‘Getting kicked off the program’: Women’s experiences of antenatal exclusion from publicly-funded homebirth in Australia.

Abstract

Problem

Eligibility criteria for publicly-funded homebirth models tend are strict and, as such, many women who initially plan a homebirth later become excluded.

Background

Fifteen publicly-funded homebirth programs are operating in Australia, offering eligible women the opportunity to give birth at home at no cost, with the care of a hospital-employed midwife.

Aim

To explore the experiences of women who planned a publicly-funded homebirth and were later excluded due to pregnancy complications or risk factors.

Methods

A qualitative descriptive approach was taken. Recruitment was via social media sites specifically related to homebirth in Australia. Data collection involved semi-structured telephone interviews. Transcripts were thematically analysed.

Findings

Thirteen women participated. They were anxious about ‘Jumping through hoops’ to maintain their low-risk status. After being ‘Kicked off the program’, women carefully negotiated ‘the system’ in order to get the birth they wanted in hospital. Some women felt bullied and coerced into complying with hospital protocols that did not account for their individual needs. Maintaining the midwife-woman relationship was a protective factor, decreasing negative experiences.

Discussion

Women plan a homebirth to avoid the medicalised hospital environment and to gain access to continuity of midwifery care. To provide maternity care that is acceptable to women, hospital institutions need to design services that enable continuity of the midwife-mother relationship and assess risk on an individual basis.

Conclusion

Exclusion from publicly-funded homebirth has the potential to negatively impact women who may feel a sense of loss, uncertainty or emotional distress related to their planned place of birth.

Keywords

Home Birth, Midwifery, Continuity of Care, Childbirth, Pregnancy Complications.

Statement of significance

Problem or issue	Strict eligibility criteria for publicly-funded homebirth models mean that many women planning a homebirth are later excluded. Little is known about women's experience of antenatal exclusion from these models.
What is already known	Publicly-funded homebirth provides access to homebirth midwifery care at no expense to the woman and the model has been positively evaluated by childbearing women and the midwives who work in them. Women who plan a homebirth do so to avoid the medicalised hospital environment and to access midwifery continuity of carer.
What this paper adds	Antenatal exclusion from a publicly-funded homebirth program can be distressing and women may wish to continue their plans to give birth at home. Women feel coerced and bullied into following hospital protocols that are not tailored to their individual circumstances. Maintaining the midwife-mother relationship acts as a protective factor, ameliorating some of the negative effects caused by changing a woman's planned place of birth.

Introduction

A body of international evidence shows that in high-income settings, planned homebirth for women at low-risk of complications in labour is safe when they are attended by professional midwives who are well integrated with back up facilities for medical referral and transfer [1–6]. Furthermore, homebirth is not only safe for women with uncomplicated pregnancies, it also significantly increases their chance of achieving a normal birth, with lower rates of caesarean section and obstetric interventions seen in women who planned homebirth when compared with matched cohorts of women who planned hospital births [6,7]. Despite this evidence, in Australia there are significant barriers for women who wish to access homebirth, with only 0.3% of all births occurring at home in 2019 [8].

Currently there are two ways women can access homebirth with the care of a midwife; via engaging a privately practising midwife or via a publicly-funded homebirth program. To date, the majority of homebirth care in Australia has been provided by privately practising midwives, but changes in the past decade to the way private midwifery practice is insured and regulated has seen a reduction in the number of midwives offering homebirth[9,10]. Conversely, the number of publicly-funded homebirth models is increasing. The first publicly-funded homebirth program commenced over 20 years ago in Western Australia[11]. Since that time, a small number of services have been implemented in other states and territories, most since 2004 [9].

Currently, 15 publicly-funded homebirth programs are operating or under development in Australia in seven states and territories including New South Wales, Victoria, Western Australia, South Australia, Tasmania, the Australian Capital Territory and the Northern Territory [12]. This model of care offers women the opportunity to be cared for by midwives who are well integrated into a public hospital system that will provide back up if necessary. As midwives remain employees of the hospital, usually as part of an existing midwifery continuity of care program, they are covered by the hospital's professional indemnity insurance and have access to regular workplace leave

entitlements[9]. This also allows women to access homebirth midwifery care at no cost, as this is covered by Medicare, Australia's universal healthcare system. Whilst this model of care increases access to homebirth by eliminating out-of-pocket expenses for women, one of the key differences between the two models is that privately practising midwives have more flexibility around which women they care for[13], whereas midwives working in publicly-funded homebirth models must work within specific eligibility criteria set by the hospital.

Eligibility criteria for access to publicly-funded homebirth models tend to be strict, though not all services follow the same policies and protocols[9,14]. Despite the body of international evidence supporting the safety of homebirth for low-risk women, homebirth remains a contentious choice, with peak professional bodies representing maternity care providers in Australia taking different standpoints on whether homebirth should be available at all [15]. As a result of this tension, and to ensure homebirth is safe for both women and babies, strict guidelines for transfer to hospital-based care are in place[9].

