Multiparous women's confidence to have a publicly-funded homebirth: a qualitative study

Abstract

Background: Hospital birth is commonly thought to be a safer option than homebirth, despite many studies showing similar rates of safety for low risk mothers and babies. Recently in Australia, demand has led to the introduction of a small number of publicly-funded homebirth programs. These offer homebirth to selected women who previously would not have considered this option. Women's confidence in having a homebirth through a publicly-funded homebirth program in Australia has not yet been explored.
Aim: The aim of the study was to explore the reasons why women feel confident to have a homebirth within a publicly-funded model of care in Australia.
Methods: Ten multiparous English-speaking women who chose to have a homebirth with the St George Hospital Homebirth Program were interviewed using semi-structured, open-ended questions. A thematic analysis of transcriptions was undertaken. Data were part of a wider set collected as part of a doctoral study.
Results: Women demonstrated a strong confidence in their ability to give birth at home and described a confidence in their bodies, their midwives, and the health system. Women weighed up the risks of homebirth through information they gathered and integration with their previous experience of birth, their family support and self-confidence.
Discussion: The publicly-funded hospital homebirth program strengthened the confidence of women to choose this model of care.
Conclusion: Women choosing publicly-funded homebirth display strong confidence in both themselves to give birth at home, and their belief in the health system's ability to cope with any complications that may arise.

Key words: childbirth, homebirth, risk, confidence

4350 words

Introduction

Homebirth is not a common choice amongst women in many parts of the western world [1-3]. In Australia only around 0.3% women have homebirths [1], and in the UK 2.7% women give birth at home [3], although this is increasing [4]. In the United States of America, 0.6% mothers have homebirths [2]. The exception to most developed countries is the Netherlands, where around 30% women have homebirths [5].

Many health professional groups in Australia, including the Australian Medical Association (AMA) and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), do not support homebirth [6, 7]. However, a small number of women continue to choose home as their preferred place to birth, despite its low 'unconventional' profile.

In Australia, women wanting a homebirth have historically employed private midwives to provide care, although in recent years this has become increasingly difficult [8], Recent reforms in maternity care will mean eligible midwives will be able to access professional indemnity insurance and the Medical benefits scheme (MBS) from November 2010. However they will not be insured or funded to provide intrapartum care at home. Since 2002, private midwives have been unable to secure affordable professional indemnity insurance. This does not include homebirth.

In response to community demand, a small number of publicly-funded homebirth services have been established in most Australian states and territories (with the exception of Tasmania, the Australian Capital Territory and Queensland) and provide an option of free homebirth to women in their geographical area. These models are located in the Hunter New England Health Service, the South Eastern Sydney and Illawarra Health Service (NSW), [9] South Australia (Northern Women's Community Midwifery Program) [10], Northern Territory and Western Australia (Community Midwifery Program) [11] and recently in Victoria (personal communication).

Despite the development of publicly-funded homebirth services around the country, it remains particularly difficult for most women to give birth at home. Apart from the dearth of services around the country, and scarcity of private midwives, even women who are fortunate enough to have a local service often have to carefully negotiate their wishes to their partners and family, become particularly strategic about who they talk to, and encounter a battlefield of negativity around the seemingly simple choice of having a baby at home. General Practitioners, usually the first base when wishing to be referred to other health professionals, do not have links with private midwives and often advise women against homebirth [12]. Hence, women who choose this option have to sometimes go to great lengths, at times with great opposition, to secure a homebirth [13]. Women's confidence to not only process the decision to have a homebirth, but also gain the services of midwives to facilitate this, should not be underestimated. Understanding how women develop the confidence to have a homebirth in a a publicly-funded model was the impetus for this study.

The St George Hospital Homebirth Program

The St George Hospital Homebirth Program in Kogarah, Sydney, operates through a hospital-based Birth Centre [14]. Eight midwives work within the Birth Centre, four of whom are able to work as the primary midwife for women who choose homebirth, having attended at least five births at home, the Advanced Life Support in Obstetrics (ALSO) course, a rigorous credentialing process [15], practice review and competence in resuscitative skills, cannulation and perineal suturing. Most women at low risk of obstetric complications who book to be cared for in the Birth Centre are given the choice of having a homebirth. Women who plan to have a vaginal birth after caesarean in the Birth Centre, or who develop risk factors during pregnancy are not given the option.

