about '*Making homebirth more accessible'*. Participants were conscious that homebirth was a very uncommon choice for women in Australia and many felt passionate about extending the option of homebirth to as many women as possible. Though some midwives began as homebirth skeptics, all participants had become homebirth champions since their experience of working in the publicly-funded homebirth model. This meant they were committed to promoting the option of homebirth for women and wanted to ensure the expansion of the publicly-funded homebirth model so that more women could access homebirth, as Annie stated:

> *I felt really strongly that there should be… it should be just a normal choice for women that is supported by not only the passionate people but the people who perhaps didn't like it but felt it could actually be done within a publicly-funded system that was supported by government and maternity service providers across the state (Annie, manager).*

Participants felt that the provision of homebirth care by a public hospital increased acceptability of homebirth in the community, which, in turn, improved women's access:

> *I think, generally, hospitals are fairly conservative places and so then if you've got conservative people doing [homebirth] then I think it becomes more mainstream… I've never really thought about it, but perhaps because it's now happening in a more public place. People before never would have met anyone that had a homebirth. They didn't see it… (Gwen, manager).*

Many participants felt that the publicly-funded homebirth model was primarily providing care for women who would not have otherwise had a homebirth. For some, this was because there were no PPMs working in the area: *We don't have any independent midwives or anything in my area so we're the only option for people wanting homebirths (Rachel, midwife).* There was also a sense that the publicly-funded model was more acceptable to certain women because it was so closely linked with the hospital and the strict eligibility criteria gave women confidence in the safety of the model:

> *A lot of women have actually said that they wouldn't have wanted a homebirth unless it was within the MGP. What gives them that security is they've got, we're part of the hospital already. So if they have to transfer or if they decide not to have a homebirth, then that [option] is already there, it's quite easy. (Lori, manager).*

One of the key aspects of the private homebirth model that participants felt limited women's ability to choose homebirth was the cost of private midwifery care. As Rachel described, the publicly-funded homebirth model was not only more acceptable to many women, it also made access to homebirth more equitable:

> *[Publicly-funded homebirth] makes it more acceptable and equitable. We have a socialised health system, to offer some women homebirths but not others just because they can't afford it, I find that completely unethical and unfair. You wouldn't deny someone an obstetrician because they couldn't afford it. (Rachel, midwife).*

The issue of affordability was something participants felt strongly about, as the following quotes demonstrate:

> *My passion was to get it into mainstream so that it wasn't the domain of people who had lots of money who could pay for it (Annie, manager).*

> *With the social demographic, I'm not sure that a lot of people would be able to afford a private independent midwife around here for homebirth… so it does open it up for a lot more people (Rachel, midwife).*

I think the majority of women that access homebirth through the MGP would not access it if they had to pay for it… because they probably can't afford it (Bianca, midwife).

Whilst midwives firmly believed that the publicly-funded homebirth model made homebirth more accessible to women, they also stressed that they did not want to see the option of private homebirth removed. Many felt that private midwives had an important role to play in offering women access to alternative birth settings and high quality maternity care, and that women had a right to choose who would provide their care:

Women will always need to access private homebirth models, because of the restrictions [in the publicly-funded model], because of access… you know publicly-funded homebirth probably won't be provided everywhere; and because women need choice as well. They might have a great rapport or have heard of great things about a private midwife or they have an association with that person and want to choose that person to provide their care. So it's about choice as well (Bianca, midwife).

Participants were aware of the challenges PPMs faced in regards to the level of scrutiny they were under and the particularly poor reception they received when transferring women to hospital. Indeed, whilst participants felt the publicly-funded

homebirth model was most suitable for their own employment, they had immense respect for the work of private midwives and many desired better relations between hospitals and PPMs:

> *I think what we've managed to achieve with publicly-funded homebirth… probably the next step should be to start bringing some of those principles into the private sector. So getting privately practising midwives involved in public health services so that they can bring women in, and to start breaking down those barriers. I think that would be the next step (Annie, manager).*

Midwives were aware of the challenges faced by PPMs in Australia and the difficulty women faced in gaining access to homebirth midwifery care. As such, they felt that it was incumbent on the public health system to offer the option of homebirth for Australian women: *At the end of the day, we've got to offer this program because women want it and unfortunately it's getting harder and harder and harder for women to have a private homebirth* (Pam, midwife).

Overall, the publicly-funded homebirth model was seen to provide benefits to both mothers and midwives. As Bianca described in the following story, the publicly-funded homebirth model opened up the option of homebirth to women who may never have considered it, often with overwhelmingly positive results:

My first ever homebirth was a homebirth that a woman would not have had if she had to pay for it. She'd had three hospital births. When I first started providing care for her, [homebirth] was not something she wanted. Then she came back and asked a few questions, and we talked more about it. The reason she had a homebirth was because for the last three labours, they'd been quick and she hated the car ride to the hospital. She wasn't passionate about homebirth, it wasn't anything she'd ever thought of. Then she did it and it was the best experience of her entire life. They're her words. I was like "Wow, that's what publicly funded homebirth does". It provides a model of care that women may not have accessed, and it provides experiences, like the best experiences, that women may not have ever been able to access or achieve (Bianca, midwife).

Summary

Participants perceived several aspects of the publicly-funded homebirth model as being beneficial for midwives, for women and for the acceptability of homebirth in Australia. Midwives enjoyed working within an MGP or CMP team and also highly valued the ease with which they could access the resources and support of an obstetric team at the hospital if needed. The ease with which midwives could transfer women to hospital in the event of a complication during labour was seen as a significant benefit of the model. In addition, participants firmly believed that all

Australian women should have the opportunity to access homebirth and that the publicly-funded model improved accessibility.

The publicly-funded homebirth model offers midwives who want to provide homebirth care to women the opportunity to work in the public health system, with the benefits of indemnity insurance and a regular income, along with the backup of the hospital obstetric team if needed.

Conclusion of Findings

Chapter 5, '*Making the leap from hospital to home'* described the emotional and practical steps midwives took when preparing to provide homebirth care. The findings showed the level of apprehension amongst some midwives who did not have prior experience with homebirth, particularly those from an Australian background where homebirth has not been an integrated part of the public health system. In addition, these findings described the importance of mentoring and support for midwives who were new to homebirth practice.

Chapter 6, '*Seeing birth in a new light',* explored midwives' experiences of working outside of the hospital environment and the resulting shift in midwives' perspectives of normal physiological birth. Exposure to homebirth not only altered the way midwives practiced in the home environment, it also impacted how they cared for women in the hospital setting as they tried to emulate positive aspects of homebirth in order to improve women's experiences of hospital birth.

Chapter 7, *'Building trust',* described the importance of the midwife-doctor relationship and the steps midwives' took to build interdisciplinary collaboration and increase doctor's trust in homebirth. In addition, these findings described the scrutiny midwives endured when providing homebirth care and their efforts to sustain the publicly-funded homebirth model despite the challenges of the hostile political environment within which the model operates.

Chapter 8, '*Recognising the benefits of publicly-funded homebirth'* outlined the benefits to both midwives and women of working in the publicly-funded homebirth model. In particular, the security midwives felt when working for a public health service and being networked into not only a midwifery team but the broader hospital obstetric team. Although not perfect, one particular advantage was the relative ease with which midwives could transfer women to hospital if complications arose during labour. Overall, the publicly-funded homebirth model was thought to increase women's access to homebirth and assist with normalising home as birthplace.

The next chapter, Chapter Nine: Discussion, will explain the grounded theory emerging from the synthesis of key findings with the extant literature.

CHAPTER NINE: DISCUSSION

Introduction

The aim of this study was to explore midwives' experiences of providing publicly-funded homebirth in Australia. The methods used to conduct the research involved semi-structured telephone interviews with 21 midwives and midwifery managers who had recent experience of working in, or with, the model. A constructivist grounded theory methodology was employed which allowed for particular focus on the processes and interactions involved in the provision of homebirth care within the public health system. This is the first national study of midwives' experiences of providing publicly-funded homebirth in Australia.

Four theoretical categories emerged from the data that illuminated midwives' experiences. As described in Chapters Five to Eight, these categories were: '*Making the leap from hospital to home', 'Seeing birth in a new light', 'Building trust'* and *'Recognising the benefits of publicly-funded homebirth'*. This study adds to the understanding of the experiences of Australian midwives who transitioned from providing primarily hospital-based care to homebirth care in a publicly-funded model. The findings demonstrate how exposure to homebirth results in a perspective transformation and an increased understanding of, and appreciation for, normal physiological birth. The grounded theory that emerged from my study, '*The transformational power of exposure to homebirth'*, is explained in the next section.