The publicly-funded homebirth model is available to women in Australia experiencing uncomplicated or 'low-risk' pregnancies, who live within a defined distance or travel time to the hospital [14]. 'Low-risk' generally refers to a woman who fulfils the criteria of Category A in the National Midwifery Guidelines for Consultation and Referral [16]. In 2013, a review of maternal and neonatal outcomes achieved in Australian publicly-funded homebirth programs showed a 90% normal vaginal birth rate and low stillbirth and early neonatal mortality rate (1.7 per 1000 births when excluding deaths of babies with known fetal anomalies)[17]. Feedback on the model has been positive from both women and midwives[18–20]. However, the small number of services available (currently 15 services out of more than 250 public maternity hospitals in Australia) means that the number of women able to access this model of care is limited.

For those women who do live within the catchment of a hospital offering this model, fulfilling the eligibility criteria for publicly-funded homebirth is a dynamic process that continues throughout pregnancy. Further to the initial eligibility criteria women must meet to be able to book into the program, the screening tests that most women undergo during pregnancy have implications for their intended place of birth, and in many cases their model of care and caregiver. In some cases, women who decline such screening are automatically excluded from planned homebirth with the service. As such, many women who were planning to birth at home in a publicly-funded homebirth model are later excluded due to risk factors or complications and are allocated to another model of care and/or caregiver within the public health system.

To date, there is little qualitative research exploring Australian women's experiences of antenatal exclusion from planned publicly-funded homebirth. A recent scoping review by Blums et al.[14] found that there is limited publicly available information regarding inclusion and exclusion criteria for many publicly-funded homebirth programs which is likely to limit women's awareness of and access to these programs. The same authors conducted a survey of 830 women concerning their perceptions of the inclusion and exclusion criteria for publicly-funded homebirth programs in Australia [21]. They found that over half of the participants disagreed or strongly disagreed that obstetric related criteria should be used to prevent women birthing at home and that women wanted their individual perceptions of risk and safety to be central when decisions about transferring to hospital-based care were being made[21]. Previous research into publicly-funded homebirth in Australia has focused on the outcomes and experiences of women who are booked into a program at the onset of labour [17,18,20,22], the experiences of midwives working in the model [19,22–24] and the cost of the model [25].

The aim of this study was to explore the experiences of women who were booked for a homebirth in a publicly-funded program and were later excluded due to the development of risk factors. More needs to be known about the experiences of women who are excluded from publicly-funded homebirth programs during pregnancy to ensure that, for women seeking to give birth at home, the

models are accessible, acceptable and woman centred. The data for this study were collected between October 2018 and August 2019, prior to the Covid-19 pandemic, therefore the participating women's perspectives included here are not influenced by impacts to health services during the pandemic.

Methods

Design

A qualitative descriptive approach was taken [26,27], using semi-structured one-to-one telephone interviews, to understand women's experiences of exclusion from planned publicly-funded homebirth during pregnancy. As there is a significant lack of evidence on this topic, the research undertaken was exploratory in nature and carried out within an interpretive research framework. This allows the researcher to gain as much insight as possible into the experience of participants.

Sample

Participation in the study was open to women over the age of 18 years who had the experience of booking into a publicly-funded homebirth program in Australia within the past five years, and were subsequently excluded from the program due to the development of pregnancy complications and/or risk factors. Women who were never accepted into a publicly-funded homebirth program due to pregnancy risk factors at booking were excluded from the study.

Flyers advertising the study were shared on Facebook social media sites specifically relating to homebirth in Australia. Interested participants were invited to contact the Chief Investigator (XX) via email or telephone. After receiving an explanation of the process and giving verbal consent, participants who decided to proceed were asked for their contact details. A written information sheet and consent form was then emailed to participants with a request for them to sign, scan and

return the form by email. Telephone interviews were then arranged to take place at a time convenient for the participants.

Ethical considerations

Approval to conduct this study was sought and obtained from the relevant university's Human Research Ethics Committee in 2018 (approval no. XXXX). In order to consider the psychological safety for participants, a distress protocol was devised to ensure those women who were dissatisfied and upset regarding their experiences of being denied the birthplace of their choosing were cared for appropriately. It was anticipated that participants may have also been disappointed in their birth and maternity carer due to the exclusion from the homebirth program. The interviewer was familiar with the protocol and how to counsel any participants should they display any audible signs of distress. All participants were assured that their data would be anonymised and that any identifying details would be deleted. It was stressed that in any publication arising from the data, they would not be identifiable.

Reflexivity

Reflexivity refers to active engagement with one's own self-awareness to identify the impact of our personal values and positions on the research process and type of data collected[28] . All qualitative research is contextual, occurring within a specific time and place between two or more people [29]. The credibility of qualitative research findings is enhanced by clearly describing the context and intersecting relationships between the participant and researcher [29]. In this study, reflexivity was a continual and ongoing process. In order to remain sensitive to whatever the data presented, we employed a number of reflexive techniques including memo writing immediately following interviews, continual conversation amongst co-authors regarding the development of findings, and a general awareness and willingness to challenge our own personal biases about homebirth.

Each of the four authors of this study are registered midwives and have significant research backgrounds related to homebirth with PhD's focused on varying aspects of the topic. The first author, whom led the study and conducted the majority of data collection and analysis, also gave birth to her own children at home and has attended homebirths as a second midwife, meaning she has both insider and outsider positioning on this topic. All authors share a belief that women have a fundamental right to choose their place of birth and are strongly supportive of women being given options for midwifery care outside of mainstream medical models.