St George Hospital became the first hospital to begin operation of a publicly funded homebirth model in NSW and to date at least 90 women have achieved a homebirth through the service [16].

Previous work has linked homebirth decisions to notions of confidence. Dahlen et al. [13] found women choosing homebirth were more willing to take responsibility for their pregnancy, labour and birth, whereas women giving birth in hospital were more likely to give this over to health professionals. In Sweden, Lindgren [17] describes, in a small qualitative study of women's perception of risks and homebirth, that women have confidence in themselves to give birth, and believe in the capabilities of their midwives.

The aim of this study was to explore the confidence of multiparous women who choose a homebirth within the St George Hospital Homebirth Program, Sydney, as part of a larger study of the influences on women choosing homebirth.

Methods

Design
A qualitative study of multiparous women who were booked to have a homebirth with the St George Hospital Homebirth Program was undertaken. Approval to conduct the study was obtained by the Human Research Ethics Committee at South Eastern Sydney Illawarra Health Service and the University of Technology, Sydney.

Sample
Ten multiparous English-speaking women who chose to have a homebirth within the St George Hospital Homebirth Program were interviewed. Women were approached by the midwives employed in the Birth Centre to participate if they had booked a homebirth during their pregnancies, and had given birth within the last six months. The first ten women approached agreed to participate. Women whose care was transferred to hospital care during their pregnancy or labour were included.

Data collection
Women were interviewed after the 6-week postnatal period. A semi-structured, open-ended question technique was used. For example, questions such as ‘why did you choose a homebirth?’ and ‘what helped you decide to have a homebirth?’ were used. Interviews were taped and transcribed by the author, and participants deidentified upon transcription.

Data analysis
An analysis of transcriptions was undertaken using thematic analysis. Thematic analysis is an ideal way of analysing interview data when participants are describing experiences as it focuses on identifiable themes and patterns of living and/or behaviour [18]. Through this method, stories are structured to form a comprehensive picture of a collective experience. A constant comparative method of analysis was used whereby the first interviews were compared for similarities and differences, then coded, compared and clustered, and categories formed, with the use of audit trails. As more data were collected, these categories moved and changed related to the data content. Management of the data was assisted by using NVivo software [19].

Findings
The participants were multiparous, between 21 and 39 years old, and all except one had completed further educational qualifications after completing high school. Four women had tertiary qualifications. All were married or in stable relationships with their partners, and nine were Caucasian with one woman of Malaysian origin.

The themes from the data were ‘confidence in my own body’, ‘having confidence in the midwives’, ‘having confidence in the health system’, and ‘processing confidence and risk’.

Confidence in my own body
Concepts in this theme included those of women expressing their independence, being different, being decision-makers, assertive, and being physically and mentally well. All of these concepts culminated in women feeling confident and being able to choose a homebirth; they felt equipped to be responsible for themselves during their labour and birth, and although aware of the necessity for support, expressed their confidence to retain control by choosing a homebirth. This was often described as an aspect of themselves that grew from other personal life experiences. For example, one woman described her chronic respiratory disease as a teenager and the alternative methods she used that eventually led to her cure. This influenced her ability to investigate and embrace homebirth when she became pregnant.

Women described how they had confidence in their bodies; and an innate confidence in their ability to give birth. They identified with being physically and mentally well, with a desire to be in control. One woman expressed:

> *"With this baby [homebirth] I really wanted to be in control and I knew that my body was capable and I didn't have any issues."*

Women and their partners were reassured by having had a previous normal birth. The experience of their previous birth was usually positive, and the knowledge that their bodies had undergone and coped with the birth process before provided reassurance that their bodies would act similarly again. A number of women wanted to avoid medication during their labour. One woman described her confidence to labour without medication:

> *"I had done it before – twice without any medication – I didn't have any pain relief – so I knew that I could do it without that"*

Having confidence in the midwives

Women had confidence in the midwives who cared for them. In particular their skills, knowledge, and attention to detail. Midwives were described as being very influential to women choosing a homebirth as they shared information and allayed fears. The ability of the midwives to address all of their questions with ease; their personable manner, and the respect given to women was expressed as responsible for the close trusting relationship that developed during pregnancy. The positive approach to birth expressed by the midwives was important, and the subtle way they facilitated women's decisions regarding place of birth was appreciated. For example, women were given the choice to change to hospital care at any time during their pregnancy and labour. These qualities all culminated in women and their partners trusting the midwives to provide appropriate skilled care, and advocate for them, if necessary. For example, one woman said:

