The influences on women who choose a publicly-funded homebirth in Australia

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CERTIFICATE OF ORIGINAL AUTHORSHIP

I certify that the work in this thesis has not previously been submitted for a degree nor has it been submitted as part of requirements for a degree except as fully acknowledged within the text.

I also certify that the thesis has been written by me. Any help that I have received in my research work and the preparation of the thesis itself has been acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

Signature of Student:

Date:

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Other personal thanks go to my wonderful offspring Rosie and Oliver for making my world brighter and to Michael for his endless love and encouragement; to Glenn, who really didn't think my doing a PhD was a brilliant idea, (but of course, this made me even more determined to do it); to my brothers whose brilliance helped develop my quietly competitive nature; to the higher research degree students in the Faculty of Health for their encouragement and solidarity; to the members of the National Publicly-Funded Homebirth Consortium who shared their experiences and data to assist with publications; to Professor Maralyn Foureur for helping me to understand feminism; to Bronwyn whose teasing about being a 'real' midwife gave rise to some lively discussions; to the UTS librarians Jane Van Balen, David Litting and Patrick Tooth for their help with tricky hard-to-find articles and Endnote mysteries, and finally the homebirth midwives at St George Hospital, and women and their partners who freely gave their time for me to do this research, and who were all such lovely people to spend time talking to.

Life has thrown me many curve balls in the last five years, and there have been times when writing my thesis has taken a distinct back seat. However, despite the distractions (many also self-imposed), it has been a pleasure to examine and highlight the topic of publicly-funded homebirth in Australia, and I hope this thesis contributes to the body of evidence that shows the importance of midwifery care and place of birth to women.

ABSTRACT

In Australia, homebirth has not been a mainstream option for childbirth for many years due to political reasons, societal attitudes towards childbirth, and a lack of services

Since the 1990s, publicly-funded homebirth services have developed as a result of a growing demand from women and midwives. These services are few in number, and often embedded within a midwifery group practice in a hospital setting. As a relatively new model of care, these services have had little formal research, and only a few evaluations. The purpose of this study was to explore the influences on women who chose a publicly-funded homebirth. The setting was a publicly-funded homebirth service in southern Sydney, New South Wales, Australia. A grounded theory methodology, using a feminist approach was used to collect and analyse the data. Data were collected though semi-structured interviews of 18 women, 5 midwives and 2 partners of the women.

Six main categories emerged from the data. These described the influences women had when they chose to have a publicly-funded homebirth. These categories were *feeling independent, strong and confident, doing it my way, protection from hospital related activities, having a safety net, selective listening and telling, and engaging support.* The core category was *having faith in normal.* This category linked all the other categories and was an overriding attitude towards themselves as women and the process of childbirth. The basic social process was *validating the decision to have a homebirth*. This was a dynamic, changeable process and principally a strategy to lessen stress regarding their decision to have a homebirth by reinforcing already-held reasons (for example, their 'low risk' status, strength and ability to have a normal birth) and beliefs (for example, their faith in normal, natural processes).

The findings establish that women have similar influences to other studies of women when choosing homebirth. However, the women in this study were reassured by the publicly-funded system's 'safety net' and seamless links with the hospital system. The flexibility of the service to permit women to change their minds to give birth in hospital, and essentially choose their birthplace at any time during pregnancy or labour was also appreciated.

PUBLICATIONS AND PRESENTATIONS RELATED TO THIS RESEARCH

The publications and presentations related to this research study are listed below. The latest Microsoft® word versions of the publications have been placed in the Appendices to maintain copyright legislation.

The paper and presentations asterisked* were preliminary analyses of data collected for the thesis. The other papers were written as part of an overall research program into publicly-funded homebirth, and as I took a lead role in their production, I have included them here to illustrate the overall body of work.

PEER-REVIEWED PUBLICATIONS

***Catling-Paull**, **C**, Dahlen H, Homer C.S.E. 2011, 'Multiparous women's confidence to have a publicly-funded homebirth: A qualitative study', *Women and Birth*, vol. 24, pp. 122—128 (see Appendix 9).

> This was the first paper published using data from this thesis. I was responsible for the concept of the paper, and undertook all data collection and analysis. I wrote the first draft of the paper and responded to comments from my co-supervisors on subsequent drafts. I was responsible for the final version, the response to reviewer comments and the final copy-editing with the journal.

Catling-Paull, C, Foureur, M.J, Homer, C.S.E. 2012, 'Publicly-funded homebirth models in Australia', *Women and Birth,* vol. 25, iss. 4, pp. 152-8 (see Appendix 10).

> I collaborated on the idea for this paper, and took a lead role in writing. I was responsible for the data collection and analysis of the data.

McMurtrie, J, **Catling-Paull, C**, Teate, A, Caplice, S, Chapman, M. & Homer, C. 2009, 'The St George Homebirth Program: an evaluation of the first 100 booked

women', *Australian and New Zealand Journal of Obstetrics and Gynaecology*, vol. 49, no. 6, pp. 631-636 (see Appendix 8).

My role in this paper was analysing the data and writing the first draft of the paper, working on subsequent drafts and the final version. I worked with the team to respond to reviewer comments. .

Catling-Paull, C, Coddington, R, Foureur, M.J, Homer, C.S.E. 'Publicly-funded homebirth in Australia: an evaluation of maternal and neonatal outcomes' submitted to a peer reviewed journal November 2012 (see Appendix 11).

My role in this paper was one of collaboration in forming the concept, and I took a primary role in the writing, data collection and analysis. The paper has been submitted but we have not as yet received comments. I will take a lead in this when the comments return.

PRESENTATIONS

The presentations listed below are in addition to the annual UTS Faculty of Health Research Student Forum presentations given throughout my PhD candidature.

***Catling-Paull, C**. Preliminary results from the PhD study: Exploring the influences on women who choose a publicly-funded homebirth, *Australian College of Midwives 16th National Conference, 'Midwives & Women: a brilliant blend'*, Adelaide Convention Centre, South Australia, September, 2010.

Catling-Paull, C. Participation in a panel (with questions from the audience) about publicly-funded homebirth, *27th Homebirth Australia Conference 'Challenging the Boundaries'*, Newcastle, NSW, August, 2011.

***Catling-Paull, C**. 'Exploring the influences on women who choose a publicly-funded homebirth: the results of a PhD study', *Australian College of Midwives 17th National Conference, 'a Midwifery Odyssey'*, Australian Technology Park, Sydney, NSW, October, 2011.

TERMS AND 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
BBA	A baby 'born before arrival' in hospital, usually for a planned hospital birth
BC	Birth Centre: A home-like place of birth either within a hospital, or free-standing, predominantly run by midwives
BMid	Bachelor of Midwifery: A 3-year undergraduate degree course in midwifery
Freebirth	A planned homebirth without health practitioners present
GP	General practitioner
Homebirth	A planned homebirth with a registered health practitioner
MBS	Medical Benefits Scheme: The Australian public health insurance system
MSR	Maternity Services Review: A national review conducted in Australia funded by the federal government (2008-2009)
NHS	National Health Service: Public health system in the United Kingdom
NMBA	Nursing and Midwifery Board of Australia: The regulatory board

	of nurses and midwives in Australia
PBS	Pharmaceutical Benefits Scheme: Public funding of health-related tests, investigations and medications
PPH	Postpartum haemorrhage
PPMs	Privately practising midwives: Registered midwives who provide care during pregnancy, labour and birth and the postpartum period (or a combination of some of these) within their own private practice
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists: The professional body for obstetricians and gynaecologists
RCOG	Royal College of Obstetricians and Gynaecologists
RCT	Randomised controlled trial
RN	Registered Nurse

CHAPTER 1: INTRODUCTION

Giving birth at home is not a common choice amongst women in many parts of the western world. Gradually, over the last century, society accepted childbirth in a hospital as being normal practice, whereas historically, homebirth was the norm. In some countries (notably some Canadian provinces), it was, for some time, illegal to practice midwifery outside a hospital, which also effectively outlawed homebirth (Canadian Midwifery Regulators Consortium 2010). Societal beliefs surrounding homebirth are often polarised; there are strong feelings of it being a dangerous and irresponsible choice - views held by some health professionals (Royal Australian & New Zealand College of Obstetricians & Gynaecologists 2011a), and many groups who support homebirth as a viable birth place (American Pregnancy Association 2011; Homebirth Australia 2011; National Childbirth Trust 2011). Pregnancy and birth are now widely thought of as inherently risky business, and as such, the modern day wider community have been led to believe that hospital birth is the safer option (Fordham 1997; Pitchforth et al. 2008).