Data collection

Semi-structured telephone interviews were conducted by the first and second authors (XX and XX) between October 2018 and August 2019. Telephone interviews provide a rich source of data for qualitative analysis[30] and may even prove advantageous when discussing sensitive information, due to the anonymity provided by not being face-to-face with the participant [31]. Telephone interviews also allowed for data to be collected from diverse geographical locations across Australia, potentially resulting in a broader range of experiences.

A semi-structured interview technique was used. Care was taken to use open-ended questions and a funnelling interview technique was employed, beginning with more general questions and then narrowing down to specific topics of interest[32]. Interviews were audio-recorded and transcribed verbatim by a professional transcription service. Transcripts were then de-identified and participants were given a pseudonym. Transcripts were stored in a secure cloud-based storage system at the University of X. After 15 years data will be destroyed, in accordance with the Australian Code for the Responsible Conduct of Research (NHMRC 2018).

Data analysis

Transcripts were thematically analysed using the methods of Braun and Clarke[33]. The first seven transcripts were coded by the fourth author (XX) to identify patterns in the data and develop initial

codes. Codes were derived directly from the data and the research team then met to discuss and develop the data into agreed codes and early themes. The remaining transcripts were then analysed by the first author (XX) and themes were discussed and further refined by the whole team as the qualitative findings were synthesised.

Findings

There were 13 participants in this study from four states and territories of Australia: New South Wales, Western Australia, Northern Territory and Victoria. Interviews typically lasted between 45 to 60 minutes. Data saturation was reached after the first 10 interviews, however a further three interviews were conducted to confirm saturation of concepts had been reached.

Four main themes were constructed from the data. These were 'Jumping through hoops', 'Getting kicked off the program', 'Negotiating the hospital system: coercion and compromise' and 'Bridging the gap: the importance of the midwife-woman relationship after exclusion'.

Jumping through hoops

For women booked into this model, screening and assessment was ongoing throughout their pregnancies, as it is for most women, the difference being that a change in risk status could mean a change in planned place of birth. Participants felt stressed by waiting for results and having to continuously keep within the strict eligibility criteria set by the homebirth program. They referred to this process as 'ticking the boxes', 'making checkpoints' or 'jumping through hoops', as one woman described:

> *We sort of jumped through all the hoops throughout the entire pregnancy. They warned us that it's trickier with the first birth… I was sort of doing everything I could to make sure I passed (Greta).*

Some women reported that the midwife advised them not to get too attached to the idea of a homebirth until they had 'passed the tests':

> *I think from the very beginning, I remember just talking to one of the midwives about all the different steps that you have to pass along the way. There was a little bit of 'we don't want to talk about homebirth too much at the very start, in case you don't get on [the program]' (Rita).*

Women commonly described not being aware of how strict the eligibility criteria were when they first booked into the homebirth program. However, over the course of their pregnancy they became cognisant of how crucial it was to pass every test to prove their low-risk status, otherwise they faced exclusion from the program:

> *I think that is one of the biggest issues I have with [the publicly-funded homebirth model] now. Like I feel really bad because again, I absolutely love my midwife, but I would never go with the program again just because of that. There's just so many hurdles and so many tick boxes that you don't really realise, especially as a first-time mum (Cindy).*

Some women happily accepted this, yet others found it anxiety provoking and it turned them off using the homebirth program and led them to seek alternative options for their care.

Getting kicked off the program

After jumping through many hoops, women expressed their shock at being told they had veered away from a low-risk classification and were no longer eligible to plan a birth at home, as Kirralee described:

I met with [the obstetrician] and he did all of these measurements, and all that kind of stuff... He felt my belly and he was like, "You've definitely got a big baby in there." I was still trying to stay positive. I shrugged it off [thinking] the baby is not going to be so big that I'm not going to be able to give birth to him! He was like, "Yeah, you're not going to be able to do it at home." I was devastated. I was so upset. Then he started talking about the induction (Kirralee).

For some women, their homebirth plans were in place throughout their entire pregnancy, until their pregnancy went beyond their due date. One woman described the disappointment she experienced after reaching full term, having the birth pool set up at home prepared for birth and then being excluded from the program at 41 weeks gestation. She referred to this as being 'timed out':

There's like a bunch of risk factors and things, or check points that you have to reach along the way to stay in the program... I made it through pretty much everything. Then had the last two appointments at home and had the [birth] pool set up, and… I got timed out by going 10 days overdue (Rita).

For many women, being told they could no longer have a publicly-funded homebirth was met with a sense of disbelief and the feeling that care providers were exaggerating the risks. They did not feel that decisions were balanced or that they were taking in an assessment of them as a whole woman:

You went from feeling like nothing can stop you, and you are going to pass all the tests and have this beautiful homebirth that you have wanted for such a long time, to suddenly being in this risk category you never knew existed (Kirralee).