> *"… I was very well watched, and even when I was having her, like in full labour, ready to pull the plug 'couldn't do it anymore!' going through my transition stage, the [midwives] were watching me and timing everything and checking me probably more than they would if I was in the hospital, just to make sure that there wasn't any problems, and I felt very confident and very comfortable with that. I think that if there was any 'oh you'll be all right, I'll come back and check you in ten minutes' then I probably wouldn't have coped but I knew they were controlling the situation in a very passive way"*

Women who attended antenatal classes (5 women) expressed the value of the information they received. The knowledge they gained solidified their confidence to pursue a homebirth, especially for those who attended classes that focused on natural birth (e.g. Calmbirth®). One woman explained how attending antenatal classes affected her:

> *'he [antenatal educator] did leave me feeling very confident you know that a woman's body is made to do it, and all you have to do is do it!'*

Having confidence in the health system as backup

Women did not necessarily have less confidence in the health system, even though they chose to give birth outside the hospital. Many women expressed their feelings of safety by having the back-up of the hospital, and the choice to easily transfer to hospital care if necessary. A number of women expressed how they merely didn't need to bother the hospital with their presence as they felt they were so low-risk that

the potential problems of being in the hospital (or even just travelling to the hospital) outweighed those of staying at home. A minority of women expressed their desire to avoid intervention, and didn't trust the hospital-based staff to facilitate their wishes in this respect. Others expressed that they wished to avoid the 'temptation' of drugs and intervention, knowing they could do without it, but mindful that they were vulnerable to agree to medication at the height of their labour. One woman described the comfort she felt from the security of the hospital:

> *"I just like the idea of the backup there, the continuity.. I just like the fact that I go to the hospital for my appointments and the hospital is the one looking after me."*

The flexibility of the publicly-funded homebirth program was appreciated. Women did not need to make a firm decision about having a homebirth; they were given time to decide. One woman expressed how this worked for her:

> *'So once I got past the anxiety issues, and making that final decision, and knowing that if I didn't want to go ahead with it then I could always back out and still go to the hospital, well then I had no, that was it, I was fine, I was very relaxed about it .. just wanted to leave the window open, because I liked the idea of doing it but I wasn't completely ready to make that decision, and I think as I got further along in my pregnancy, it was easier for me to make that decision'*

Weighing up the risks and benefits

Women weighed up the risks of homebirth and this knowledge increased their confidence in their chosen birthplace. There were similarities amongst the women with how they processed the concept of risk, and often they would use words such as 'safety', instead of the word 'risk'. Most women spent time talking to others who had either had a homebirth, or who worked with women who had homebirths. Central to this were the midwives who worked within the homebirth program. One woman expressed this as:

> *'just that it was a big thing for me, with my anxieties and things, knowing that the procedures, that the [midwives] at St George got grilled – I needed to know absolutely everything about how it worked'*

Women gathered information about homebirth. This came from books, the internet (blogs, chat rooms), other health professionals, and friends. This, together with their previous experience of birth and the support from their family, culminated in confidence that grew in strength during their pregnancy. Often women only felt ready to confirm their choice of birth place later in their pregnancy after this process had taken place. One woman said:

> *'I knew that if I was well monitored in my pregnancy, then I could have one, and that's what led me to that level of wanting to have a homebirth. I didn't actually decide to have a homebirth until I had had my 28-week gestational diabetes test, because I had had a false positive with that, so then after I'd had my second test for that then I decided that yes, I wanted to go ahead and have a homebirth. I needed to have everything clear in my head that everything was going to be healthy for me to be able to have a homebirth'*

Most women based the expectations of their homebirth on their previous birth experience, and the level of medical intervention they needed at that time. This gave

them a point of reference regarding the risk of complications during their planned homebirth, and was an important element to their confidence in planning a homebirth.