Developing a grounded theory

The development of a theory grounded in the data is the ultimate aim of grounded theory methodology. Whilst many published qualitative studies employ grounded theory methods, not all of them culminate in the production of a theory (Charmaz 2006). It was important for me to construct a substantive theory from my PhD research, as I wanted to do justice to the rich data generated from the interviews in which participants so generously shared their experiences. I also wanted to contribute a fresh theoretical perspective that provides insight into the feasibility of offering homebirth via the publicly-funded maternity care system and whether the model helps to improve the perception of homebirth in Australia.

In constructivist grounded theory methodology, developing a theory usually involves synthesis of the analysis with existing theories either during the final phase of coding, or once coding is complete (Birks & Mills 2015). In this thesis I have drawn on theoretical perspectives, subsequent to the process of coding, from the discipline of adult education regarding perspective transformation (Mezirow 1978), midwifery theories regarding birth territory (Fahy & Parratt 2006; Foureur 2008) and anthropological perspectives of maternity care and homebirth (Cheyney 2008,). These theoretical perspectives were synthesised with the analysis of findings to develop my grounded theory: '*The transformational power of exposure to homebirth'* which is described in Figure 4. My grounded theory is presented here as it pulls together the four Findings chapters.

Figure 4. Grounded theory: *'The transformational power of exposure to homebirth'.*

Homebirth is uncommon in Australia and, as such, many midwives and doctors have not been exposed to homebirth in either their personal or professional lives. Maternity care providers who have no lived experience of homebirth often do not have a frame of reference that incorporates homebirth as normal or acceptable. Additionally, as the majority of Australian midwives and doctors have only ever witnessed birth in the hospital setting - where technological interventions are routinely applied to childbearing women - their capacity to understand how birth can be safe in the home environment, where these interventions are not available, is limited. These factors result in a climate of fear and mistrust in homebirth and a lack of confidence in midwives' ability to safely care for women at home.

Homebirth challenges the dominant medical model of childbirth by encouraging women to rely on their innate resources to give birth, rather than technological obstetric interventions. When midwives are exposed to homebirth it transforms their understanding, not only of homebirth, but of birth itself. At homebirths, midwives see women in an undisturbed birth environment – this environment facilitates the enactment of instinctual behaviour in labour and optimal oxytocin production, creating ideal conditions for normal physiological birth. As conventional hospital labour ward settings are typically not conducive to undisturbed birth, witnessing undisturbed birth for the first time in the home environment serves as a disorienting dilemma for midwives. This causes them to re-evaluate their understanding of birth and the impact of the birth environment on the woman. After exposure to homebirth, midwives alter their practice in the hospital environment in order to emulate the positive aspects of home and protect the labouring woman from disturbance.

In summation, exposure to homebirth leads to a process of perspective transformation for midwives which results in positive changes to their midwifery practice both in the home and hospital environments.

This substantive grounded theory is a unique construct because it is the first time that transformation theory has been synthesised with qualitative data about midwifery practise and homebirth. The potential for application of the theory reaches beyond the scope of homebirth midwifery practise but also indicates the potential for system-wide changes in the education and practical experience of maternity care providers, especially in support of physiological birth. The theory also generates insight into the impact of offering a service, such as publicly-funded homebirth, that operates against the dominant culture of hospital-based birth.

The remainder of this chapter will show how the substantive theory was constructed, by examining how the categories of findings were aligned with the current literature on homebirth and birth environment. First, a description of transformation theory is provided, along with an explanation of how it fits with the analysis of my study.

Transformation theory

American sociologist Jack Mezirow (1978) developed transformation theory based on the idea that critical reflection on our assumptions and beliefs leads to perspective transformation and subsequent behavioural change. Since its inception, Mezirow's (1978) transformation theory has developed into a comprehensive and complex description of how individuals interpret, validate and reformulate the meaning of their experiences. Although the theory was originally developed in the context of adult education and learning, the concept of perspective transformation

is relevant to my findings because midwives in my study described a process of transformation following exposure to homebirth that fits with Mezirow's theory. As such, I have synthesised Mezirow's transformation theory with the findings of my study to develop the substantive grounded theory *'The transformational power of exposure to homebirth',* detailed in Figure 4 above.

Mezirow (1994) reasoned that each of us develop unique meaning perspectives, which are broad sets of predispositions that result from psychocultural assumptions and determine the horizons of our expectations. His theory is constructivist, in that it assumes that the way individuals interpret and re-interpret their experiences is centred on the making of meaning, and hence learning (Mezirow 1994). In my study, midwives who had previously only been exposed to hospital birth had an understanding of birth based on the dominant medical model of childbirth that currently exists in the Australian public health system. Their entire lived experience of birth had been confined to the hospital setting - so despite many years of practice and an evident level of expertise - their expectations and assumptions about birth were limited to what they had seen, and participated in, in hospital. When midwives were exposed to homebirth, however, their frame of reference changed and this experience caused them to question what they knew birth to be. Mezirow (1994) describes this as a 'disorienting dilemma', the first of ten phases in the process of transformative learning. The ten phases are shown in Figure 5.

Figure 5. Mezirow's ten phases of transformative learning.

1. *A disorienting dilemma*
2. *A self-examination with feelings of guilt or shame*
3. *A critical assessment of epistemic, sociocultural, or psychic assumptions*
4. *Recognition that one's discontent and the process of transformation are shared and that others have negotiated a similar change*
5. *Exploration of options for new roles, relationships, and actions*
6. *Planning of a course of action*
7. *Acquisition of knowledge and skills for implementing one's plans*
8. *Provisional trying of new roles*
9. *Building of competence and self-confidence in new roles and relationships*
10. *A reintegration into one's life on the basis of conditions dictated by one's perspective*

I will now describe how each of the phases defined by Mezirow (1994) were experienced by midwives in my study, following exposure to homebirth and acceptance of their new role in the publicly-funded homebirth model.

Phase One: Experiencing a disorienting dilemma is the first phase in transformative learning and it serves as a trigger for reflection, causing the individual to reconsider previously unexamined beliefs (Mezirow 1994). Midwives in my study described how seeing birth taking place at home for the first time opened their minds to a new experience of birth, despite their many years of midwifery practise. This prompted

critical reflection on their understanding of birth and the development of a new understanding of physiological birth.

Phase two: Self-examination with feelings of guilt and shame was described by participants when they began to question whether their previous understanding of normal birth had been limited by the hospital birth environment and their subsequent sadness and resentment for women who had missed out on the opportunity to experience an undisturbed birth such as those they had witnessed at homebirths.

Phase three: Midwives' reported critical assessment of sociocultural assumptions – examining both personal and cultural beliefs about homebirth that categorised it as a dangerous, fringe activity that only appealed to people living 'alternative' lifestyles. Following exposure to homebirth, midwives who were initially apprehensive or skeptical began to reject the dominant cultural characterisation of homebirth as inherently risky.

Phase four: Recognition of one's discontent and the process of transformation as a shared experience was described by participants who reported the importance of friendship and support from midwifery colleagues whom they felt were the only ones who understood the unique experience of publicly-funded homebirth. Midwives' were then drawn to support and mentor others into homebirth – such as

new graduate midwives or obstetricians – in order to facilitate a transformation in their understanding and attitudes towards birth.

Phases five to nine: These four phases are more pragmatic aspects of transformation, including exploring and building confidence in new roles and relationships and acquiring requisite knowledge and skills for the role. These aspects of midwives' experiences were evident in their accounts of transitioning from hospital to home. Midwives also worked hard to build strategic relationships with doctors clinically supporting the model and actively advocated for individual women they cared for. Additionally they worked towards sustainability of the model by negotiating the, at times, competing demands of the institution with the desires of the childbearing woman.

Phase ten: The reintegration based on their transformed perspective of birth is evident in midwives' reports of changing in their midwifery practice in both the home and hospital environment.

The findings of my study indicate that, for many midwives, providing care for women at homebirths transformed their perspective of what normal physiological birth looked like and led them to question whether their previous labelling of a 'normal birth' was in fact truly physiologically normal given the level of disturbance and intervention often present in the hospital environment. As midwives became more aware of how crucial it was for the woman to remain undisturbed in labour, and the

benefits of being on the woman's territory, some described feeling angry for the women who were not able to have this type of experience in the hospital environment. This led them to change the way they practised in the hospital environment in order to facilitate better experiences for all childbearing women.