There are a diversity of views regarding childbirth internationally (Kirkham 2010; Pilley Edwards 2000; Queensland Government 2012). Despite the strong presence of midwifery in maternity care, questions remain on issues of safety and who should provide care (obstetricians or midwives), and in what setting (hospital, Birth Centre or home). The use of evidence in maternity care is often contested and divisive, and strong opinions and culturally-led practices often underpin community beliefs (MacColl 2009; Pesce 2009). MacColl states that different disciplines have different opinions that are supported by sections of the available evidence, and that the politics of power and control pervade the interpretation of research. This can also be seen in maternity care providers, where medicine and midwifery have historically had different perspectives on many issues of maternity care. Nowhere have the challenges in development and use of evidence been more concentrated and contentious than in the

practice of homebirth (Gyte et al. 2010; MacColl 2009; Nolan 2010). Despite these controversies, publicly-funded homebirth services have started in Australia. This will be the topic of this thesis. In particular, the decisions and choices of the women will be examined.

This chapter will state the aim, the research question, and give a background to the study by outlining the history of midwifery regulation and education in relation to homebirth practice, and discussing issues of medical dominance and birthplace. This chapter will also discuss relevant government reports and practice recommendations that have led to the development of publicly-funded homebirth models of care in Australia. First it is necessary to outline the health care system of Australia.

THE AUSTRALIAN CONTEXT

As this study was undertaken in Australia, a brief understanding of the context of maternity care is necessary. The health care system in Australia comprises of both private and government run institutions. Australian citizens can access free medical care through the public health insurance system known as Medicare, which is income tax levied and government funded. Maternity care consists of free obstetric-led care in public (government) hospitals, midwifery-led care in hospitals and birth centres (which may or may not be attached to a hospital), and independent midwifery care – which is essentially a private arrangement between women and midwives who work in this capacity. General Practitioners also provide antenatal 'shared' care in collaboration with midwife or obstetric-led care in hospital, or in rural areas, provide all the maternity care. The private health care system is funded by health insurance organisations, and the Australian government encourages individuals with tax incentives to take out private health insurance and access this system if their income is above a set level. A proportion of women requiring maternity care will access care from obstetricians who work in private hospitals. They will predominantly see the obstetrician during pregnancy, and are cared for in a private hospital by midwives and the obstetrician. There is usually a gap between the obstetrician's fee and the rebate from the private health insurance. Currently 30.2% women access private hospitals for maternity care, 70.1% access public hospitals

(midwifery-led and obstetric-led care) (Li et al. 2012), and less than 1% women engage the care of an independent midwife.

The women who seek privately practising midwives (PPMs), ostensibly for homebirth, pay the midwife directly for her care (approximately $5,000). This amount is similar to the out-of-pocket expenses necessary for private obstetric care, but fees vary widely around the country. Currently, very few private health insurance companies will cover part of the cost of a homebirth in Australia.

Many Australian hospitals now offer midwifery-led care. This type of care has midwives as the lead maternity carers in the organisation and delivery of care given to women throughout pregnancy, birth and the postnatal period (Hatem et al. 2008). Midwifery-led care can be organised in a number of ways. Within antenatal clinics there are groups of midwives who work in teams and care for women throughout the antenatal, intrapartum and postnatal periods, and other teams that will provide care for a group of women antenatally and postnatally (Australian Health Ministers Advisory Council 2008). Some midwifery teams may be set up to care for predominantly low-risk women, whilst others may care for women of all levels of risk, in collaboration with the obstetric medical staff and allied health team.

Many hospitals in Australia will have a ‘midwifery group practice’ which provide caseload care to women. Midwives working in a caseload model of care will have a finite number of women booked to care for each month (often in collaboration with another midwife), and be responsible for planning, referring to other professionals as appropriate, and ensuring provision of care within a hospital, Birth Centre or community setting. Midwives work with a second midwife, or within a small team, and each woman has a primary and a second back-up midwife (Dahlen, Barclay & Homer 2010).

Caseload models provide women with continuity of care and carer, have favourable maternal and neonatal outcomes (Benjamin, Walsh & Taub 2001; McLachlan et al. 2012), and high satisfaction rates from women (Johnson et al. 2003; Williams et al. 2010). Midwives working in these models also have high

satisfaction rates (McLachlan et al. 2012), although some midwives dislike being on-call for women in labour (Collins et al. 2010). Midwifery-led care has been shown to have good outcomes in a systematic review (Hatem et al. 2008). Despite the good outcomes and desirability of these models, few women in Australia are able to access midwifery-led caseload models and other continuity models. In Australia, 2.2% women are recorded as having given birth in a Birth Centre and 0.5% at home (Li et al. 2012). Future hope for women accessing these models is varied, for example, the Queensland government has a future commitment to providing midwifery continuity of care to only 10 percent of women (Queensland Government 2012), whereas in NSW, the aim is 35% (NSW Health Department 2010). It is not known how many women access a continuity of care model of care, however it is likely to be less than 10%. Even fewer women have access to a model that incorporates a publicly-funded homebirth option (Catling-Paull, Foureur & Homer 2012).

PUBLICLY-FUNDED HOMEBIRTH PROGRAMS

Publicly-funded homebirth programs are hospital-based models that often evolve out of birth centre/caseload midwifery-led models of care. Currently there are 15 publicly-funded homebirth programs around the country (Catling-Paull, Foureur & Homer 2012). They vary in size from being small services with 4-5 midwives to large practices that employ over twenty midwives. A recent survey undertaken in conjunction with this thesis on the set up of publicly-funded homebirth services in Australia found they utilised many common strategies to develop their service (eg. multidisciplinary and consumer consultation), but had notable differences in data collection and policy criteria (Catling-Paull, Foureur & Homer 2012). Women accessing the services were required to be at low risk of obstetric complications (as defined by the Australian College of Midwives 2008) although there were slight local differences. Women were cared for by a small number of midwives (often two) and as such had continuity of care and carer. Antenatal care within a publicly-funded homebirth program comprises of a combination of hospital clinic and home visits. Support partners and people planning to be at the homebirth are included in the preparations by the midwives caring for the woman, and explanations are given regarding the processes of hospital transfer, should it be necessary, and the midwives role

and scope of practice. Should obstetric complications occur in the antenatal period, most services continue to care for women in collaboration with obstetricians, and women would plan to give birth in hospital if they remained outside of the criteria for suitability for a homebirth. Similarly, should an intrapartum hospital transfer be necessary, the primary midwife caring for the woman would remain the lead carer when in hospital, providing seamless continuity of carer from home to hospital. Hospital policy frameworks ensure low-risk healthy pregnant women are given the choice of birthplace (including publicly-funded homebirth where available), whereas those women with higher risk pregnancies are advised to have more obstetric-led care due to the higher likelihood of complications necessitating medical intervention.

In 2005, St. George Hospital became the first hospital in NSW to have a publicly-funded homebirth model after two years of planning (Minister of Health NSW 2005) (St George Hospital is in the southern suburbs of Sydney, see map in Appendix 14). The two years of development involved much negotiation with governmental legal teams and the creation of policies and documents. The multidisciplinary consultative process and delays in acceptance of the required documents also contributed to the long developmental phase (Homer & Caplice 2007). Operated through the Birth Centre by midwives, this service has cared for approximately 150 women having a homebirth to date. Similar models in NSW have since been developed in the Hunter New England Health Service, the Illawarra, Northern NSW and central Sydney (Royal Hospital for Women, Randwick). Existing models have been in operation for a number of years in South Australia (Northern Women's Community Midwifery Program), Northern Territory and Western Australia (Community Midwifery Program) (Catling-Paull, Foureur & Homer 2012; McMurtrie et al. 2009). More recently, services have been developed in Bunbury in Western Australia and Victoria (Casey and Sunshine Hospitals).