The need to pass numerous checkpoints throughout the pregnancy meant that women were always in doubt about whether they would actually give birth at home through the publicly-funded program. They were aware that with each screening test there was a possibility that their plans would have to change. This provoked a constant sense of anxiety. One woman described the

midwife telling her she had 'failed' the Glucose Tolerance Test and knowing immediately that this meant she was no longer eligible for homebirth:

> *I was disappointed. I remember my midwife rang me and said "You failed that quite terribly" and the first thing I said to her was 'Oh, no more homebirth'... (Aminah).*

Another woman explained her decision to engage a privately practising midwife after having an elevated blood sugar reading in early pregnancy and being told she was no longer eligible for a publicly-funded homebirth:

> *I was quite upset… I said, "Is there anything I can do? Because I really want to have a homebirth." And they said, "Well, you could get the blood sugar test, again, just to check that the result was reliable." And I did that... the [second] test was in a normal range. But, by that stage, because I had been upset about being kicked off the homebirth program, and because it had become so clear to me how easy it was to not be allowed within that system, to have a homebirth, I had already decided to go with a private midwife (Marion).*

Marion's experience was reflective of several women who decided to seek care elsewhere as they felt that their status in the publicly-funded model was precarious. Many of these women decided to pursue homebirth with a private midwife instead.

Some felt they had no choice but to freebirth without any health care professional present, in order to plan for the birth they wanted, as Rachel recounted:

> *In the end I just felt like it wasn't worth it. The amount of hassle, trying to convince some person who doesn't know me that I'm allowed to do what I want with my body just wasn't worth it (Rachel).*

Rachel went on to describe how for herself, and other women she knew, the choice to freebirth was often because of poor access to homebirth services:

> *Having freebirthed myself now I know of a lot of women, locally and around Australia who are freebirthing and a lot of them would like to have a midwife but they just can't because of where they're living or whatever the situation is… I would like to have another baby and I would like to have a midwife at the next birth (Rachel).*

Getting 'kicked off' the program was distressing for some women as they had to mentally prepare for a different place of birth. This experience tended to be easier for women who were in agreement that a hospital birth was now the safest plan for them and/or their baby. For those who were unconvinced by their care provider's advice, the restrictions regarding where they could give birth were more difficult to accept.

Negotiating the hospital system: coercion and compromise

Following exclusion from publicly-funded homebirth, women felt they needed to carefully negotiate 'the system' in order to get the birth they wanted in hospital. The hospital was seen as a rigid place where women's individual needs were not considered. Often women's initial motivation for a homebirth was to avoid the standard hospital care provided, and to their mind, would help avoid the risk of unnecessary interventions. There was an understanding that the hospital system was governed by policies which were often 'risk averse'. Participants described how information regarding potential risks were weighted towards the worst-case scenario if interventions were not consented to, rather than care providers explaining all the risks and benefits involved. This often led to a sense of mistrust regarding the advice being provided by health professionals and women wanting a more balanced explanation:

> *[The obstetrician] told me about the risks that he wanted me to know about, but not really about any risks that I associated with induction. It was more just about the risk if I don't get induced (Cindy).*

For some women, negotiating the system meant fighting hard for what they wanted, even amidst immense pressure to accept interventions. Several women described feeling bullied, as Natalia described:

> *We really genuinely feel like the doctor who was on at that particular point, there was this quite bullying behaviour… I was pretty strong in saying, "I'm not interested in making any decisions or taking any action towards induction tonight."... She literally, without exaggeration, slammed her folder down and walked out. I didn't see her again. So that was her response to me choosing what to do with my body (Natalia).*

The policies of the hospital dictated the advice given to women, which was seen as inflexible, and not tailored to their individual needs. One woman described this as being a '*Victim to criteria' (Rita).*

Women noted that obstetricians were particularly challenged when discussing their options following the development of risk factors and attempted to coerce women into certain decisions. Many women stated that they were told by obstetricians that their baby could die, should they not follow their advice. On reflection, women felt the risks were being exaggerated in order to coerce them into accepting interventions:

> *I did a lot of research about my pregnancy, about everything. And I was very firm on the facts, and on everything that I needed to know. [The obstetrician] really tried to scare me into the induction… He was just like 'the longer you wait'… He pretty much quite bluntly said to me, 'Your baby's gonna die if you don't get induced' (Cindy).*

It was clear that many women felt pressured to comply with interventions they were not convinced were necessary and, at times, the care provided was not appropriately individualised or woman-centred care.

Bridging the gap: the importance of the midwife-woman relationship after exclusion

Due to the diverse nature of each publicly-funded homebirth program's operating procedures, levels of continuity of care experienced by women following being excluded from the program were varied. For women who stayed in the hospital system, some were able to maintain continuity with their midwife and simply changed the planned place of birth to hospital. Others, however, lost their relationship with their known midwife and became part of a fragmented model, receiving standard midwifery care or care in the doctor's clinic. Women had a strong preference for maintaining care with their known midwife:

> *If I had been told I had to leave MGP [continuity of care model] and go to the hospital, that would have been far more traumatic. The fact that I was able to have this journey of having to reorient myself from having a homebirth to a hospital birth [was difficult] but keeping the same midwives made it a much more gentle experience (Kate).*

Once they had developed risk factors, many women wanted their known midwife's support to negotiate the next steps in their journey:

> *I guess the bigger issue for me was, although I was really, really sad about not having the homebirth. It was more, "Okay, so what's happening now to my midwives?" I wanted her to be there with me whether I was at home or in the hospital (Cindy).*

When women were excluded from publicly-funded homebirth they often found themselves outside of their comfort zone, needing to readjust their expectations for their birth. When midwives were able to act as a mediator between the woman and the hospital, they supported women to negotiate their changing expectations. Several women described how their midwife advocated for them, 'bridging the gap' between the birth they wanted, and the birth they were experiencing:

[The midwife] came in and we had a good chat… she was able to advocate for us so that I was able to have a water birth [in hospital], because we were planning a water birth at home. Initially they'd said that I wouldn't be able to have a water birth… [but] she was able to advocate for us and get that, and I think for us that helped to bridge the gap between what we'd wanted and what was unfolding (Natalia).

Women appreciated the advocacy midwives provided to not rush an intervention that was not urgently needed, as this woman described before her induction of labour:

Even the night before [my induction] when we were at the hospital getting the [CTG] monitor on we had a different obstetrician sort of waltz in and he wanted to start everything straight away. Even then [our midwife] really stood up for us and was like, 'I think we can wait, at least until the morning. Let's do an examination and see where you're at and let's just hold you off', sort of thing… so again, I still don't actually know how much she put herself in possible trouble just to be there for me (Cindy).

Some women felt they weren't well prepared for the possibility of being excluded from having a publicly-funded homebirth and that the communication wasn't handled well by their midwife, as Rita described:

I really enjoyed the MGP. On reflection, once we did kind of get kicked off, I didn't think it was handled that well. There wasn't that bit of compassion or just understanding [of the impact on me]... And I thought we were really reasonable. I wasn't in tears or, you know, blaming anyone or angry. It was just, [my reaction] was not even noticed in some ways (Rita).

When midwives demonstrated that they understood and empathised with the woman's disappointment about not being able to birth at home, it helped women to feel

supported and that their feelings were validated. Midwives also 'bridged the gap' between hospital and home by rearranging the hospital space, so it was more home-like and conducive to optimising physiological processes:

> *Two out of the three midwives [in the MGP team] I was dealing with regularly were both homebirth midwives, they'd had homebirths themselves and I think they just really understood the disappointment I felt not being able to and they did everything they could to be able to help allay my fears… That was really, really reassuring and she just spoke to me about some other ways that women she knew had made the birthing suite a bit more personal to make it a pleasant experience (Kate).*

The need for women to 'jump through hoops' throughout pregnancy led to an ongoing sense of anxiety due to the uncertainty around their planned place of birth. Women who felt the risk factors they developed were a valid reason to discontinue their plans for homebirth found it much easier to adapt to making a new plan for birth. Maintaining their relationship with their midwife was a protective factor, supporting women to manage changing expectations and ameliorating their sense that they were being coerced into complying with strict protocols that did not account for their individual needs.

Discussion

Homebirth remains a contentious issue in Australia with maternity care providers' peak professional bodies taking differing stances on whether homebirth should be available to women who seek it[15]. Women's access to publicly-funded homebirth is governed by strict eligibility criteria, including the geographical location of their home and whether their pregnancy is deemed as being at low-risk of complications. Previous research by Catling-Paull et al.[18] found that women appreciated the safety-net of the publicly-funded homebirth model and the seamless interaction between hospital and

home. Our findings indicate that whilst this is true for some women, others were significantly affected by being excluded from publicly-funded homebirth and did not always feel adequately supported by care providers when risk factors or complications arose. It was evident that women planned to give birth at home because they believed this was the best and safest place for them to give birth. When women were told those plans needed to change, some had trouble accepting this advice and mourned the loss not only of their planned place of birth, but also the loss of the midwife-woman relationship.

A survey by Sassine et al.[34] exploring Australian women's reasons for planning a homebirth indicated that women's primary motivations were to avoid the medicalised hospital environment and to gain access to continuity of midwifery care[34]. Nearly one third of the 1,681 women surveyed revealed that their desire to homebirth was related to a previous hospital birth experience that was traumatic (n = 32%) which in 6% of cases lead to a diagnosis of post-traumatic stress disorder[34]. A past traumatic birth experience has previously been linked to women's decisions to freebirth or use an unregulated birth worker[13,35]. More explicitly, women have reported their experiences of psychological birth trauma in hospital to be related to a prioritisation of the care provider's agenda over their own needs and a sense of being told 'lies and threats', combined with an experience of 'violation' [36]. Similarly, in our study, women recalled the stress they felt when negotiating the hospital system as they tried to navigate advice from health professionals which they felt was coercive and bullying. This led some women to exit the publicly-funded homebirth model and seek care with a private midwife or to birth at home unassisted.