> *'I think if I'd had a very challenging, a difficult labour, then perhaps I would think I needed the medical support, you know what I mean, if something had gone wrong the first time, maybe I would have been thinking I need to be close, I need the medical support, and all that'*

Some women expressed the desire for their birth to be a family event, which was something they felt they could not get in hospital. They wanted their children involved, and did not want their husbands to leave at the end of hospital visiting time. One woman said:

> *'I wanted him* [previous child] *involved, I wanted him there and I wanted it to be a family thing, a family affair and I knew it was, I'd done a lot of research and reading about it and I knew it was a safe option'*

Women went to great lengths to avoid talking to people and health professionals who would give a negative view of homebirth. They also wished to avoid confrontation, and even as their confidence to birth at home grew, they tired of having to explain and justify their choice to people who concentrated on the negative aspects. Women did not necessarily avoid talking about the possibility of adverse events at home, they merely wished to talk with people who were knowledgeable and encouraging, rather than alarmist and negative. One woman, who worked within the hospital system, describes her feeling after talking with her GP:

> *'..because there definitely was a bit of negative energy there, because as you know they just come from that risk perspective, and its all about risk management and "these horrible things go wrong"'*

Women place an emphasis on their social situation when processing issues of risk surrounding homebirth. Their family's involvement with the birth, a strong wish to avoid travelling to the hospital in labour, and an overwhelming desire for a calm relaxing home environment were all important. These factors are given prime importance in women who choose homebirth, and the risks of birth complications were thought of as negligible, mostly due to their confidence of having experienced a previous normal birth.

Discussion

This study found that women felt confident to give birth at home with the back-up of the hospital and had a strong trust in the abilities of the midwives, and their own personal strength to achieve a homebirth. They weighed up the risks of home and hospital birth, and felt they were not at an increased risk of birth complications by having their babies at home.

Women were confident in their ability to achieve homebirth [17]. They did not dwell on the possibility of negative outcomes or labour complications, but surroundedthemselves with like-minded people who supported their decision to homebirth [20, 21]. Similarly, they sought antenatal courses that promoted normal birth. Courses like Calmbirth® focus on the normal, physiological aspects of birth, and build on lessening parent's fear and promoting their confidence and ability to have a normal birth [22]. Antenatal classes have been found to further instill confidence, and lessen fear of childbirth in women [23]. The multiparous sample in this study also held an advantage, having had a prior normal birth, whereas

primiparous women have been reported to have higher levels of birth-related fear [24] which has been linked to labour dystocia and emergency caesarean section [25]. Hence the confidence described by this sample is grounded in past experience, and is key to them choosing a homebirth. We chose to only include multiparous women because this group comprised the largest number booking on the homebirth program.

Confidence can be defined as 'a feeling of self-assurance arising from one's own abilities or qualities' [26]. This is similar to the concept of self-efficacy, which is the ability to believe in one's own capabilities, and has been measured in quantitative studies [27-29]. The term 'confidence' is less specific, i.e. one can be confident to fail at a task. Many studies on women having homebirths relate the reasons women choose homebirth [30, 31], and the safety and risk aspects [32-35].

As part of building their confidence to choose a homebirth, women spent time weighing up the risks and benefits. Decision-making helped by the assessment of risk are complex issues used continually within the healthcare environment. Modern society has seen a growth of a 'risk culture' in health care as a result of litigation and high societal expectations of health care in general. Notions of risk can affect the building of confidence.

Dahlen [36] describes the different weights placed on risk by different health professionals. Obstetricians, and those more aligned with the biomedical model of birth will describe a risk as being likely to happen 1:1000, whereas midwives, and those with the 'social' philosophy, describe the same risk as not happening 999 times out of a thousand [36]. This subtle difference in delivering information can contribute to women's positive attitudes and confidence in their ability to give birth at home. A similar difference in birth philosophy and risk has been found by Cheyney and Everson [37] where a less than collaborative nature between hospital staff and homebirth practitioners resulted in hospital staff believing that homebirth was far more dangerous than studies indicate. Cheyney and Everson state that homebirth midwives believe hospital staff have a very skewed view of homebirth, as they only see the women who need transfer. Similarly, the wider community also have this distorted view of homebirth, often fuelled by the media [38, 39].

Decision-making and risk perception have a close relationship [40], and trust in caregivers greatly influences women's decision-making [41, 42]. Pilley Edwards and Murphy-Lawless [43] discuss the rise of technology and the greatly expanded perception of risk around new science and treatments for women in maternity care. They conclude this has led to the labelling of women who contest the medical definitions of risk as 'immoral', despite the risk factors in question really being little more than 'probabilistic logic' (p. 38). Women choosing homebirth will often come up against the more conventional views of risk and safety, and be forced to defend their decisions not to give birth in hospital. Women in our study avoided talking with people who they felt would be negative.