The importance of an undisturbed birth environment has been described in midwifery literature by several authors (Blix 2011; Foureur 2008; Simkin & Ancheta 2005), as have the limitations of the traditional hospital labour ward to provide this (Davis & Homer 2016; Hammond, Foureur & Homer 2014). So long as the medical model of birth remains dominant in the Australian health care system, midwives and allied health workers who provide care for childbearing women do not have a frame of reference that fully comprehends physiological birth in an undisturbed environment. Midwifery scholar Foureur, (2008) has suggested: "*The state of our knowledge of 'normal birth' is so limited by the medically dominated paradigm governing our academic preparation for practice, and how we currently practice, that we… need a new way of thinking about women and birth"* (Foureur 2008, p. 57). I propose that exposure to homebirth opens the pathway for this new way of thinking about women and birth and that more widespread exposure to homebirth amongst Australian maternity care providers would enhance their willingness and capacity to promote and protect physiological birth in both the home and hospital environments.

As set out in the quality maternal and newborn care (QMNC) framework by Renfrew et al (2014), the provision of good quality maternity care requires balance between the promotion of normal reproductive processes and the management of complications and skilled emergency care. The publicly-funded homebirth model achieves this balance, supporting women's innate capabilities to give birth by facilitating undisturbed physiological birth and decreasing unnecessary interventions whilst providing easy access to emergency care and backup if required (Catling-Paull et al. 2013). Further to this, the findings from my study indicate the potential for a systems-wide change in maternity care. My grounded theory, '*The transformational power of exposure to homebirth'* indicates that exposure to homebirth has the potential to shift our culturally accepted understanding of birth in the institution of the hospital, moving towards a new way of thinking about birth that prioritises the physiological process of birth above technological intervention. A shift to valuing undisturbed physiological birth for women in both the home and hospital environments has the potential to decrease the number of unnecessary interventions experienced by childbearing women, which are known to have potentially negative implications for women and babies (Miller et al. 2016; Peters et al. 2018).

The remainder of this chapter will link my findings with current literature, primarily from the field of midwifery.

Feeling apprehensive

The findings of my study presented in Chapter Five, '*Making the leap from hospital to home',* explained the practical and emotional processes midwives underwent when transitioning from providing hospital-based to homebirth care. The first sub-category, '*Feeling apprehensive',* described the level of apprehension felt by some midwives about providing homebirth care, as they had no prior exposure to homebirth and were primarily accustomed to providing care in the hospital environment. My findings indicate that exposure to homebirth increases midwives' confidence to provide care for women at home. Typically, after witnessing several homebirths supported by colleagues, midwives' confidence in the safety of homebirth and their capacity to facilitate homebirth grew. Several authors have examined care provider's attitudes towards homebirth and their willingness to provide out-of-hospital care (McCourt et al. 2012; McLachlan et al. 2016; Vedam et al. 2012; Vedam et al. 2014).

Vedam et al. (2014) examined maternity care provider's attitudes towards planned homebirth as part of the Birthplace in Canada study. They found that exposure to planned homebirth during midwifery or medical education and practice was significantly associated with favourability towards homebirth (Vedam et al. 2014). Similarly, a small study by McLachlan et al. (2016), focused on publicly-funded homebirth in one state of Australia (Victoria), showed that maternity care providers who had worked with the publicly-funded homebirth model tended to be more supportive and consider the model to be safe than those who had not worked in or

with the model. These findings are in keeping with the findings of my research, which demonstrated that midwives who were initially apprehensive about providing homebirth were converted into strong supporters of the model following exposure to homebirth.

In a similar way, McCourt, et al. (2012) studied midwives' readiness to provide care for out of hospital births as part of the Birthplace in England study. Their findings showed that many community midwives working in women's homes lacked homebirth experience. This was due to the organisational design of the homebirth model which meant midwives' attendance at homebirths was irregular in some regions and, as a result, some midwives were not confident in attending births or arranging transfer to hospital if required (McCourt et al. 2012). These findings indicate that ongoing exposure to homebirth is important to maintain skills and confidence for midwives providing care. This can be an issue in some models where only a small number of women are choosing to give birth at home each year, limiting midwives' ongoing exposure and experience with homebirth midwifery care.

In Australia, the supervision model employed by publicly-funded homebirth services ideally means that midwives who are lacking confidence or experience are able to be mentored and act as the third or second midwife until such time as they feel confident in their skills to facilitate homebirth as the primary midwife. However, implementation of this system is quite ad hoc and there is not a consistent approach across all publicly-funded homebirth services. A national standard may help to

ensure midwives are adequately prepared for the provision of homebirth care. Additionally, as the publicly-funded homebirth model begins to shift the acceptance of homebirth in Australia, it is hoped that more women will seek out homebirth care and therefore there will be an increase in demand for midwives services.

Stepping into the woman's territory

In Chapter Six, the power dynamic at homebirths were explained in the sub-category '*Stepping into the woman's territory'.* Midwives were conscious of a shift in the power dynamics of their relationship with the woman that occurred at a homebirth. When the midwife entered the woman's home, her behaviour changed due to an unspoken understanding that the home was the woman's territory, and the midwife was a guest in the woman's domain. This was notably different to the experience of hospital-based care, an environment that was considered to be the midwife's territory, making the woman a guest in the midwife's domain.

The concept of territory in relation to birthplace has been described by several authors (Fahy 2008a; Fahy & Parratt 2006; Foureur 2008). The notion of birth territory refers to both the features of the birth space and the use of power within that space (Fahy 2008a). Birth territory, as described by Fahy and Parratt (2006) is concerned with how midwives act within the woman's birth space, and the authors propose two different modes of midwifery that tend to be enacted; 'midwifery guardianship' and 'midwifery domination' (Fahy & Parratt 2006, p. 45). 'Midwifery guardianship' entails guarding the woman's birth space and preventing intrusion

from ‘midwifery domination’ which involves manipulation or coercion of the woman to give up her own power and simply follow instructions. Fahy and Parratt (2006) suggest that along with midwifery guardianship, an undisturbed birth environment is critical for the labouring woman to feel safe enough to let go of the need to be on guard herself. Only then can she fully experience and respond to her body’s sensations and follow her instinctive behaviour during labour.

In my study, midwives described one of the benefits of homebirth was the birth space being separate from the noise and busyness of the hospital, and that midwives felt relieved from the need to protect the birth space from intrusion or disturbance. Midwives believed this had a positive impact both on the woman’s capacity to relax and connect with the rhythm of her labour, as well as the midwife’s own capacity to focus completely on the woman. For some midwives this made the home environment feel safer than hospital.

The relationship between the birth environment and midwifery practice has been studied by Hammond et al. (2013), with a particular focus on the impact of the environment on the midwife’s own production of oxytocin. Hammond et al. (2013) suggest that the trigger and release of oxytocin in the midwife’s brain can support the provision of quality midwifery care. This is because oxytocin assists with feelings of trust, reduces fear and enhances the ability to read and understand others emotional cues – behaviours that are considered to be central to quality midwifery care (Hammond et al. 2013). When midwives feel stressed and associate negative

feelings with their workplace, this can impact on their production of oxytocin, and therefore their capacity to provide quality midwifery care (Hammond et al. 2013). As such, the birth environment has a significant impact on the midwife as well as the woman. Midwives in my study reported that, once they were accustomed to providing care in the home environment, they tended to feel more relaxed when caring for women at home, as opposed to how they felt in the hospital environment. They enjoyed being able to provide focused one-to-one midwifery care in the undisturbed home environment.

Witnessing undisturbed birth

In Chapter Six, the sub-category '*Witnessing undisturbed birth'* described midwives' experiences of witnessing undisturbed birth, often for the first time when attending homebirths. The notion of being undisturbed related to the woman being in control of how the space was set up and who was present throughout the duration of her labour and birth. Foureur (2008) describes the importance of creating a birth space that enables undisturbed birth based on an understanding of the hormonal influences on childbirth. Oxytocin has long been recognised as the most important hormone in labour, as it is responsible for the production of uterine contractions, however, there is growing awareness of how strongly the environment impacts women's capacity to produce endogenous oxytocin during birth. This is related to the two predominant bio-behavioural states in humans known as 'calm and connection' and 'fight or flight' (Taylor et al. 2000; Uvnas-Moberg 2003). In childbirth, it is essential for the woman to be in a state of 'calm and connection' in

order for labour to progress. This state can be interrupted, however, if the woman finds herself in unsafe birth territory or if people disturb her in her birth space (Foureur 2008).