There was a lengthy planning period for the homebirth model at St George Hospital. This involved an initial application in 2003 to the NSW Health Treasury Managed Funds (NSW government health insurer) for professional liability insurance for midwives through the public health system, and the provision of

clarifying documents ensuring safety and quality. The set-up involved satisfying legal requirements, and developing documents relating to the criteria for booking women for homebirth, provision of consent forms, and clear understanding of transfer requirements, not only from the woman herself, but from other people who were planning to be present at the birth. Specific details regarding the mentoring process of midwives, and the safety of individual women's homes to provide optimal working environments were also covered, amongst others. The Area Health Service funded extra equipment and the salary for a part-time project Clinical Midwifery Consultant for Practice Development over a two-year period and plans were made for the service to exist under current maternity unit funding. The St George Hospital Homebirth model has been favourably evaluated although the numbers were small (Homer & Caplice 2007; McMurtrie et al. 2009).

My study explored the influences on women who chose a publicly-funded homebirth at St George Hospital. I chose this because of my personal interest and experience of homebirth, and because I felt it is often mistakenly construed as a birthplace choice of women who are misinformed or extreme in nature. I also chose this subject because of the relative rarity of homebirth in Australia and the new development of publicly-funded homebirth programs around the country which were largely unstudied. After working for many years in a maternity unit that developed a homebirth program in 2005, I observed anecdotally that some women who chose this model often did not originally intend to have a homebirth from the outset of their pregnancies. Many of these women appeared to plan their homebirth at a later gestation, and report high levels of satisfaction with the service (Homer & Caplice 2007).

There were also a number of personal reasons why I chose to study homebirth. Having had personal experience of my son's homebirth shortly after arriving in Australia in 1995, and midwifery experience in the United Kingdom (UK) (which included attending publicly-funded homebirths) and Australia, my interest grew as it became evident that there were barriers to homebirth, yet a similar number of women choosing this birthplace each year. Prior to the development of publicly-funded homebirth programs, women had to employ PPMs to support

them. However, from personal experience and wider anecdotal evidence, arranging this care took a level of determination and strength on behalf of the woman, as private midwifery practice is outside of the normal maternity care pathways in Australia and also costly. Within my own workplace, the set-up of the publicly-funded homebirth program enabled an easier access to homebirth for women. This led me to investigate what the influential factors were on women who chose a publicly-funded homebirth.

AIM OF THE STUDY

This aim of this study was to explore the influences (internal and external) on women who choose a publicly-funded homebirth. The study also investigated women's decision-making regarding publicly-funded homebirth, the level of women's prior knowledge of homebirth, and the people around them that affected their choice. By undertaking a detailed study of women's decision-making surrounding publicly-funded homebirth, it was expected that a greater insight into how and why women make these decisions will be gained.

RESEARCH QUESTION

The question posed in this study was: what influenced women to choose a homebirth within the publicly-funded model of care at St George Hospital?

JUSTIFICATION

Providing midwifery continuity of care, informed choice, and services that give the option of homebirth can increase the rates of homebirth to as high as 50% (Sandall, Davies & Warwick 2001). This high homebirth rate was found in the evaluation of the Albany Midwifery Practice in London (Sandall, Davies & Warwick 2001) where innovative woman-centred practices supported the 'normality' of childbirth (this is expanded upon in Chapter 2). The report by Sandall et al. showed that accessible and appropriate care, combined with the provision of information, continuity of carer and choice of birthplace were essential to the facilitation of normal birth, lack of intervention in labour, and high homebirth rates in particular. In a similar way, publicly-funded homebirth programs such as the program at St George Hospital facilitate normal birth. This

said, most women in Australia continue to choose to have a hospital birth, of which a large percentage opt for an obstetric-led service, despite there being no indication for medically oriented care. It was possible that the women who chose a hospital led homebirth program had different reasons and influences to those that gave birth outside the system. Often women choosing a PPM want no hospital involvement at all unless there is an emergency whereas women accessing a publicly-funded program were accepting its involvement by default. Overall, there was a need to find out why and how women chose to have a publicly-funded homebirth.

The publicly-funded homebirth service at St George Hospital caters for low risk women who choose to give birth at home (Homer & Caplice 2007; McMurtrie et al. 2009). The fifteen similar models within Australia are all relatively unstudied, except for some evaluation reports (Centre for Clinical Effectiveness, 2011; Hider 2011; Homer & Caplice 2007; Homer & Nicholl 2008; McMurtrie et al. 2009; Nixon, Bryne & Church 2003; Thiele & Thorogood 1997). There have been no studies undertaken on the influences on women who choose a homebirth within a publicly-funded homebirth model in Australia. This study will benefit midwives and managers embarking on the development of publicly-funded homebirth services. It will provide data on why women have chosen to utilise the service and what factors comprised their decision-making in order for organisations to provide services that are functional, accessible and effective. In addition, this study will highlight publicly-funded homebirth programs and contribute to their further development around the country. In turn, more services will enable an increase in women's choice of birthplace, which will not only facilitate normal birth, but ensure women and their families have a safe transition to parenthood through care that is both best practice and woman centred. In order to understand the importance of birthplace, it is important to outline the history (or her-story) of midwifery and homebirth.

BACKGROUND TO THE STUDY

MIDWIFERY IN HISTORY

Midwives, in some form, have been attending women for many thousands of years, mostly at home. Some of the oldest records available are childbirth texts written in the first century which have biblical reference to a twin birth attended by a midwife (Genesis 38:27-30) and clay tablets and papyrus records describing birth attendants and their practices around 1700 BC (Dempsey 1949). Midwifery skills were usually shared by women with no formal education until the 1900s (Barclay 2008). Homebirth practice is historically linked to midwifery and the history of midwifery. At the beginning of the twentieth century in Australia, midwives and women's neighbours were the most likely birth attendants for women giving birth at home (NSW Midwives Association 1984). This section provides a truncated history of Australian midwifery and its relationship to current homebirth practice. An outline of the history of homebirth in Australia is necessary to set the context for the present day, and explain the changes in societal knowledge and acceptance of homebirth in particular. The importance of regulation and education of midwives, and the medical dominance of childbirth throughout the last century towards homebirth will be explained. This is important as all these factors impacted on homebirth rates and practice, and relate to how homebirth is perceived and practiced today.

REGULATION OF MIDWIVES

Prior to the beginning of the last century, midwifery in most countries was disorganised and unregulated; anybody could call themselves a midwife and set up practice (Leap & Hunter 1993). It became important to regulate midwives and develop some educational and professional standards to ensure a level of education and knowledge within the profession which would safeguard women and their babies. This was discussed by Brodie and Barclay (2001) in their examination of Nurses' Acts, regulations and current policies that had a bearing on midwifery in Australia. This paper uncovered how the discrepancies and inadequacies of education standards, and the inconsistencies in policy all contributed to the 'invisibility' of midwifery, which had been steadily occurring since the 1920s. In the early 1900s, similar processes towards midwifery

regulation were occurring in the United Kingdom (UK), Europe, United States of America (USA), Canada and Australia. The regulation affected the practice of many lay midwives (who were likely to have been attending the majority of homebirths at this time), by rendering their unregistered practice illegal because they had no formal qualifications in which to be able to formally register as a midwife. However, there was a degree of social pressure and reform groups lobbying for the provision of improved maternity care for the poor and formal training and licensing and for these midwives (Bogossian 1998).

In Victoria, in Southern Australia, in the early 1900s, a ‘baby bonus’ of five pounds was introduced that allowed women to select a doctor to care for them. Willis (1983) notes that in order to receive the baby bonus it was mandatory that mothers had their birth overseen by a doctor. Because of this, women’s birthplace was more likely to be in a hospital setting, although some doctors did support and practice homebirth. This monetary bonus however, was likely taken up by many women which would have further contributed to a falling homebirth rate.