Childbirth can be seen predominantly in two ways, through a 'biomedical' (or 'technocratic') model or 'social' model, depending on personal philosophy [44, 45]. The biomedical model will emphasise the elements of danger in pregnancy and birth, whereas the social model philosophy veers towards viewing birth as a more natural physiological event. Similar attitudes to the risks of childbirth are held by both health professionals and women, and as such, can influence decision-making based on quite different perceptions of risk. Women choosing homebirth veer towards the 'social' model of birth and believe risks involved in childbirth are not limited to the home, and are part of a more complicated phenomenon [17].

The interpretation of risk can also differ between women. For example, some women believe the risks involved in having a hospital birth outweigh those of having a homebirth [41], although the majority believe hospital birth to be safer [46]. This was apparent in the women in this study; they were confident that their risks of complications were equal, or lower, by having their babies at home. Women were certain their total birth experience would be better at home, and this holistic view emphasised the social aspects of birth while minimising the risk of complications in labour and birth.

Differences of perceived risk are discussed by Williams [40], who feels the concept of risk focuses on the physical and neglects important issues such as financial, psychological and social impacts; there are many complex factors at play when presented with risk information - which is apparent when women choose a homebirth. Bailes and Jackson [47], in a case study, describe the non-hierarchical collaborative approach between women, midwives and the medical system in a homebirth scenario. This is reflected clearly in the St George homebirth program, and appears to be a factor that serves to strengthen the confidence and trust women have in their caregivers, and facilitates women's overall confidence in their decision to give birth at home.

Similarly, Andrews [48], reported themes that explain how women process a number of issues when deciding to have a homebirth. These are based on previous birth experience and social circumstances, the desire to maintain normality, and a calm atmosphere, however, issues of confidence in women were not explored in depth. Decisions are also influenced by women's medical history, ethnicity, religion, socio-economic and educational status, and their own personality style [49]. This reflects work by Handworker (1994), in a study of interactions between health workers and pregnant women. He found that risk perception is dependent upon women's values, class and education; whereas health professionals use science to predict and discuss risk, women often negate it through their wider social world.

In our study, women believed the risks of serious problems occurring were small, and through surrounding themselves with like-minded people, the positive and normal features of birth were emphasized and built on through pregnancy. In this way, women displayed self-protective confidence, either avoiding potential conflict, or tired of the repetition involved in having to constantly explain her choice for a homebirth. This was also found in Dahlen et al., [42] and Lindgren [21] who reported that women avoided talking to people about childbirth related risks, and occasionally resorted to lying to avoid conversations with particular health professionals.

The flexibility of the publicly-funded homebirth program gave women control over their birthplace and built confidence. Women booked to have a homebirth could, at any time during pregnancy or labour, choose to give birth in the Birth Centre instead. This ensured women felt safe and comfortable in their chosen birthplace, and back-up care in the hospital was always available. The importance of women feeling in control during labour and birth has been documented extensively and is closely linked to women's satisfaction with their birth experience [30, 50, 51].

Trust in the midwives was paramount to women choosing a homebirth. Women and their partners felt safe and supported in the knowledge that their midwives displayed adequate knowledge, training and carried emergency equipment. The systems of transfer were also reassuring to women and their partners, who often had to discuss these aspects of emergency care during the process of choosing their birthplace. Trust in caregivers has been found to be important in other studies [17, 52], and

women having homebirths describe a close relationship with their midwives [53]. Similarly, the confidence women have in the birth process itself, and their ability to have a natural, normal birth was a strong theme in this study. This trust and belief in a normal birth process is common in other studies of women having homebirths [17, 30, 31].

The limitations of this study are its size, its multiparous sample, and the specificity to a publicly-funded model of care within an area of Sydney, Australia. The sample were all English-speaking women living in the St George area, and not wholly representative of the area.

Conclusion

The women in this study were confident in their ability to give birth at home, boosted by the availability of hospital care, if needed. Their confidence often grew through antenatal preparation, and by seeking like-minded people. They described the importance of their midwives to build confidence. Often there was a protective selectivity on who they told about their plans for a homebirth. Both women and their families were very reassured that should complications arise, there were seamless back-up systems of hospital transfer in place.

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