Given the strict eligibility criteria to access publicly-funded homebirth programs, it is apparent that many women who initially book in for a homebirth will later be 'risked out'. Sassine et al's [34] survey of women who planned a homebirth in Australia indicated that 60% of women in the study had at least one risk factor that would have excluded them from a publicly-funded homebirth program. Our findings revealed that some women felt coerced and mistrustful of the hospital system. They

described needing to spend considerable time and energy working out how to negotiate the hospital system to meet their needs. Often, women's' perceptions of risk to themselves did not correlate with the inclusion criteria related to the homebirth service. Lane and Reiger[37] argue that institutions' attempts to 'organise' risks and manage uncertainties often align with neo-liberal philosophies and, in particular, the medical discipline. Consumer and midwifery organisations continuously lobby for more care options and choices for women. Conversely, the medical discipline-heavy hierarchy of the hospital system (with its emphasis on risk, budget, and efficiency) clearly delineates women as having either 'low' or 'high' obstetric risks, disregarding philosophical attitudes or risk perceptions of the women themselves. It was evident in our study that participants felt at the mercy of the hospital system, sometimes coerced into care options that they did not want, and that their views on their 'risk' status were not heard.

Hunter et al. proposed that 'the quality of relationships is fundamental to the quality of maternity care' [38]. Our findings demonstrated that when women were able to maintain their relationship with their known midwife, it ameliorated the impact of having to change their planned place of birth. Women were reassured to know that their known midwife understood what was important to them and would advocate for their needs in the hospital setting. This is aligned with research on the midwife-woman relationship in continuity models [39–41] and previous research on women's experiences of transfer to hospital during labour after planning a homebirth[22,42]. The research by Fox et al.[22,42] pertaining to women's experiences of intrapartum transfer from planned homebirth showed that women felt reassured during the antenatal period when they were prepared for the possibility of intrapartum transfer to hospital. Feeling connected to a hospital during pregnancy helped women feel more prepared for an intrapartum transfer as they had some knowledge of the destination hospital in the event of a transfer [18,22,42]. This integration of care is an advantage of publicly-funded homebirth programs. Coddington et al.[23] also described midwives' sense of reassurance in the event of transfer when working in publicly-funded models. Our findings, however,

indicate that some women did not feel adequately prepared for antenatal transfer or exclusion from the model and, at times, did not feel that their midwife understood the emotional impact this might have on them.

Publicly-funded homebirth programs have the potential to make planned homebirth accessible to women who are not financially able to pay out-of-pocket for a privately practising midwife. Long ago, the World Health Organization stated that for equity, maternity services needed to be accessible, acceptable, and available[43]. Over 40 years later, in Australia, a high-income country, many women are still unable to access the maternity carer and birthplace of their choice. More work needs to be undertaken to ensure that when women book into a homebirth service and then have their planned birthplace changed due to ineligibility, they are assessed on a case-by-case basis and receive woman-centred, evidence-based care that is tailored to their needs[44]. Given the current pandemic, many women are considering homebirth as a safer option than hospital in which to give birth[45]. More publicly-funded homebirth services need to be developed to meet consumer demand, but we need to ensure that these services are offering a safe and satisfying pregnancy and birth experience for women.

Strengths and limitations

As previously stated, the data for this study were collected prior to the Covid-19 pandemic, therefore the women's perspectives included do not incorporate impacts to health services during the pandemic. We see this as a strength as it allows for analysis of this topic separate from impacts of the pandemic on women's birth choices – a topic which has since been addressed by other researchers. The sample size was appropriate for an in-depth qualitative study and data saturation was reached with a number of differing viewpoints expressed by participants. Another strength of the study was that we recruited nationally, and participants came from four states out of the six which were operating publicly-funded homebirth programs at the time of data collection. Given the

lack of homogeneity of services offered in different states and territories, however, it is possible that the experiences of women in the states we were not successful in recruiting from is substantially different from those who participated.

Conclusion

Publicly-funded homebirth has the potential to increase rates of normal birth and make women's choices to plan a homebirth more broadly accessible, including for those women who cannot access private midwifery care. However, women's experiences of exclusion from the program need to be considered. Our study indicates that women can be excluded from accessing publicly-funded homebirth care at any point during their pregnancy, leading to an ongoing sense of anxiety and potentially the need to make significant adjustments regarding their plans for birth late in the third trimester.

Exclusion from publicly-funded homebirth has the potential to negatively impact pregnant women who may feel a sense of loss, uncertainty or emotional distress related to their planned place of birth. Whilst some women are able to continue care with their known midwife and plan a hospital birth, others who wish to continue their plans for a homebirth may feel they are left no choice but to urgently seek the services of a privately practising midwife or to freebirth, unattended by any healthcare professionals. When women can maintain continuity with their known midwife, their disappointment about changing their planned place of birth may be reduced and they benefit from their midwife's advocacy in the hospital environment.

Further research should focus on the communication and interaction between women and their care providers when exclusion from homebirth and antenatal transfer to hospital-based care is recommended. Service providers need to be supported to develop integrated systems that support women's needs and meet the expectations of the maternity care system and those who work within it.

References

1. Brocklehurst P, Hardy P, Hollowell J, et al. Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study. *BMJ* 2011; **343**(7840): 243-17. doi:10.1136/bmj.d7400.

2. Davis D, Baddock S, Pairman S, et al. Planned Place of Birth in New Zealand: Does it Affect Mode of Birth and Intervention Rates Among Low-Risk Women? *Birth* 2011; **38**(2): 111-9. doi:10.1111/j.1523-536X.2010.00458.x.