In Australia, Tasmania was the first state to formally regulate midwifery after the introduction of the Midwives Act of 1901. NSW regulated in 1923, and by 1929 midwives in all Australia’s states and territories were regulated under a Board of Nurses. Midwifery was seen as a specialty of nursing, and midwives were identified as ‘nurses’ and overseen by nurses (Brodie & Barclay 2001). Up until the late 1990s, midwifery education programs were instructed to have a ‘nursing focus, and required midwifery teachers to have a nursing background (Brodie & Barclay 2001). Only recently (in 2010) has the national registration in Australia taken effect allowing midwives to be distinct from nurses (Nursing and Midwifery Board of Australia 2012). This has been important in defining the profession, and has also recognised the growing number of midwifery graduates who have completed a direct-entry Bachelor of Midwifery program that is separate from nursing.

All registered midwives in Australia are now regulated by the Nursing and Midwifery Board of Australia governed by the Australian Health Practitioner

Regulation Agency (AHPRA 2012). In order to register each year to practice midwives need to state their compliance with the Australian Nursing and Midwifery Councils Competency Standards for the Midwife (ANMC, 2006b), the Code of Professional Conduct (ANMC, 2006a) and the Code of Ethics for Midwives (ANMC, 2008). In addition, midwives have to state attendance of at least 20 hours of continuing professional development (CPD) activities each year. There is no recording on the register of midwives who work in a homebirth service, whether privately or within a public hospital, though this data is now being collected through an annual survey.

The regulation processes during the last century, although important and necessary, may have played a part in reducing the number of lay midwives who fell outside the registration boundaries. This together with many other factors (discussed below) in turn lowered homebirth rates as many lay midwives worked predominantly in the practice of homebirth. Today, similar regulatory and legislative processes have also shown the potential to lower homebirth rates due to the inability of midwives providing a homebirth service to have professional indemnity insurance (Dahlen et al. 2011b). This is because most midwives in private practice work wholly with women having a homebirth, and many may find the risks of practising without professional indemnity insurance too high and leave the workforce. Professional indemnity insurance has been a significant issue for midwives providing homebirth in Australia.

PROFESSIONAL INDEMNITY INSURANCE FOR HOMEBIRTH

Midwives have to meet a number of registration standards as part of being on the national register. One of these standards is the necessity to hold professional indemnity insurance (PII). Under section 129 (1) of the Health Practitioner Regulation National Law, a health practitioner must not practise the health profession in which the practitioner is registered unless there are appropriate PII arrangements. Most registered practising midwives are covered by insurance through their employer. However, privately practising midwives have to purchase their own PII which covers antenatal and postnatal care and presently there is only one source of insurance available that covers intranatal care in a ‘clinical setting’ (i.e. hospital). Currently there is no PII product that

covers homebirth, which has been a source of discontent amongst the profession and women requiring homebirths in Australia (Dahlen 2010).

The lack of PII for midwives who practice homebirth stemmed from the collapse of the Health International Holdings (HIH) Limited insurance company in 2001. This was not related to homebirth and was more a global downturn combined with issues within the insurance industry. This was the largest insurance company collapse in Australian history, with liquidators estimating losses of around 5 billion dollars. The following Royal Commission enquiry explained the far-reaching consequences of the collapse, which included impact upon individuals, the wider community, building and health industries (Commonwealth of Australia 2003). The collapse of HIH meant insurers developed an increased sensitivity to risk, and subsequently, in their judgment, included homebirth cover for midwives a risk that was too high. Of particular concern was the small number of privately practising midwives, meaning it would only take one legal case to make it unviable for the insurance company.

In September 2010, the Australian Health Ministers' Council provided an exemption from the requirement for privately practising midwives to hold PII for a period of two years (NSW Consolidated Acts 2010) allowing midwives to continue to provide a homebirth service. Recently this has been extended to June 2015; the result of lobbing from community consumer groups, such as the Maternity Coalition, Homebirth Australia and the professional body for midwives, the Australian College of Midwives. The Nursing and Midwifery Board of Australia (NMBA) required that midwives working under this exemption had to comply with three particular working conditions. These were that midwives had to ensure they gained informed consent from women (including sharing that women were aware of the absence of PII); they had to share their perinatal data with relevant state/territory authorities; and work within the quality and safety framework of the NMBA. The latter requirement requested that midwives adhered to the professional codes and guidelines that were in place at the time – for example, the National Midwifery Guidelines for Consultation and Referral (Australian College of Midwives 2008).

The absence of PII for privately practising homebirth midwives has likely contributed to the fall in numbers of midwives working in this capacity and impacted homebirth rates, although accurate figures are unavailable. Ultimately, the lack of PII for independent midwives has the potential to increase the marginalisation of homebirth, and in the absence of widespread publicly-funded homebirth programs, increase the rate of freebirth[1] in women who cannot find a midwife to help them have a homebirth (Dahlen, Jackson & Stevens 2011; Jackson, Dahlen & Schmied 2012). One of the alternatives to the difficulties the lack of PII causes, is publicly-funded homebirth. It is important to note that the first publicly-funded homebirth services in Western Australia were set up prior to the insurance collapse of HIH that triggered the difficulties for midwives to obtain PII. To explore the influences on women who choose a publicly-funded homebirth will assist with the increase in profile of this model of care and help towards maintaining the option of homebirth to women.

MIDWIFERY EDUCATION AND HOMEBIRTH

Midwifery education is essential to good practice and the promotion and maintenance of normal birth, to which homebirth is closely linked (Vedam, Goff & Marnin 2007). In Australia, privately practising homebirth midwives need to be registered as a midwife, and comply with the educational requirements of the AHPRA (explained previously on pages 10 and 11) to maintain their registration. They will have varying degrees of midwifery experience, and can, in theory, set up practice as soon as they gain their registration. Conversely, midwives working within a publicly-funded homebirth service often have a high level of education and midwifery experience, and to be eligible to work in a publicly-funded model they need to demonstrate competence in many areas. These are maternal and neonatal resuscitation, cannulation, and obstetric emergencies such as post-partum haemorrhage. They also need to have experience in midwifery-led care as well as a philosophy of care that facilitates normal, natural birth (Catling-Paull, Foureur & Homer 2012). There have been a number of different systems of midwifery education in place in Australia that have affected the philosophy and practices of midwives over the years. This

[1] A homebirth intentionally planned to be unattended by midwifery or obstetric personnel, or any other registered professional healthcare provider

section will give an overview of the education of midwives during the last century, and how this may relate to homebirth practice.

In the last two decades of the nineteenth century, Australian midwifery education consisted of hospital-based programs. The first hospital to train midwives in Australia was in Melbourne in 1877 and by 1907, there were four midwifery training hospitals in NSW (Barclay 2008; Fahy 2007; NSW Midwives Association 1984). The trained 'hospital midwives' or 'midwifery nurses', as they were known, had a different status from the experienced 'lay' midwives, as those who were already trained nurses had shorter training than the 'direct-entry' candidates. Willis argued that it was preferred within medically-dominated (that is, male-dominated) hospitals that midwives were Registered Nurses (RN) first in order to maintain an element of subordination (1983). Often, RNs gained a midwifery registration certificate to be able to work in rural or remote communities, or for career advancement – not necessarily because they wanted to work as midwives. Throughout the twentieth century it became very common for midwives to have a nursing background, although limited direct entry training (midwifery training without being a RN first) was available in Australia until 1977 (Barclay 1985). The direct-entry program ceased to operate largely due to the mainstreaming of the medical model[2] of childbirth at this time, and the push for prerequisite RN training. The medicalisation of childbirth (discussed below) would have likely had an impact on homebirth practices at this time, ostensibly because most midwives were already RNs, and had knowledge and grounding in the medical model of care, predominantly based in hospitals.