According to Lepori, Foureur and Hastie (2008), the traditional hospital labour ward environment has, in essence, been designed to facilitate the experience of medical technologists, with the woman framed as a passive actor in the act of childbirth. Historically, the movement of childbirth from the home to hospital shifted the focus from one of physiology to one of pathology (Lepori, Foureur & Hastie 2008). For women, being in a foreign space is known to elicit a fear cascade that can interrupt her production of oxytocin due to the unfamiliarity of the birthing space (Foureur 2008b; Sheehy et al. 2011). Additionally, visible technology in the birth room can create feelings of stress and anxiety in women as it infers the potential for emergencies (Sheehy et al. 2011). The aesthetic of hospital is vastly different from home. Commonly hospital environments contain bright lights, white sheets, vinyl floors and metallic finishes that evoke a clinical or sterile aesthetic (Sheehy et al. 2011). The obstetric bed is commonly the only piece of furniture the woman can use, potentially surrounded by people standing around and observing her (Lepori, Foureur & Hastie 2008). Furthermore, hospital labour wards universally house several labouring women at a time, making for a busy and noisy environment that can disturb and distract the labouring woman, interrupting her production of oxytocin.

The current design of many hospital birth rooms has been shown to challenge the provision of effective midwifery practice and several studies indicate that midwives are commonly aware of the shortcomings of the traditional labour ward environment and act to moderate any deleterious effects on women (Hammond, Foureur & Homer 2014; Sheehy et al. 2011). In my study, midwives described how the home environment facilitated a sense of safety and security for the woman because the only people present were those who had been invited to the birth by the woman herself. There were no unfamiliar noises, smells, or people interrupting the woman's state of calm and connection, like in most hospital settings. Midwives consciously didn't 'interfere' with the woman, but instead gave her privacy and space to be supported by her partner or other support people.

The homebirth environment has also been studied in Norway by Blix (2011), who explored the notion of avoiding disturbance in a study of midwifery practice in homebirth settings. Homebirth midwives in this study saw it as their role to prevent the woman from being disturbed and actively protected the woman from potential disturbance during labour. This stemmed from an understanding that disturbance to the woman could interrupt the process of labour, and a belief that the woman needed to feel able to concentrate fully on her labour and enter an 'inner world' (Blix 2011). Midwives' reflected on their own role as care providers, and recognised that their behaviour, how they carried out their clinical observations and their way of being present in the room could disturb the woman (Blix 2011). These were similar to the findings in my study that indicated midwives were conscious of not

disturbing women during homebirths. Instead, they tended to remain watchful from a distance, in order to avoid disturbing the labouring woman.

A new understanding of normal physiological birth

In Chapter Six, '*Seeing birth in a new light'*, the sub category *'A new understanding of normal physiological birth'* explained how midwives began to question their previous definition of normal birth after witnessing undisturbed birth in the home environment. Prior to working in the publicly-funded homebirth model, the majority of midwives in my study were accustomed, primarily, to the medically dominated hospital labour ward environment. As such, their understanding of 'normal birth' was restricted to how birth was performed within the institution of the hospital. Research from the United Kingdom by Downe, McCormick and Beech (2001) indicated that a high percentage of women whose births were recorded as 'normal' or 'spontaneous' may have actually experienced intervention during their labours. Evidently, the definition of what constitutes 'normal birth' is not universal (Darra 2009; Downe & Davis-Floyd 2004; Powell-Kennedy et al. 2015) and at times includes the use of technological intervention in labour. This is indicative of a culture in maternity care that has normalised technological intervention in birth so much, that it has become 'invisible' to those applying it. This is supported by the findings of my study where midwives reported that despite their years of hospital-based midwifery experience, they felt as if they were witnessing truly undisturbed, normal physiological birth for the first time when they were exposed to homebirth.

O'Connell and Downe (2009) have also suggested that, whilst hospital-based midwives claim to have expertise in normal birth, they generally tend to comply with the technocratic approach to childbirth and despite their intentions to provide 'real midwifery', most midwives are overwhelmed by heavy workloads and pressure to comply with the cultural norms of the institution (Downe, McCormick & Lawrence-Beech 2001, p. 602). The quality maternal and newborn care (QMNC) framework developed by Renfrew et al. (2014), recognises the importance of optimisation of normal processes of reproduction in order to strengthen women's capabilities to care for themselves and their families. Quality midwifery care has been identified as care that both promotes normal physiological processes and prevents complications (Renfrew et al. 2014). The findings of my study demonstrate that midwives felt being away from the hospital environment improved their capacity to facilitate normal physiological birth in an environment where both the woman and midwife were undisturbed.

Changing midwifery practise

Chapter Six, '*Seeing birth in a new light'*, also described the influence that exposure to homebirth had on midwives' practice in the sub-category '*Changing midwifery practice'*. Midwives in my study reflected on how exposure to homebirth had changed their practise both in the home environment and then when they returned to care for women in the hospital labour ward. For midwives who are used to working in an environment where intervention in birth is commonplace, caring for women at home results in a shift in their midwifery practice. A woman's decision to

give birth at home is an active choice to, as much as possible, avoid all technological intervention in birth (Catling-Paull, Dahlen & Homer 2011). As such, the midwife is required to change her practise to support the woman in non-technological ways. The only technological interventions routinely performed by homebirth midwives are basic observations, intermittent auscultation of the fetal heart during labour and emergency interventions in the unusual instance that they are required.

Midwives in my study described being able to practise what they called 'real midwifery' in the home setting, which involved using their clinical judgment to assess progress of labour and any potential complications without interference or intimidation from other midwives or doctors. The notion of practising 'real midwifery' is problematic as it infers that some ways of practising midwifery are not real, or are of lesser value. Whilst I acknowledge that the notion of having one 'real' way of practising midwifery has the potential to be politically inflammatory, in this study it was an important concept that represented midwives' desire for autonomy from medical control.

'Real midwifery' was also a concept identified by O'Connell and Downe (2009, p. 602) in their metasynthesis of qualitative research relating to midwives practice in the labour ward environment. O'Connell and Downe's (2009) research suggests the concept of real midwifery is an idealised approach to childbirth where the midwife works autonomously to actively facilitate the woman's progress though labour and birth without any intervention, resulting in a positive birth experience for the

woman. This notion was fundamental to midwives' professional identity, however, it was noted as being difficult to achieve in the hospital setting (O'Connell & Downe 2009). Similar barriers to facilitating physiological birth in the Australian hospital setting have been identified (Hammond, Foureur & Homer 2014; Sheehy et al. 2011). This definition of 'real midwifery' fits with the findings of my study wherein midwives described their enjoyment of working as autonomous practitioners supporting women to give birth without intervention in the home environment.

Numerous authors have examined the relationship between the birth environment and midwifery practice (Bourgeault et al. 2012; Davis & Homer 2016; Freeman et al. 2006; Hammond et al. 2013; Hammond, Foureur & Homer 2014; Miller & Skinner 2012). In a study by Davis and Homer (2016), midwives acknowledged that birthplace significantly shaped their practice, perceiving greater autonomy when providing homebirth care and identified the home environment as less stress-inducing for midwives. Freeman et al. (2006) has suggested that the environment in which birth takes place may influence midwives' decision making during the management of labour. They found that when midwives practised in an environment that was dominated by the medical model of care, (such as the hospital) their practice was influenced by the availability of intervention and women's acceptance of technology as part of labour care (Freeman et al. 2006). Miller and Skinner (2012) also explored the influence of birth setting on midwives and found that the same midwives tended to provide different care in different settings. Their study showed that midwives practised more evidence-informed midwifery when caring for women

in the home setting, in part, because midwives were able to allow time for events to unfold without unnecessary interference (Miller & Skinner 2012).

These findings are in keeping with the findings from my study that indicate midwives felt more confident in using their clinical judgement when caring for women at home. Although they worked under the same hospital guidelines when providing homebirth care, midwives felt they were able to provide safer care to women at home, without the distractions and stress of being in a busy labour ward. Midwives in Davis and Homer's (2016b) study expressed a similar sentiment – feeling more relaxed in the home environment despite having less medical backup available.

Midwives in my study also described how exposure to homebirth had impacted the way they care for women in hospital. When returning to provide hospital care after exposure to homebirth, midwives enacted techniques such as guarding the door to avoid unnecessary disturbance to the woman and speaking with doctors or midwives outside the birth room before they enter, in order to explain the importance of facilitating an undisturbed birth space. Midwives advocated for women's needs based on their new understanding of what is conducive to normal physiological birth.