3. de Jonge A, Mesman, JAJM., Manniën J, Zwart JJ, van Dillen J, van Roosmalen J. Severe adverse maternal outcomes among low risk women with planned home versus hospital births in the Netherlands: nationwide cohort study. *BMJ* 2013; **346**(7914): e1001184-f3263. doi:10.1136/bmj.f3263.

4. Hutton EK, Cappelletti A, Reitsma AH, Simioni J, Horne J, McGregor C, Ahmed RJ. Outcomes associated with planned place of birth among women with low-risk pregnancies. *CMAJ* 2016; **188**(5): e80-90. doi:10.1503/cmaj.150564.

5. Scarf VL, Rossiter C, Vedam S, et al. Maternal and perinatal outcomes by planned place of birth among women with low-risk pregnancies in high-income countries: A systematic review and meta-analysis. *Midwifery* 2018; **62**: 240-55. doi:10.1016/j.midw.2018.03.024.

6. Homer C, Cheah SL, Rossiter C, et al. Maternal and perinatal outcomes by planned place of birth in Australia 2000 - 2012: a linked population data study. *BMJ open* 2019; **9**(10): 1-12. doi: 10.1136/bmjopen-2019-029192.

7. Reitsma A, Simioni J, Brunton G, Kaufman K, Hutton EK. Maternal outcomes and birth interventions among women who begin labour intending to give birth at home compared to women of low obstetrical risk who intend to give birth in hospital: A systematic review and meta-analyses. *EClinicalMedicine* 2020; **21**: 100319. doi:10.1016/j.eclinm.2020.100319.

8. Australian Institute of Health and Welfare. Australia's mothers and babies. 2021. Available from https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies

9. Catling-Paull C, Foureur MJ, Homer CSE. Publicly-funded homebirth models in Australia. *Women and Birth* 2012; **25**(4): 152-8. doi:https://doi.org/10.1016/j.wombi.2011.10.003.

10. Hunter J, Dixon K, Dahlen HG. The experiences of privately practising midwives in Australia who have been reported to the Australian Health Practitioner Regulation Agency: A qualitative study. *Women and Birth* 2021; **34**(1): e23-31. doi:https://doi.org/10.1016/j.wombi.2020.07.008.

11. Thiele B, Thorogood C. Community Based Midwifery Program in Fremantle WA. Fremantle: Centre for Research for Women (WA) and the Fremantle Community Midwives. 1997.

12. University of Technology Sydney. National publicly-funded homebirth consortium . 2021; Available at: https://www.uts.edu.au/about/faculty-health/school-nursing-and-midwifery/centre-midwifery-child-and-family-health/research/past-projects/national-publicly-funded-homebirth. Accessed 8 December, 2021.

13. Jackson MK, Schmied V, Dahlen HG. Birthing outside the system: The motivation behind the choice to freebirth or have a homebirth with risk factors in Australia. *BMC Pregnancy Childbirth* 2020; **20**(1): 254. doi:10.1186/s12884-020-02944-6.

14. Blums T, Donnellan-Fernandez R, Sweet L. Inclusion and exclusion criteria for publicly-funded homebirth in Australia: A scoping review. *Women and birth : journal of the Australian College of Midwives; Women Birth* 2021; . doi:10.1016/j.wombi.2021.01.009.

15. Roome S, Hartz D, Tracy S, Welsh AW. Why such differing stances? A review of position statements on home birth from professional colleges. *BJOG* 2016; **123**(3): 376-82. doi:10.1111/1471-0528.13594.

16. Australian College of Midwives. National Midwifery Guidelines for Consultation and Referral . 4th ed. ; 2021.

17. Catling-Paull C, Coddington RL, Foureur MJ, Homer CSE. Publicly funded homebirth in Australia: a review of maternal and neonatal outcomes over 6 years. *Med J Aust* 2013; **198**(11): 616-20. doi:10.5694/mja12.11665.

18. Catling-Paull C, Dahlen H, Homer, Caroline C. S. E. Multiparous women's confidence to have a publicly-funded homebirth: A qualitative study. *Women and birth : journal of the Australian College of Midwives; Women Birth* 2011; **24**(3): 122-8. doi:10.1016/j.wombi.2010.09.001.

19. Coddington R, Catling C, Homer C. Seeing birth in a new light: The transformational effect of exposure to homebirth for hospital-based midwives. *Midwifery* 2020; **88**: 102755. doi:10.1016/j.midw.2020.102755.

20. Forster DA, McKay H, Davey M, et al. Women's views and experiences of publicly-funded homebirth programs in Victoria, Australia: A cross-sectional survey. *Women and birth : journal of the Australian College of Midwives; Women Birth* 2019; **32**(3): 221-30. doi:10.1016/j.wombi.2018.07.019.

21. Blums T, Donnellan-Fernandez R, Sweet L. Women's perceptions of inclusion and exclusion criteria for publicly-funded homebirth — A survey. *Women and birth : journal of the Australian College of Midwives* 2021; . doi:10.1016/j.wombi.2021.08.007.

22. Fox D, Sheehan A, Homer C. Birthplace in Australia: Processes and interactions during the intrapartum transfer of women from planned homebirth to hospital. *Midwifery* 2018; **57**: 18-25. doi:10.1016/j.midw.2017.10.022.