Midwifery training in Australia moved along in a parallel fashion with nursing. In 1984, the Federal Government proposed nurse training move to a tertiary setting, and midwifery training remained a post-nursing qualification set within university nursing schools. This well-established subordination of midwifery within nursing gave rise to a number of concerns regarding the ability of midwives to work within the new midwifery-led models of care that were being developed at the time (Centre for Epidemiology and Research 2011). A few

[2] A medical model of childbirth is a philosophy focusing on the management of pregnancy and birth, its technological aspects and interventional practices, as opposed to viewing birth as a natural physiological process.

years later, the Australian Midwifery Action Project (AMAP) report provided strong evidence of inconsistencies in quality of midwifery education around the country (Barclay, Brodie & Tracy 1999; Leap 2002). This and the growing concern over an inadequate midwifery workforce stimulated the need for midwifery education to be separate from nursing – the Bachelor of Midwifery (BMid) degree. After much commitment and determination from the Australian College of Midwives, BMid programs began operating in South Australia and Victoria in 2002, followed by NSW in 2004 (Centre for Midwifery Child and Family Health 2004).

Currently in Australia, BMid programs, as well as the Graduate Diploma courses for Registered Nurses, are available in all states and territories except Tasmania. Double degrees incorporating nursing and midwifery are also offered and popular (Preston 2009). Other countries have also reintroduced direct entry programs. In the UK, these programs began in 1989 (Department of Education Science and Training 2001) although, unlike Australia, midwives have always been regulated under a separate register to nurses. The USA and Canada began accrediting direct entry programs in 1996 (Midwifery Education Accreditation Council 2009; Rooks & Mahan 1999), and in Canada, after a period of midwifery practice being deemed illegal, this is now a popular and sought after way of training (de Vries et al. 2001). Some states in Canada, in particular have since developed a strong homebirth practice; for example in Ontario, around 20 percent of midwife-attended births are at home, although overall homebirth rates are lower (College of Midwives of Ontario 2011). Other countries in Europe have had ongoing direct entry programs and have always recognised independent and autonomous midwifery practice. In particular, the Netherlands has a strong history of community-based midwifery practice, with around 25% of women giving birth at home (van der Kooy et al. 2011).

In recent years there has been a clear reversal of trends in developed countries for midwifery training to be related to prerequisite nurse training. This has been acknowledged by some as a move away from an ‘obstetric nurse’ focus (Bluff & Holloway 2008), and may be a positive step towards a more self-regulated approach in midwifery which can only serve to improve the profile of homebirth

in the future. One of the more prevalent philosophies taught to midwives nowadays is to work in a 'woman-centred' way; this is discussed further in Chapter 6. The next section will discuss the historical factors that have contributed to the controversies in birth place over the last century.

CONTROVERSIES AROUND PLACE OF BIRTH

Controversies around place of birth are important to examine in order to place in context the position of midwifery in history and the relationship with homebirth practice. This section will also discuss the sociological and legislative issues that reduced the prevalence of homebirth up to the twenty-first century, the medical dominance of childbirth, and the approaches to maternity care. Most literature detailing these events is focused on the United Kingdom (UK); this is important to include as it can be argued that sociological and legislative events from 1800s to the early 1900s in Australia would have been heavily influenced by policy in the UK given the numbers of British migrants at this time and the fact that Australia was a British colony until 1901.

SOCIOLOGICAL AND LEGISLATIVE FACTORS

There were a number of sociological and legislative factors that had a strong influence on the status of midwifery and effectively halved the numbers of women seeking homebirth over the last century (Anthony et al. 2005; Barclay, Brodie & Tracy 1999; Catling-Paull, Foureur & Homer 2012). In the UK, USA, Canada and Australia in the early twentieth century, most babies were born at home (Jackson & Bailes 1995; Mason 1987). Antenatal care was in its infancy and hospital-based midwives, with limited training, usually only cared for women with complicated pregnancies. Lay midwives were still active in the community and would attend women at home who could not afford the services of a trained midwife or doctor (Raisler & Kennedy 2005).

One of the factors that heavily influenced the practice of homebirth was the general lack of opportunities for women and sexual discrimination during the late 1800s and early 1900s. Prior to the widespread acceptance of research-based evidence to guide decisions, health policy was determined by the 'expert'

opinion of medical practitioners. Assisted by their male gender, educational opportunities and class, medical practitioners became particularly influential within governmental spheres, and their opinions held much weight within parliament in the 1800s and 1900s (Tew 1998). A strong patriarchal society existed at this time where men far outweighed women in positions of power, and women were socially, educationally, and legally disadvantaged (Oldfield 1992). For example, after Australian universities began educating women in the 1880s, some female post-graduates were prevented from practising; medical graduates were not accepted to work in some hospitals and female law graduates could not be admitted to the bar until 1918 (Oldfield 1992). The all pervading acceptable social construct was that men could be in the public arena (the workforce), whereas women should remain in the private arena (essentially home duties, childrearing). Boys were given more educational opportunities than girls and automatically given greater salaries than women, often because women were simply blocked from being employed in 'male' occupations and were not allowed to join trade unions (Oldfield 1992). Equity in voting rights (although some states still excluded Aboriginal women) in Australia was achieved over a period of years with South Australia first granting women the right to vote in 1894. Western Australia gave women the vote in 1899, NSW in 1902 and finally Victoria in 1908 (the Northern Territory was not recognised as separate from South Australia until 1911). Australia led the world in granting political rights to women, although it was not until 1926 that women were able to both vote and stand for all Houses of Parliament in all parts of the Commonwealth.

Hence it can be seen that equality with men was a long fought battle, and really only the beginning of sweeping social change regarding women and women's issues during the twentieth century. Midwifery, being predominantly a female occupation, was not immune to the discriminations and subordination present in this patriarchal society. Contributing to the low profile of midwifery in the UK in the early 1900s was a lack of midwifery leadership and the Midwives Act, 1902 (which introduced compulsory registration) that did not give professional autonomy but ensured midwives were supervised by boards of medical men (the General Medical Council). This male-dominated hierarchical structure had

far-reaching implications and influence on midwifery practice, and homebirth into the twentieth century. One of the major factors that reduced the profile of midwifery and homebirth was the rise of medical dominance in maternity care.

MEDICAL DOMINANCE OF MIDWIFERY

The unification of the medical and nursing fraternity had an impact on midwifery and homebirth in the UK in the first half of the twentieth century. Prior to this, in the middle 1800s, the medical fraternity became more organised and amalgamated apothecaries, physicians and to some extent the 'men-midwives' under the 1858 Medical Registration Act. This provided a more regulated medical 'profession' that then sought to regulate other health practitioners in a similar way. An Act mirroring this was introduced in Australia shortly afterwards (Willis 1983). In the UK, Donnison (1977) explains that at this time there were differing opinions on delineating roles for midwives debated by the GPs and obstetricians. The GPs were keen that midwives had a minimal role similar to an obstetric nurse, and obstetricians (not having such a direct threat to their livelihood) felt they should be registered to attend only normal births. In particular, General Practitioners, whose practices often encompassed large rural areas, voiced fervent opposition to the Midwives Bill tabled in the 1890s. One GP stated that the Bill (proposing better education for midwives, a need to attract better educated women to the profession and to generally improve their position) would make GPs extinct by robbing them of their income and likened it to how dentistry had been taken away from physicians by its separate registration in 1878 (Donnison 1977). Tew (1998) and Donnison (1977) explain an effective campaign predominantly by medical staff (and 'men-midwives' as far back as the late 1700s) which led women to think their pregnancy was inherently dangerous, and that by engaging medical care, the danger could be overcome. Tew explained, 'since the prosperity of doctors concerned with maternity care is vitally dependent on this belief, it is understandable that they should make great efforts to propagate it' (1998 p. 5). Other reasons contributing to the move towards hospital birth during this time were the closure of many cottage hospitals during the depression, the Nightingale nursing philosophy of 'subservience' (Barclay 2008) and the escalation of the status of doctors in the community. The undermining of midwifery and women's

confidence in their ability to bear children would lead to fewer births taking place at home, and a steady increase in medically-managed births within hospital (Barclay 2008).

In Australia, a similar decline in midwifery and rise in medical dominance, assisted by unification with nursing, occurred at this time (Fahy 2007). Both legal and disciplinary power were used to effectively discredit the practice of midwifery. This was effected by apportioning blame for the level of perinatal deaths and puerperal sepsis to midwives citing their lack of cleanliness, which Fahy notes was likely to be seen as plausible by society at the time as lay midwives were often of a lower class, which carried a stigma of being 'unclean'.