Whilst Davis and Homer (2016b) acknowledged the impact of the environment on both women and midwives, they suggest that midwives can modify many aspects of a less than ideal birth environment in order to make it more conducive to labour.

Rather than focusing on the physicality of birth space, the authors placed greater emphasis on how poor workplace and organisational culture impedes midwives capacity to be with women (Davis & Homer 2016). However, given the strength of the theories put forward by Hammond (2013), Taylor (2000) and Foureur (2008) regarding the neurobiological implications of the birth environment on both midwives and women, it is likely that a combination of the organisational aspects of care and the physicality of the birth space influence midwifery practice.

Normalising homebirth

Chapter Eight, '*Recognising the benefits of publicly-funded homebirth',* described several aspects of the publicly-funded model that midwives felt provided unique advantages for midwives, for women and for homebirth in Australia. One of these advantages was the impact the publicly-funded homebirth model had on the perception of homebirth, described in the sub-category '*Normalising homebirth'.*

Care provider attitudes towards homebirth in Australia have not explicitly been studied on a large scale. However, analysis of homebirth policies by peak professional bodies representing obstetricians (the Royal Australian College of Obstetricians and Gynaecologists - RANZCOG) and midwives (the Australian College of Midwives - ACM), reveal significantly divergent stances in regards to their support for women's choice to give birth at home (Roome et al. 2015). RANZCOG firmly believe hospital to be the safest place for all women to give birth (RANZCOG 2017), whilst the ACM view midwife-attended homebirth as a safe option for women with

uncomplicated pregnancies (ACM 2011). Roome et al's (2015) analysis of position statements from peak professional bodies representing midwifery and obstetrics indicated that widely differing stances regarding the safety of homebirth were reached, often times, after reading the same body of research evidence indicating a level of confirmatory bias. These divergent views were reflected in my study wherein midwives described the challenges of working to establish publicly-funded homebirth services, despite commonly facing opposition from doctors at their hospital.

Conflicting ideologies regarding safety were also revealed by Fox, Sheehan and Homer (2018) in an Australian study exploring the challenges faced by obstetricians, midwives and childbearing women in intrapartum homebirth transfer scenarios. The findings from this study indicate that maternity care providers had to confront their conflicting paradigms of safety and risk regarding birth in order to work together when a woman transferred from a planned homebirth to hospital in the intrapartum period (Fox, Sheehan & Homer 2018). Intrapartum transfers commonly resulted in a display of 'us and them' dynamics and stereotyping behaviours (Fox, Sheehan & Homer 2018). However, when maternity care providers respected each other's roles, responsibilities and expertise, this resulted in greater levels of collaboration and ameliorated 'us and them' dynamics, subsequently leading to a better experience for the woman being transferred (Fox, Sheehan & Homer 2018). The findings from Fox's qualitative study, which formed part of the Birthplace in Australia project alongside mine, support the sentiment expressed in my findings where midwives described in

detail how they worked to gain the trust of their obstetric colleagues, in order to help break down the barriers between them.

In Australia, the subordination of midwifery to medicine results in the medical control of homebirth services. Furthermore, disparate views regarding the legitimacy of homebirth make it difficult for publicly-funded homebirth models to become established and sustained in the long-term, as there is not universal support for the provision of homebirth to low risk women. When this challenge is overcome, however, the operation of a publicly-funded homebirth service serves to normalise the practise of homebirth and reject its reputation as an unsafe fringe activity.

Publicly-funded homebirth as systems challenging praxis

Several authors have applied an anthropological perspective to the field of childbirth that provides insight into the politics surrounding homebirth and the conflicting belief systems that influence notions of safety (Davis-Floyd 1994; Kitzinger 2005; Van Teijlingen 2005). Homebirth has long been considered a political act of rejecting the dominant maternity care system – which is conceivably what makes a woman's decision to give birth at home so controversial despite evidence to support its safety for low risk women. The idea of homebirth as a denunciation of the dominant system has been conceptualised by Cheyney (2008) as a 'systems-challenging praxis'. Cheyney (2008) frames women's choice to give birth at home as a rejection of the cultural norm that involves challenging established forms of authoritative knowledge

in favour of valuing intuitive or embodied ways of knowing. Typically, for women planning a homebirth, this comprises the following three stages:

1. Questioning accepted public narratives around childbirth
2. Constructing counter-narratives
3. Supporting and belonging to an alternative collective belief (Cheyney 2008).

Just as Cheyney (2008) has described an individual woman's choice to give birth at home as systems-challenging, I propose that the establishment and operation of publicly-funded homebirth programs throughout Australia is, in itself, a systems-challenging praxis. The publicly-funded homebirth model follows the three stages outlined by Cheyney (2008) as follows: Firstly, the establishment of a homebirth program within the umbrella of public maternity care serves to question and reject accepted public narratives around childbirth that frame homebirth as unsafe and a fringe activity. Secondly, the operation of publicly-funded homebirth programs assists in the construction of a counter-narrative that exposes midwives and women to homebirth and sensitises other maternity care providers to positive homebirth stories vicariously through continuous saturation of positive homebirth outcomes, counteracting fear and mistrust. Thirdly, in most cases, midwives and doctors who are involved with the publicly-funded homebirth model become firm supporters of homebirth and act to ensure the sustainability of the program in the long term - thus supporting and belonging to an alternative collective belief that homebirth is safe and women have a right to choose it.

The particularly remarkable aspect of this scenario is that the publicly-funded model operates counter to the dominant medical model of childbirth – yet it exists within the very system it is rejecting. This is not without compromise, however, as described by midwives in my study who reported intense scrutiny of their practise and of the women who were planning publicly-funded homebirths. The notion that publicly-funded homebirth serves as a systems-challenging praxis is evidenced by how hard midwives and midwifery managers fought to get services established in some hospitals. Establishment of a homebirth service typically involved a lengthy consultation process with key stakeholders including obstetricians and anaesthetists who had to effectively be convinced to support the model. It is evident from my findings that doctors acted as gate-keepers on both an individual and collective level, reinforcing the patriarchal structure of maternity care in Australia.

Enduring scrutiny

Ultimately, fears around the safety of midwife-led models of care and out-of-hospital births, despite evidence indicating excellent outcomes for well women with normal pregnancies (Catling-Paull, et. al 2013, Sandall et. al 2016), are used to leverage medical control over women's birth choices. An example of medical control over women was described in Chapter Seven, sub-category '*Enduring scrutiny*'. Midwives reported that many of the services they worked in had strict eligibility criteria for publicly-funded homebirth where women were required to undergo a series of tests in the antenatal period to assess their risk status. If a woman chose to decline any one of these screening tests or ultrasound scans, then the offer of a publicly-funded

homebirth could be withdrawn. Such policies effectively coerce women into screening they might otherwise decline, in order to keep their place in the publicly-funded homebirth program. Ethically, this presents some serious challenges in regards to navigating the blurry boundaries between maternal autonomy and hospital protocols. Firstly, guidelines are determined at the population level, and therefore, not designed to guide individual care. Rigid hospital protocols leave little room for consideration of factors that may either complicate or mitigate each woman's individual risk profile. Additionally, this practice reduces the capacity for women to exercise autonomy in relation to informed choice and declination as the desire to continue being cared for in the model outweighs their wish to decline particular tests or scans. It is well recognised that the definition of what constitutes 'low risk' is contested both in Australia and internationally, resulting in disagreement over who is a good candidate for homebirth (Roome et. al 2015, Bovbjerg et. al 2017). Women should have a right to make an informed, autonomous decision regarding their pregnancy and birth – guided by her caregivers if she wishes.

My findings indicate that once a hospital had agreed to establish a publicly-funded homebirth program, there tended to be a focus on midwives needing to 'skill up' to be able to provide homebirth care. Notably, the concept of skilling up was focused on medical skills, rather than the promotion of physiology or other important midwifery skills for homebirth. This reflects a medicalised notion of 'skills' and the need to demonstrate to those in power that midwives are 'safe'. Midwives themselves felt deeply committed to keeping women safe, with their concept of

safety encompassing spiritual, emotional, cultural and psychosocial safety, along with physiological. Some midwives grappled with adhering to safety guidelines that they felt were unnecessarily strict and not evidence-based, whilst others were happy to work within inflexible guidelines as they felt uneasy about negotiating individually with women. The compromise for midwives and women in this model, compared with private midwifery practise, is that publicly-funded midwives are primarily accountable to the hospital as their employer, rather than to the woman as a health professional. As such, midwives continually walk the line between serving the needs of the woman, and the needs of the institution that pays her wage. Whilst some publicly-funded homebirth services have found ways to offer flexibility regarding risk factors that women may have, each service relies heavily on an individual obstetrician to grant obstetric 'approval' to individual women, and the program as a whole. Without obstetric cooperation, the service would be severely compromised sometimes to the point of ceasing to start or function.