23. Coddington R, Catling C, Homer CSE. From hospital to home: Australian midwives' experiences of transitioning into publicly-funded homebirth programs. *Women and birth : journal of the Australian College of Midwives; Women Birth* 2017; **30**(1): 70-6. doi:10.1016/j.wombi.2016.08.001.

24. McLachlan H, McKay H, Powell R, et al. Publicly-funded home birth in Victoria, Australia: Exploring the views and experiences of midwives and doctors. *Midwifery* 2016; **35**: 24-30. doi:10.1016/j.midw.2016.02.004.

25. Scarf VL, Yu S, Viney R, et al. Modelling the cost of place of birth: a pathway analysis. *BMC health services research* 2021; **21**(1): 1-816. doi:10.1186/s12913-021-06810-9.

26. Sandelowski M. What's in a name? Qualitative description revisited. *Res Nurs Health* 2010; **33**(1): 77-84. doi:10.1002/nur.20362.

27. Bradshaw C, Atkinson S, Doody O. Employing a Qualitative Description Approach in Health Care Research. *Global qualitative nursing research; Glob Qual Nurs Res* 2017; **4**: 2333393617742282. doi:10.1177/2333393617742282.

28. Burns E, Fenwick J, Schmied V, Sheehan A. Reflexivity in midwifery research: The insider/outsider debate. *Midwifery* 2012; **28**(1): 52-60. doi:10.1016/j.midw.2010.10.018.

29. Dodgson JE. Reflexivity in Qualitative Research. *J Hum Lact* 2019; **35**(2): 220-2. doi:10.1177/0890334419830990.

30. Cachia M, Millward L. The telephone medium and semi-structured interviews: a complementary fit. *Qualitative research in organizations and management* 2011; **6**(3): 265-77. doi:10.1108/17465641111188420.

31. Novick G. Is there a bias against telephone interviews in qualitative research? *Res Nurs Health* 2008; **31**(4): 391-8. doi:10.1002/nur.20259.

32. Minichiello V, Aroni R, Hays T. In-depth Interviewing: Principles, Techniques, Analysis. 3rd ed. Australia: Pearson Australia Group; 2008.

33. Braun V, Clarke V. What can "thematic analysis" offer health and wellbeing researchers? *International journal of qualitative studies on health and well-being; Int J Qual Stud Health Well-being* 2014; **9**(1): 26152. doi:10.3402/qhw.v9.26152.

34. Sassine H, Burns E, Ormsby S, Dahlen HG. Why do women choose homebirth in Australia? A national survey. *Women and birth : journal of the Australian College of Midwives* 2021; **34**(4): 396-404. doi:10.1016/j.wombi.2020.06.005.

35. Rigg EC, Schmied V, Peters K, Dahlen HG. Why do women choose an unregulated birth worker to birth at home in Australia: A qualitative study. *BMC Pregnancy Childbirth* 2017; **17**(1): 99. doi:10.1186/s12884-017-1281-0.

36. Reed R, Sharman R, Inglis C. Women's descriptions of childbirth trauma relating to care provider actions and interactions. *BMC Pregnancy Childbirth* 2017; **17**(1): 21. doi:10.1186/s12884-016-1197-0.

37. Lane K, Reiger K. Regime change in Australian maternity hospitals. *Soc Theory Health* 2013; **11**(4): 407-27. doi:10.1057/sth.2013.7.

38. Hunter B, Berg M, Lundgren I, Ólafsdóttir ÓÁ, Kirkham M. Relationships: The hidden threads in the tapestry of maternity care. *Midwifery* 2008; **24**(2): 132-7. doi:10.1016/j.midw.2008.02.003.

39. Homer CSE. Models of maternity care: evidence for midwifery continuity of care. *Med J Aust* 2016; **205**(8): 370-4. doi:10.5694/mja16.00844.

40. Lundgren I, Berg M. Central concepts in the midwife-woman relationship. *Scand J Caring Sci* 2007; **21**(2): 220-8. doi:10.1111/j.1471-6712.2007.00460.x.

41. Perriman N, Davis DL, Ferguson S. What women value in the midwifery continuity of care model: A systematic review with meta-synthesis. *Midwifery* 2018; **62**: 220-9. doi:10.1016/j.midw.2018.04.011.

42. Fox D, Sheehan A, Homer C. Experiences of Women Planning a Home Birth Who Require Intrapartum Transfer to Hospital: A Metasynthesis of the Qualitative Literature. *International journal of childbirth; Int J Childbirth* 2014; **4**(2): 103-19. doi:10.1891/2156-5287.4.2.103.

43. World Health Organization (1978). International Conference on Primary Health Care Declaration of Alma-Ata. Available at: http://www.who.int/publications/almaata_declaration_en.pdf

44. Renfrew MJ, Mcfadden A, Bastos MH, et al. Midwifery and quality care: findings from a new evidence-informed framework for maternal and newborn care. *The Lancet* 2014; **384**(9948): 1129-45. doi:10.1016/S0140-6736(14)60789-3.

45. Romanis EC, Nelson A. Homebirthing in the United Kingdom during COVID-19. *Medical law international* 2020; **20**(3): 183-200. doi:10.1177/0968533220955224.