PERINATAL MORTALITY RATES IN THE 20TH CENTURY

Another factor that appeared to be in favour of hospital birth was the declining perinatal mortality rate reported in the twentieth century in the UK and Australia (Archer 1963; Tew 1998). There was a correlation between lower perinatal mortality rates and a higher number of women attending hospital for maternity care and this provided fuel for the medical profession to attribute the rates to their care in a hospital setting. Upon examination, Tew (1998) argues this was coincidental and factors such as the improvement in nutritional and living standards at this time were more influential. In the UK, maternal and neonatal mortality rates did not reduce significantly until 1935-50 when drugs such as sulphonamides (synthetic antimicrobial agents), penicillin and ergometrine were introduced, and other factors such as improved and more widely available antenatal care, the availability of blood transfusions, and a surge in the standard of living and nutritional state of the population occurred (Loudon 1992).

Similarly in Australia, sanitary standards, drainage and sewerage, hygiene standards, more refined surgical aseptic techniques and antibiotics, as well as vaccines were introduced which had a positive effect on morbidity and mortality. Gandevia (1978) relates how Australian reports vary in their reliability at the beginning of the century, but Litchfields's comprehensive review in 1909 relates how infant mortality rates (from birth to 12 months of age) were between 9-12% (of all births) between 1860-73 (cited in Gandevia 1978). The rate of infant

deaths then decreased after 1903 to around 8% by 1909, although there were significant differences between metropolitan and more rural areas. For example, notable differences were apparent after sewage systems in metropolitan areas were established and the supply of water and milk improved.

In the middle of the twentieth century, Archer (1963) reported the average annual stillbirth rate showed a steep decline in NSW from 29 per 1000 births in the period 1936-40 to 15 per 1000 births in 1956-60. This early data is likely to be inaccurate for a number of reasons: underreporting (especially in rural and remote areas), and differing definitions of stillbirth in each state and territory at this time. More specific national data on perinatal mortality at this point in history in relation to place of birth is not available. However, the data does show that the steady decline in perinatal mortality in the twentieth century is probably unrelated to the rise in hospital-based birth.

As discussed, the reduction in the perinatal mortality rate that accompanied more women having babies in hospital contributed to a pervading assumption that it was safer for all women to have their babies in a hospital than at home. This paralleled society's embracement of technology and medical discoveries that proliferated at this time, particularly in the 1940-60s. It also may have had influence over the acceptance of many interventional obstetric practices that began to occur in hospitals and the divide in the philosophy and approach to midwifery care.

PHILOSOPHICAL APPROACHES

Local attitudes and philosophies can be strongly influenced by the way in which maternity care is modeled and delivered. In Australia, as in many westernised countries, two extremes of approach are apparent in current maternity care. These are the medical (or 'technological', 'biomedical' or technocratic') approach and the social (or 'humanising') approach (Davis-Floyd 2001; Downe & Davis-Floyd 2004; MacColl 2009). Generally the medical approach focuses on curing ill health and averting risk situations through the use of technology, whereas the social approach is characterised by the maintenance of well-being

and enhancing normal physiological processes with minimal intervention. The medical approach is criticised for objectifying people and focusing on body parts instead of practicing in a more holistic way, taking into account psycho-social and emotional factors (Sandall et al. 2010; Seefat-van Teeffelen, Nieuwenhuijze & Korstjens 2011). It is possible that midwives working with women in homebirth models adopt a woman-centred and social approach due to the structure of their service (which incorporates continuity of care), but also because they have a personal philosophy that reflects this way of working. However, most hospitals remain medically dominated – which has been recognised as one of the reasons women choose a homebirth (Boucher et al. 2009).

MEDICAL DOMINANCE OF POLICY

Medical dominance of maternity policy has been visible within recent years, argue Dahlen et al. (2011b). Despite a strong push from consumers for maternity services to provide more choice of birth place, there remains a level of opposition from some medical colleagues for this to occur. Dahlen et al. (2011a), in their analysis of the 832 submissions from consumers to the Maternity Service Review (MSR) in 2010, stated how women requested Birth Centres that were midwife-led, had continuity of carer and provided 'a sanctum from medicalised care' (p. 5). In a content analysis of the same data, Dahlen found 60 percent of submissions related to homebirth that reiterated the benefits and barriers to achieving birth at home (Dahlen et al. 2011b). Despite the overwhelming consumer demand for choice of birthplace, including homebirth, homebirth was not recommended in the review (discussed further in this section). Dahlen stated that the MSR recommendations showed that the 'medical profession, while small in comparison to [the] large number of submissions, dominated loudly when it came to the MSR making its recommendations' (p. 6).

However, the powerful position held by the medical profession in maternity care may be becoming eroded. McIntyre et al. (2012), in a critical discourse analysis of selected submissions from maternity service providers to the MSR, discussed a change in power relationships between policy makers and maternity care

professionals. This was largely due to the alliance of consumers, midwives, maternity service managers and some medical professions.

It can be seen that the medical dominance of birth, the rise in technology, legislative factors and social influence affected homebirth practice over the twentieth century, and up to the present day. These same factors are likely to have had a similar influence on childbirth in developed countries in the twenty-first century that have led to high rates of birth intervention and national caesarean section rates as high as 32% as reported by the Centers for Disease Control in the USA (Menacker & Hamilton 2010). Interestingly, the USA have reported a 20% rise in homebirth rates between 2004-8 (MacDorman, Declercq & Menacker 2011). Small rises in homebirth rates have also been reported in the UK (Office for National Statistics 2010) where a government led drive has encouraged women to have homebirths (NHS 2012), and Canada (Public Health Agency of Canada 2009), where midwifery is slowly strengthening after a period of being outlawed in many provinces and territories (Canadian Midwifery Regulators Consortium 2010). However, rates of homebirth have remained the same in New Zealand (New Zealand Health Information Service 2007) and homebirth remains a marginalised activity in many countries and is illegal in others such as Hungary and China (No author 2012; Selin & Stone 2009). The Australian government, whilst not overtly supporting homebirth, has published many reports over the years that reiterate the need to have choice of birthplace for women.

GOVERNMENT POLICY IN AUSTRALIA

Within the last ten years, a number of planning documents, reviews and frameworks for maternity services have been published in NSW (Commonwealth of Australia 2009, 2010; NSW Health Department 2000, 2003). All of these have recommended an increase in midwifery continuity of care models, and a larger presence of midwifery care in the public hospital sector. However, as early as 1989 the landmark Shearman Report (NSW Health Department 1989), in response to an increasingly medicalised maternity system, recommended many new approaches that recognised the need for women's choice in maternity care. These included issues around equity of

access to care, the needs of culturally and linguistically diverse (CALD) women, ensuring women participated in decision-making throughout their maternity care, and a collaborative workplace. The report went further to recommend midwives expand their work within the community to care for low-risk women, which led to the establishment of Birth Centres in six hospitals. The Shearman Report did not radically change the nature of maternity services (NSW Department of Health 1991), but its funds enabled hospitals to provide many upgrades to facilities and programs, including birth centres to enable women to have more choice in carer and length of stay in hospital. The report also facilitated a collaborative committee comprising members of the Australian College of Midwives, the Royal Australian College of Obstetrics and Gynaecology and the Royal Australian College of General Practitioners which aimed to work together in review of standards of practice and safety and quality issues (Cranny 1994). Nowhere in the report did it recommend publicly-funded homebirth services. The next important step in State health policy came in 2000, although homebirth was still largely absent.

In 2000, NSW Department of Health released the Framework for Maternity Services. This report focused on the provision of safety and quality in maternity care, culturally sensitive care, and the expansion of a range of models of care within the system. As well as these important goals, the report stated aims to increase women's awareness of midwifery continuity of care models and choices in maternity care, recognise birth as a normal process, and 'consider support for a pilot project to evaluate a homebirth model of care for low-risk women within an Area Health Service' (NSW Health Department 2000 p.37). Using this report as a platform, in 2003, the Models of Maternity Service Provision report identified some core principles in the existing maternity models (NSW Health Department 2003). Using an evidence base, these focused on matching services to clinical need, case management or having a 'lead maternity carer' approach, continuity of care, and the maintenance of networks and collaboration across all levels of care. The document also highlighted the clinical outcomes, women's satisfaction levels and costs of continuity of midwifery care models. Publicly-funded homebirth models were not within the

document, although it did acknowledge the work of PPMs and their increasingly restrictive practice due to lack of professional indemnity insurance.