The reliance on an individual obstetrician and/or the collective culture that exists within a hospital to be supportive of homebirth considerably restricts the capacity for the publicly-funded homebirth model to expand, particularly whilst the peak professional body representing doctors in Australia (the Australian Medical Association) remains actively opposed to homebirth. Ultimately, for homebirth to remain a viable choice for women in Australia, the removal of medical control over the provision of midwifery services is required as the current system serves to oppress both women and midwives. There is hope, however, for the future of

homebirth in Australia. The findings of my study and resulting grounded theory illuminating '*The transformational power of exposure to homebirth'* indicate that the operation of publicly-funded homebirth programs via Australian maternity hospitals is positively influencing attitudes towards homebirth. In addition, midwives who experience working in this model develop a deeper understanding of physiological birth and subsequently change their midwifery practise in order to offer care that best facilitates normal birth for women in any setting.

Strengths of the study

This study aimed to explore midwives' experiences of providing publicly-funded homebirth in Australia. At the commencement of this study in 2012, there were only a handful of small studies undertaken by individual publicly-funded homebirth programs evaluating their own service (Hider 2011; McMurtrie et al. 2009; Nixon, Bryne & Church 2003; Thiele & Thorogood 1997). These were primarily focused on outcomes for women and babies planning a publicly-funded homebirth. A national review of maternal and neonatal outcomes for women planning a publicly-funded homebirth by Catling-Paull et al. (2013) indicated that the model was safe, however, from a qualitative perspective, little was known about midwives experiences of providing care in this unique model.

A particular strength of this study is the theoretical focus on the processes and interactions experienced by midwives when transitioning from providing hospital-based to homebirth care. This provides insights that may prove useful to public

maternity hospitals that wish to establish a publicly-funded homebirth program within their service. This study also contributes to our understanding of the unique challenges involved in establishing individual publicly-funded homebirth programs and sustaining them in the long term. To my knowledge, this is the first time transformation theory has been synthesised with data from maternity care research. This research and subsequent development of a substantive theory has illuminated the remarkable potential that exists for publicly-funded homebirth models to transform the attitudes of maternity care providers towards homebirth.

Another strength of this study is that it explored the experiences of midwives who cross the two distinct birth environments of hospital and home. Midwives in this study were able to provide unique insight into the experience of working in both the institutional setting of the hospital labour ward, and the domestic setting of women's homes. With the exception of a small number of privately practising midwives who have visiting rights in public maternity hospitals in Australia, midwives working in publicly-funded homebirth models are the only midwives in the country who provide birth and labour support to women both at home and in hospital.

The research outlined in this thesis presented a unique opportunity to evaluate midwives experiences and satisfaction with providing publicly-funded homebirth, offering insight into the feasibility of further expanding the provision of publicly-funded homebirth models in Australia. Additionally, the findings and grounded theory described in this thesis should prompt consideration of how the maternity

care system can better support physiological birth in hospitals, and the potential for exposure to homebirth to provide a new lens with which normal childbirth can be viewed.

Limitations of the study

A limitation of this study is that it did not include participants from every publicly-funded homebirth service in operation at the time of data collection, however there was representation from 11 of the 14 services amongst participants and 5 of the 6 states. As the participants were from diverse geographical locations, telephone interviews were chosen for practical reasons related to the availability of funding for travel and my own capacity to travel and be away from family commitments. However, as described in the Methods Chapter, telephone interviews are recognised as providing a rich data source for qualitative analysis (Cachia & Millward 2011) and may even prove advantageous when discussing sensitive information due to the anonymity provided by not being face-to-face with the participant (Novick 2008).

Whilst the study was primarily focused on midwives' experiences of providing publicly-funded homebirth, once data emerged regarding the transformation of attitudes towards homebirth I was interested in interviewing obstetricians regarding their own feelings toward homebirth before and after working alongside this model of care. These data would have strengthened the theory regarding the transformational power of exposure to homebirth by providing additional data regarding vicarious exposure through reporting of homebirth outcomes.

Interviewing doctors, however, would have required an amendment to the study's ethics application and was not feasible within the time frame available to finalise the research for a PhD. This is suggested as further research that could be undertaken following conclusion of this thesis.

Some may consider the small amount of homebirths that occur in Australia each year as a limitation to this study, as it could be perceived to indicate that the research area lacks relevance. In 2015, only 0.4% of Australian women gave birth at home (AIHW 2017) and only a portion of these would have been cared for in a publicly-funded homebirth model. Despite the low number of women actually accessing publicly-funded homebirth models of care, however, there is evidence of considerable interest and demand for out-of-hospital birthplaces, including homebirth (Dahlen, Jackson & Stevens 2011; Keedle et al. 2015; Rigg et al. 2017). Furthermore, the findings of this study are relevant for the promotion of normal birth for women planning to birth in hospital, as well as at home.

Ever increasing rates of obstetric intervention in birth and increasing rates of birth trauma (Leinweber et al. 2017) are drawing attention to potential deficits in the dominant medical model of childbirth, and the need to look for alternative models to facilitate women achieving a safe, satisfying birth. Publicly-funded homebirth is one such option that has the potential to provide safe and affordable midwifery care for low risk women seeking an alternative to hospital (Catling-Paull et al. 2013).

CHAPTER TEN: CONCLUSION

Transforming homebirth in Australia

In Australia, both public and private midwives have reported difficulties overcoming negative attitudes towards homebirth and face a lack of understanding from maternity care providers and the general public about homebirth models of care. In order for the home to become a more widely accepted place of birth in Australia, negative attitudes towards homebirth and a lack of understanding of homebirth models of care need to be addressed. The findings of my study demonstrate that publicly-funded homebirth programs improve the acceptability of homebirth amongst midwives and suggest that exposure to homebirth encourages maternity care providers to develop a more nuanced understanding of the maternal body's physiological processes. Significantly, the power of witnessing undisturbed birth - which is far more likely to occur in the home setting – transformed midwives' attitudes towards birth and positively influenced their midwifery practise.

The opportunity to witness physiological birth without the application of medical intervention or control is something that can be lost when working in acute settings where intervention is the norm. Furthermore, even without the intentional application of obstetric interventions, it is evident that the environment a woman labours in has a significant impact on her behaviour and capacity for undisturbed birth. Even in a planned hospital birth, transporting the labouring woman from the comfort of her home to the unfamiliar institutional setting of the labour ward is, in

itself, a form of intervention that will potentially alter her physiological process. As such, exposure to homebirth offers an opportunity for midwives to expand their understanding of, and appreciation for, physiological birth which may provide the impetus for a perspective transformation that will potentially benefit all childbearing women in their care - not just those who plan to give birth at home. Maternity care provider's capacity to recognise the variations of normal in labour is a crucial component in the quest to halt the ever-increasing rates of unnecessary interventions that are being applied to women during childbirth. I recommend that, as far as possible, all student midwives and doctors are exposed to homebirth during their education. This initiative would go a long way in addressing the fear of homebirth amongst maternity care providers in Australia. Additionally, this would provide an excellent opportunity for students to witness truly undisturbed birth, serving as a benchmark in their developing understanding of what physiological birth looks like.

Another positive aspect of the publicly-funded homebirth model that could improve mainstream maternity services is the mentoring and support that is offered to new midwives transitioning into providing publicly-funded homebirth care. Midwives in my study noted that the opportunity to work clinically along side one-another at homebirths provided excellent opportunities for parallel learning and peer mentoring. There is great potential for a similar peer support program to be developed for new graduate midwives across all practice areas where the demands

of midwifery work can be shared and positive learning experiences supported by mentors.

Currently, there are significant barriers for women wishing to access homebirth in Australia. Expansion of the publicly-funded homebirth has the potential to be part of the solution to this problem, however, given the strict criteria for access (including close geographical proximity to the hospital) a substantial number of women will still be unable to access this model of care. A review of outcomes for women who planned a publicly-funded homebirth by Catling-Paull et al. (2013), showed that in the five year period between 2005 and 2010, only 1,807 women gave birth in one of nine publicly-funded homebirth services available at the time. On average, this works out as just 360 women giving birth via the publicly-funded homebirth model each year, when there are approximately 300,000 births per year in Australia (AIHW 2017). There are now 14 publicly-funded homebirth services operating nationally. Hence, a significant increase in the number of hospitals offering publicly-funded homebirth is needed to increase equity of access.