Three specific policies addressing publicly-funded homebirth have been developed in Australia within the last decade. The most comprehensive was the South Australian Policy on Homebirth, which was driven by the need to increase safety by reducing the number of women having unplanned homebirths (or babies born before arrival to hospital, or arrival of midwife at home [BBAs][3]) (Newman et al. 2009) by outlining strict eligibility criteria and strategies for risk minimisation (Government of South Australia 2007). This positive step towards the funding of publicly-funded homebirth models in South Australia was welcomed by women and midwives state-wide, although acknowledged that the model would be accessible to very few women at first. It has also proven useful for other states' managers of publicly-funded homebirth programs to refer to when setting up services and providing criteria for practice (Catling-Paull, Foureur & Homer 2012). Similarly, a year earlier, a NSW Policy Directive[4] (NSW Health Department 2006) was published in support of homebirth, that also stressed the safety aspect for women. This included "risk assessment, strict exclusion criteria, consultation and transfer referral guidelines, networked arrangements providing appropriate obstetric support and transfer, credentialling of the midwives, clinical privileges for medical practitioners and rigorous evaluation of the models" (p. 1-2). The policy recommended that Area Health Services improve their range of models of care and consider public homebirth services. In Western Australia, a recent government policy for publicly-funded homebirth services was published which built on existing policies from the Community Midwifery Program, and recommendations from state reviews of homebirth (Department of Health Western Australia 2012; Homer & Nicholl 2011; Homer & Nicholl 2008).

More recently two other government reports have been pivotal to the shaping of maternity services within NSW. These were the Report of the Maternity Services Review and the National Maternity Services Plan (Commonwealth of

[3] A BBA is an acronym for Baby Born before Arrival [to hospital]
[4] A Policy Directive from NSW Health is a government led guideline on a given topic that health services are advised to use when formulating local policy documents

Australia 2009, 2010). The background to the development of the documents comprised of a number of reports that outlined problems within maternity services in Australia. One of the major drivers for the review was the disparity in maternal and neonatal health outcomes, and social disadvantage of Aboriginal and Torres Strait Islander women and babies within Australia. This, together with the quality and access to maternity care, the rising intervention rates (notably the caesarean section rate), and the restricted birth choices for some women was the impetus for the review.

The report of the Maternity Services Review (MSR) (Commonwealth of Australia 2009) was the result of many stakeholder and consumer submissions in response to a discussion paper, Improving Maternity Services in Australia: A Discussion Paper from the Australian Government (Commonwealth of Australia 2008). This paper identified key themes and priority issues in Australia and invited consultation and held round table forums over a seven week period in September/October 2008. Similar to other reports within the last ten years, the key areas identified were those of the expansion of women's choice in maternity care and continuity models of care. Over 900 submissions were received with a large proportion of contributions coming from women who had experienced a homebirth. The report of the MSR, effectively dismissed homebirth as a minority activity, stating 'the Review Team has formed the view that the relationship between maternity health care professionals is not such as to support homebirth as a mainstream Commonwealth-funded option' and that incorporating homebirth into mainstream maternity care would 'risk polarising the professions' (p. 20-1). The dismissal of homebirth as a viable option caused uproar from midwives and women and claims that the issue was 'too hot to handle' (Dahlen et al. 2011).

As previously stated, the content analysis by Dahlen et al. (2011b) of the submissions to the MSR that found women wrote extensively about the benefits and barriers to homebirth in Australia were ostensibly ignored. These factors included lack of access to a midwife, no funding for homebirth, no insurance for

midwives to facilitate homebirth and lack of clinical privileging[5] for midwives. The government response: 'Providing more choice in Maternity Care: Access to Medicare and PBS for midwives' was announced in the 2009-10 federal budget (Australian Government 2009). This outlined an improved maternity service for women in rural areas, and extra training and support for health practitioners in these areas, an improvement to the existing National Pregnancy Telephone Counseling Helpline, and the legislation necessary to activate the access to Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) for eligible midwives. It also relayed that PPMs, similar to all health practitioners, needed to have Professional Indemnity Insurance to cover their homebirth practice (previously discussed).

In 2010 the National Maternity Service Plan (the Plan), that resulted from the MSR, was released by the Australian government. This recognised the continuing demand for homebirth and stated that any further plans regarding homebirth services and further exemption of the requirement for midwives to hold PII would be considered after evaluations of publicly-funded programs had been prepared (although these were never funded or commissioned). The report stated that the government planned to continue providing a range of maternity options and encouraged states and territories to investigate options for the provision of publicly-funded homebirth. A safety and quality framework endorsed by the NMBA was proposed for PPMs providing homebirth to guide their work. This framework outlined the necessity of PPMs to work within the Australian College of Midwives (ACM) Consultation and Referral Guidelines (Australian College of Midwives 2008) and follow recommendations from the National Health and Medical Research Council (NHMRC) National Guidance on Collaborative Maternity Care (NHMRC, 2010). It also encouraged PPMs to clearly document their plans of care and referral, especially when caring for women who had high risk pregnancies, and gain a second midwife's opinion when women chose not to follow clinical advice. However, the issue of PII for independently practising midwives was not addressed in the Plan and remains to be adequately addressed by government maternity reforms.

[5] Clinical privileging is where eligible independently practicing midwives (and other health professionals) have admitting and practice rights within public maternity services.

The National Maternity Service Plan (Commonwealth of Australia 2010) recommended the expansion of publicly-funded homebirth programs in Australia. The Plan acknowledged that the demand for homebirth was anticipated to continue, and recommended that all health services evaluate their programs. Those without a service were encouraged to implement one. The Plan also encouragingly stated that providing a range of maternity care options, including homebirth, was deemed a priority – but provided no means for this to occur.

Effectively the maternity reforms outlined in the 2009-10 budget were a step forward for midwives to legally have the ability to practice autonomously and to the full scope of their practice. However, currently PPMs with homebirth practices remain unfunded and uninsured for the intrapartum component of homebirth, and publicly-funded models are few in number. The volume of submissions to the MSR showed the strength of feeling women have towards their choice of place of birth and maternity care.

One other important Government document within NSW released in 2010 was ‘Maternity – Towards Normal Birth in NSW’ (NSW Health Department 2010). This policy statement did not promote homebirth per se, but acknowledged the importance of developing, implementing and evaluating strategies to increase the normal birth rate and decrease caesarean section operations. NSW hospitals had clear key performance indicators to reach by 2015 which included a target of 35% women being offerred midwifery continuity of care models, all services having a written normal birth policy and 100% women being given options for birthplace and information about the importance of normal birth. This policy was followed by a tool-kit to assist implementation (NSW Ministry of Health 2012) in recognition of the importance of midwifery continuity of care to improving normal birth rates.

This study on the influences on women who choose a publicly-funded homebirth has enabled a deeper understanding of women’s decisions regarding birth place. This understanding will enhance the governmental emphasis on

normal birth and allow a more effective direction and delivery of information regarding homebirth to women and their families within health organisations and the wider community.

OUTLINE OF THESIS

Chapter One has provided a background to the study and introduced publicly-funded homebirth in the Australian context. It has provided a brief history of midwifery and homebirth in Australia and outlined the education and regulation of midwives. Issues of medical dominance, perinatal mortality rates over the twentieth century and controversies around place of birth were also discussed.

In Chapter Two of this thesis, I provide a literature review on the safety of homebirth, and other specific topics relating to the influences on women when choosing a homebirth. These are: the importance of women's choice and control over their maternity care, information sharing, and women's decision-making and issues of risk. Previous work on the evaluation of publicly-funded homebirth services in Australia and birthplace reports and studies from the UK are reviewed. This literature was collected by searching relevant databases and search engines. In addition, to enable awareness of current trends and newly published papers, I set up email alerts and used social media sites to maintain currency and source new literature throughout the course of this study.