Women have the right to make an informed decision regarding their preferred place of birth and preferred care provider, and should have access to a range of options. For this reason, it is vital that the publicly-funded homebirth model is not promoted as a replacement to homebirth provided by privately practising midwives (PPMs). There is a risk that, with the expansion of the publicly-funded homebirth model, a dichotomy between perceived 'good midwives' (hospital employed) and 'bad

midwives' (privately practising) will perpetuate. PPMs have an extremely important role to play in offering an alternative model of care for women who seek homebirth and may wish to avoid engaging with a hospital-based midwife (Reed 2014). Consequently, we must be careful to avoid a climate wherein homebirth is accepted, but only for a narrow, systems-sanctioned group. Marginalisation of PPMs is already occurring in Australia, resulting in a reduction in the number of midwives providing private homebirth care and an increase in the number of women choosing to freebirth without any maternity care providers in attendance (Reed 2014, Dahlen, Jackson & Stevens 2011, Rigg et al. 2017). As such, a drive to increase women's access to homebirth must include improving conditions for PPMs. The findings of my study offer some insight into how relations can be improved between PPMs and hospital-based midwives and doctors, and it is hoped that rather than perpetuating the 'good midwife'/'bad midwife' dichotomy, the normalisation of homebirth via the publicly-funded model will have a flow-on effect for all women and midwives involved in homebirth, whether private or public.

Overall, publicly-funded homebirth offers women greater choices with regards to their preferred place of birth and promotes a transformation in attitudes towards homebirth and a positive change in midwifery practise. My research contributes a new understanding of the ease with which hospital-employed midwives can begin to provide homebirth care when given the right mentoring and support. More research on publicly-funded homebirth programs in Australia is justified in order to better understand the strengths and limitations of this unique model of care and how it can

contribute to quality maternal and newborn outcomes. In particular, an exploration of obstetrician's attitudes towards homebirth before and after involvement with a publicly-funded homebirth program would offer useful insight into the impact of vicarious homebirth exposure. Additionally, research into how services care for women who do not meet the eligibility criteria but still wish to access homebirth might offer a workable solution that supports women's right to choose a homebirth, balancing a practitioners duty of care.

The power of the publicly-funded model is that it opens up the option of homebirth to a cohort of women who may have otherwise never considered it. In addition, it has started the process of destigmatising homebirth in Australia by exposing hospital-based midwives to homebirth and vicariously exposing other maternity care provider's and allied health workers via the distribution of positive homebirth stories and outcomes. In this way, the publicly-funded homebirth model is helping to shift the discourse about homebirth in Australia to a more positive one. It is my sincere hope that the publicly-funded homebirth model's capacity to shift attitudes towards homebirth will contribute to the development of more positive relationships and a reduction in hostility between hospital-based maternity care providers and privately practising midwives, so that all women planning to give birth at home can be fully supported in their choice.

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APPENDICES

Appendix A – Manuscript 'From hospital to home: Australian midwives' experiences of transitioning into publicly-funded homebirth programs'

Reference: 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.

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.

Appendix B – Study Flyer

UNIVERSITY OF TECHNOLOGY SYDNEY

+ Research

Midwives' experiences of providing Publicly-funded homebirth in Australia

An invitation to participate

Are you a midwife, midwifery manager or obstetrician who has been working in or with a publicly-funded homebirth program in the last five years? If so, then I want to hear from you!

My name is Rebecca Coddington and I am a PhD student at the University of Technology, Sydney.

In conjunction with my supervisors, Caroline Homer, Athena Sheehan and Christine Catling, I am conducting research into the experiences and opinions of midwives, managers and obstetricians working in publicly-funded homebirth programs in Australia.

The aim of this research is to gather stories and insights from care providers that indicate how the programs are currently working and how they might be improved.

Participation in the study involves a telephone interview lasting approximately one hour that will be audio-recorded and later transcribed. Any information you provide will be kept confidential and your identity and that of your workplace will remain private at all times.

If you are interested in participating or would like more information please contact:

Rebecca Coddington (PhD Candidate)

Rebecca.L.Coddington@student.uts.edu.au

or

Professor Caroline Homer (Principle Supervisor)

Caroline.Homer@uts.edu.au

02 9514 4886

Thank you

Appendix C – Information Sheet

UNIVERSITY OF TECHNOLOGY SYDNEY

INFORMATION SHEET

UTS ethics approval number: 2014000316

Midwives' experiences of providing publicly funded homebirth in Australia

WHO IS DOING THE RESEARCH?

My name is Rebecca Coddington and I am a PhD student at the University of Technology Sydney. My supervisors are Professor Caroline Homer, Associate Professor Athena Sheehan and Dr Christine Catling.

WHAT IS THIS RESEARCH ABOUT?

This research will contribute qualitative data to The Birthplace in Australia study by exploring the experiences of midwives working in publicly-funded homebirth models and midwifery managers and doctors working in and with these programs.

This study offers a unique opportunity to explore midwives, doctors and managers experiences and satisfaction with providing publicly-funded homebirth. It is hoped that the findings of this study will provide insight into the feasibility of further expanding the provision of publicly-funded homebirth models in Australia and will assist maternity service managers in addressing aspects of the model that need improvement. This will in turn contribute to the maintenance and/or improvement of retention rates and the expansion of new and existing models in order to meet consumer demand.

IF I SAY YES, WHAT WILL IT INVOLVE?

I will ask you to fill out a brief participant demographics information sheet and then arrange a time for a telephone interview that will last approximately one hour. The interview will be audio-recorded and later transcribed.

ARE THERE ANY RISKS/INCONVENIENCES?

There are very few if any risks because the research has been carefully designed. Confidentiality of your interview data will be ensured. To protect your identity all data will be de-identified at transcription and pseudonyms will be used for yourself and your work place.

There is a slight possibility that you may feel distressed or have a negative emotional response to being interviewed. If at anytime you no longer wish to continue then the interview will be terminated and any data collected will be destroyed. If necessary, counselling is available through Employee Support Services at your hospital.

It is also important to know that, if during the interview, you describe a clinical interaction or work place procedure that is considered significantly inappropriate or unsafe then I am obliged to report this. In the rare event that this might occur I would inform you of the situation and refer the matter to your employer and/or registration body.

WHY HAVE I BEEN ASKED?

You are able to give me the information I need because you are a midwife, manager or doctor who has worked in or with a publicly funded homebirth program in Australia.

DO I HAVE TO SAY YES?

You don't have to say yes.

WHAT WILL HAPPEN IF I SAY NO?

Nothing. I will thank you for your time so far and won't contact you about this research again.

IF I SAY YES, CAN I CHANGE MY MIND LATER?

You can change your mind at any time and you don't have to say why. I will thank you for your time so far and won't contact you about this research again.

WHAT IF I HAVE CONCERNS OR A COMPLAINT?

If you have concerns about the research that you think my supervisor or I can help you with, please feel free to contact us:

Rebecca Coddington
email: Rebecca.L.Coddington@student.uts.edu.au

Caroline Homer 02 9514 4886
email: Caroline.Homer@uts.edu.au

If you would like to talk to someone who is not connected with the research, you may contact the University's Research Ethics Officer on 02 9514 9772 and quote this number 2014000316

Thank you

Appendix D – Consent Form

CONSENT FORM

Midwives' experiences of providing publicly funded homebirth in Australia

I _____ agree to participate in the research project *'Midwives' experiences of providing publicly-funded homebirth in Australia'* HREC approval reference number 2014000316 being conducted by Rebecca Coddington of the University of Technology, Sydney - Building 10, Level 7, Broadway NSW 2007. I understand that this research is being undertaken for her degree 'Doctor of Philosophy: Midwifery' and that funding for this research has been provided by the National Health and Medical Research Council as part of the Birthplace in Australia Study.

I understand that the purpose of this study is to explore midwives' experiences and satisfaction with providing publicly-funded homebirth in Australia, as well midwifery managers and doctor's experiences of working in and with these models.

I understand that I have been asked to participate in this research because I am a midwife, manager or doctor who has worked in, or been involved with a publicly-funded homebirth program in Australia in the last five years and that my participation in this research will involve an audio-recorded telephone interview lasting approximately one hour. I understand that if I become distressed or wish to terminate the interview at any time I am able to do this and that, at my request, any data collected on me will be destroyed. I understand that my personal identity and that of my workplace will remain confidential and that all data will be de-identified and remain anonymous.

I understand that Rebecca is legally obliged to report any disclosure by me of a clinical interaction or work place procedure that is considered significantly inappropriate or unsafe and that in the rare event that this might occur the matter will be referred to my employer and/or registering body.

I am aware that I can contact Rebecca Coddington - Mobile number 0435 038 322 - email Rebecca.L.Coddington@student.uts.edu.au or her supervisor Professor Caroline Homer – Phone 02 9514 4886 – email Caroline.Homer@uts.edu.au if I have any concerns about the research. I also understand that I am free to withdraw my participation from this research project at any time I wish, without consequences, and without giving a reason.

I agree that Rebecca Coddington has answered all my questions fully and clearly.
I agree that the research data gathered from this project may be published in a form that does not identify me in any way.

_____ ____/____/____
Signature (participant)

_____ ____/____/____
Signature (researcher)

NOTE:
This study has been approved by the University of Technology Sydney's Human Research Ethics Committee. If you have any complaints or reservations about any aspect of your participation in this research that you cannot resolve with the researcher, you may contact the Ethics Committee through the Research Ethics Officer (ph: +61 2 9514 9772 Research.Ethics@uts.edu.au) and quote the UTS HREC reference number. Any complaint you make will be treated in confidence and investigated fully and you will be informed of the outcome.

Appendix E – Demographics Survey

UNIVERSITY OF TECHNOLOGY SYDNEY

Midwives' experiences of providing publicly-funded homebirth in Australia

Participant Demographics:

1. In which State or Territory do you practice?

2. What is your age? (delete non-applicable categories)

   20-25 26-30 31-35 36-40 41-45 46-50 51-55 56-60 61-65 66-70

3. How many years have you been qualified to practice as a midwife or doctor?

4. Were you a Direct Entry, Double Degree or Graduate Diploma trained midwife?

5. In this model, do you practice on a full-time, part-time or casual basis?

6. What is your caseload, i.e. on average how many births per month do you attend in this model of care?

7. How many midwives work in your service?

8. On average, how many births per month does your service cater for?

9. How long have you worked in or with a publicly-funded homebirth model in Australia?

Appendix F – Example of Audit Trail Table

Raw data	**Properties / Characteristics**	**Open code / Concept**	**Thoughts?**
THE MIDWIFERY TEAM			
C71 'So, my experience has been fantastic. We work well with our medical staff, our midwifery staff are amazing, not just the midwives who provide the home birth service, but the midwives who work on the floor who are also their teammates. 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. So that's what I've found so rewarding about it.' C81 'We work at it every day. Everyday it's like any relationship that you do. If you don't work on it, if you don't use good communication and if you don't constantly sort of promote it and I guess work on the relationship, it will become difficult. So for us, we make sure that every home birth success is a team success, it's not just an individual success. Every transfer in is a teammate transfer. If there's an adverse outcome we work together as a team to sort of work through it. So that's really important. I think the day that you stop working on it is the day that you start dissolving that.' L306 'I'd feel different if I was on my own. I enjoy having two because you've just got a second pair of hands and a second perspective.	-Collaborating with allied health staff -Belonging -Being insiders/internal rather than outsiders/external	**PFHB is better because it's part of a team**	Working in a team model might be better for the midwives, but is it better for the women?

Which often isn't needed, but when it is you're very thankful that it's there. So, I wouldn't work on my own I don't think.' J31 And for me as a midwife, it was good having that backup of the hospital system, knowing the doctors and it's like if you transfer in, the reception was fantastic. You know, they just "All right, you need to come". We know you. You know the women and the doctors were great.			
B109 'All the other midwives I work with, we all have the same philosophy. We're all different but we're all very similar as well.'	- Trusting other midwives in the team	**Shared philosophy**	
C101 'we mandate that there's good communication'	-Following procedures for good communication - Focusing on keeping relationships in tact with good communication	**Communication is key**	Good communication is "mandated". I wonder if this top down approach is effective?
B186 'We all became really close, because you need each other. You need that debrief time, you need someone to talk to that totally understands and can feed off you. Just like your partner and your other friends want to care for you and want to understand, and they do to a certain degree, but no one knows the ins and outs like your colleagues do.' B648 'You're a midwife to women, but you're a midwife to midwives too. You're constantly caring and looking out for each other, and we need it and we need to provide it because I think we learn from it,	- Developing close friendships with other midwives - Sharing the emotional load with someone who understands - Pulling each other through -Being a midwife to other midwives - Being cared for by colleagues	**'You need each other'**	

and we need to give it as well. I think that's the biggest thing, just that communication and respect. Respect for each other's different practices and different beliefs, and different ways of working because just because I want to go and work on-call on my day off doesn't mean you should have to and doesn't mean I think you should have to because that's my choice.' D539 'I think a big part of this job is debriefing and talking, consulting with your other staff members about particular issues. I think having someone who's been there and done that at the other end of the phone at whatever time of day I think is probably the big thing.' B192 'Yeah, it's a great practice. It really feels like home.' B193 '*It's a family*'			
B174 'It takes a good 6-12 months to really get your head around caseload and the model and the midwives. Then a midwife will leave and you'll get a new one and it changes the whole practice and everything's different. That adds another level of stress to the job.'	- Taking time to adapt to this new way of working - Understanding the model and getting to know your team mates	**Group dynamics**	

Appendix G – Example Memos

1st September 2014

So far I have completed two interviews for my study. The results have been a little surprising and it's been interesting for me to reflect on what my biases are.

In particular the issue of providing care for women inside the (what I see as) strict hospital guidelines has so far not been an issue. I was expecting this to come up but in fact, both midwives I have spoken to so far have actually defended the guidelines and see them as right and fully justified.

Both talked about the need to protect the reputation of the service in order to keep it afloat, making reference to the extremely volatile political climate in which homebirth in Australia exists.

I suppose these programs are seen as safe and sanitised versions of homebirth, perhaps more palatable (read controlled) to the mainstream and medico's.

They both thought that the PFHB program had improved the public perception of homebirth but the skeptic in me wonders if this is truly the case.

I didn't realise that the midwives providing homebirth are caring for lots of MGP women who birth in hospital too. I guess in my mind they would have a full-time caseload of homebirth women but this is not the case. It's similar to the UK in some respects. Although the difference being that all midwives are expected to be able to care for any woman in any region at home whereas we still have designated programs.

I was pleased to hear B talk about the elation she felt at a homebirth and very interested to hear her describe that feeling I have of – 'if only women knew!' If only they knew how amazing birth can be.

Something that has really stuck in my mind from talking with independent midwife R is that she said she hardly ever feels fear at a homebirth, whereas when she was working in a hospital delivery suite she felt fear all the time.

I wonder how much the environment itself impacts on this (…Athena's work) and Birth Territory issues.

23rd September 2014

I was listening to interview 1 today which is with a midwifery manager and it was very interesting to note how she referred to needing to look after her staff re protecting them from an adverse event. We were discussing working with guideline/policies/protocols and

she stated that they were there to protect midwives against adverse events as well as the women.

I guess I'd never really considered this as I myself have held the position of midwife and homebirthing mother … I tend to feel allied most closely with the women who desire a homebirth and have many times lamented how strict the guidelines are… my personal perspective tends to be one of supporting the woman's choice. But when I put myself in the midwife's shoes I can see how hard that would be – caring for a woman who was making a decision that went against my advice and clinical judgment on what constitutes 'safe'.

I think a big part of this is the face that I have never personally encountered an adverse outcome. Never cared for a woman for whom things didn't go do well. In reality I have not experienced the full-spectrum of midwifery in the sense that it encompasses both life and death.

I guess, coming back to interview 1, a midwifery manager, her role is to support her team of midwives so protecting them from adverse events seems like a reasonable pursuit. The sticking point thought, really is that some of the guidelines, I feel, are based on good, string evidence. Whereas others are not.

As always the whole argument seems to boil down to ***a woman's right to choose.*** *Is it a woman's right to make a decision on behalf of herself and her baby as to what is the best and safest option for her. And on top of that issue is the concept of* ***a midwife's right to refuse****. Is it ethical for a midwife to "withdraw" the offer of a homebirth if she no longer feels it is appropriate for this woman and her baby (presumably based on screening tools used antenatally that give some indication of risk)?*

Perhaps my problem with this approach is that it doesn't allow for individualisation of a woman's care. I know so many stories from women who would not or did not fit the hospital eligibility criteria but went on to have a wonderfully successful and fulfilling homebirth under the care of a private midwife.