Chapter Three provides an outline of the methodology of the study. I used grounded theory to explore the influences women had on their decisions to have a publicly-funded homebirth. An explanation of this methodology, as well as differing perspectives on grounded theory are discussed, and my preference towards a more constructivist approach is outlined. The approach to data collection and analysis in this study is discussed in relation to grounded theory. In addition, other studies of maternity care using grounded theory are reviewed.

In Chapter Four, after providing an understanding of the setting of the studied homebirth service, I state the methods I used to conduct this study. These were

describing the participant inclusion and exclusion criteria, discussing the interview techniques used and the management of data collection and analysis. In addition, the ethical considerations and processes from this research was explained and the method of data storage described.
Chapter Five presents the findings of the study. The findings comprise of six categories. The core category and the basic social process are also presented.

Chapter Six then discusses the study's findings in relation to the literature and the implications. In particular, this chapter discusses women's decision-making in relation to their faith in normal birth, their perception of risk and the importance of choice and control in maternity care. Issues of satisfaction in maternity care, woman-centred care, socio-economic status, and the responsibility and practicalities of having a homebirth are discussed. The importance of women's the relationship with caregivers (midwives and support people) is also explored. Conclusions and limitations to the study are stated. Finally, the importance of maternity services adapting to incorporate the choice of publicly-funded homebirth is considered.

SUMMARY

This chapter has introduced the study by exploring briefly the history of midwifery regulation and practice in the last century and its relation to homebirth. An overview of midwifery education in Australia was given to provide an understanding and comparison of midwifery in relation to similarly developed countries. Also outlined was the practice of homebirth within an Australian context and government maternity reports that have shaped maternity services over the years. The controversies around place of birth have been discussed. This included the different philosophies of maternity care, and the medical dominance that has influenced the way maternity care has been organised and delivered. In addition, the perinatal mortality rates in Australia over the last century have been explored, and their relation to birthplace noted. The next chapter will review the literature on homebirth.

CHAPTER 2: LITERATURE REVIEW

INTRODUCTION

This chapter examines the literature on the safety of homebirth. In addition to more general issues relating to homebirth, specific topics relating to the influences that affect women's decision to choose homebirth will also be explored. These include: the importance of women's choice in maternity services and feelings of control; information sharing; decision-making and risk; and the characteristics of women who choose homebirth.

METHOD OF THE LITERATURE REVIEW

Databases used for the review include Medline, CINAHL, Cochrane Database of Systematic Reviews, Maternity and Infant Care (MIDIRS) and PsycINFO. Keywords used were pregnancy, home birth or homebirth, freebirth or free birth, hospital birth, place of birth, neonatal morbidity, neonatal mortality, maternal morbidity, maternal mortality, safety, fear, and decision-making. All articles were considered but priority given to the higher levels of evidence (National Health and Medical Research Council 1998) consisting of systematic reviews and randomised controlled trials (RCT), although cohort or case-control studies comprise the majority of studies investigating the safety of homebirth. The reference lists of relevant articles were also used as a source of additional articles.

SAFETY OF HOMEBIRTH

The best evidence for the safety of a specified situation is through a RCT (Centre for Epidemiology and Research 2011). There are no RCTs comparing home and hospital birth as few women have been willing to be randomly assigned to either home or hospital. This was demonstrated by Dowswell et al. (1996) in a small feasibility study where only 11 out of 71 low-risk women

agreed to randomisation, and also Hendrix et al. (2009) who also found women were reluctant to hand over their choice of birth place. McLachlan and Forster (2009) discuss that, despite the large numbers needed to show a difference in maternal or neonatal outcomes, the study by Hendrix et al. shows that randomisation of women to hospital or homebirth is possible. However, given that Dowswell (1996) took one year to randomise 11 women, a study with enough statistical power would possibly take several decades, or 700,000 women in each group as suggested by Alberman (1984). Johnson and Daviss (2005) remark that prospective cohort studies are the most appropriate measure of the safety of homebirth, given the unfeasibility of an RCT. There is extensive evidence supporting homebirth as a safe option for the majority of healthy women at low obstetric risk using cohort or observational studies (Ackermann-Liebrich et al. 1996; Birthplace in England Collaborative Group 2011; de Jonge et al. 2009; Howe 1988; Janssen et al. 2002; Johnson & Daviss 2005; Olsen 1997).

One of the largest cohort studies on homebirth was a retrospective study in the Netherlands by de Jonge et al. (2009). The Netherlands has a unique maternity care system. Women in this country who are at low obstetric risk are cared for by independent primary care midwives and obstetric (or 'secondary care') is accessed when women have pre-existing or develop risk factors, either during pregnancy, birth or in the postnatal period. Approximately 25% women have homebirths in the Netherlands, and midwifery and homebirth is well integrated into the maternity care system (van der Kooy et al. 2011).

The study by de Jonge et al. (2009) compared perinatal mortality and severe perinatal morbidity between planned homebirths and planned hospital births. The authors studied data from a national perinatal database of a nationwide cohort of 529,688 women, spanning seven years. Results of the study showed that planned homebirth in low-risk women was not associated with higher perinatal morbidity or mortality compared to hospital birth. This was found in analyses both with and without adjustment for the confounding factors of gestational age, maternal age, ethnicity, parity, and socio-economic status. Women older than 35 years, primparous women, and those who gave birth at

37 or 41 weeks had higher levels of neonatal morbidity, but this was not related to place of birth. There were some missing data in this study, notably paediatric data from non-academic (non-teaching) hospitals, which was acknowledged. This would have affected the numbers of neonates recorded to have been transferred to the Neonatal Intensive Care Unit, and would have reduced the power of the statistical findings in this respect.

The Netherlands, despite its strong midwifery profile and homebirth rates, has been the subject of scrutiny lately due to the reporting of higher perinatal mortality rates in comparison to the rest of Europe (Ravelli et al. 2009). Ravelli et al. in a retrospective cohort study of 1.4 million women found the perinatal mortality rate had lowered from 10.5 to 9.1 deaths per total births from 2000 to 2006. However, the rate remains higher than the UK - 7.6 per 1000 total births reported in 2009 (Centre for Maternal and Child Enquiries 2011), 5.3 per 1000 total births in Germany and 4.4 per 1000 total births in Greece in 2008 (World Health Organization 2012). Van der Kooy (2011), upon a case-mix analysis of 693,592 women in the Netherlands, found very similar rates of intrapartum and neonatal death between homebirths and hospital births, but an increase of up to 20% in mortality when women with risk factors are cared for at home. This study, although based in quite a different setting, shows the relationship between perinatal mortality rates and women who have homebirths with obstetric risk factors.

A meta-analysis of observational studies provides high levels of evidence in the absence of RCTs. In a meta-analysis of planned hospital birth versus unplanned homebirth by Olsen (1997), international controlled observational studies, comparing perinatal and maternal mortality were analysed. Six studies met the inclusion criteria from 607 initially identified. Studies were excluded if they did not have an appropriate comparison group (hospital cohorts were not matched, or absent), and inadequate analysis and reporting. This review showed no significant differences in outcome between home or hospital birth for low-risk women, and perinatal mortality between the groups were comparable. However, there were fewer interventions and morbidity in the homebirth group, notably a large reduction in rates of perineal trauma. This study sparked a

rigorous review of the global evidence around the safety of homebirth at the time. The next year Olsen and Jewell (1998) undertook a review of their meta-analysis and searched the Cochrane Register for controlled trials that compared home and hospital birth. Only one study by Dowswell et al. (1996) fitted the criteria but was too small (11 participants) to draw any conclusions. The Cochrane Register repeated the search in 2006 and 2012, but no new trials were found. However, in 2012, the Register stated the inclusion of 'ethically well-designed trials' was justified (Olsen & Clausen 2012 p. 2), and that results from good quality observational studies were worth considering in future reviews.

The Birthplace study in the UK (Birthplace in England Collaborative Group 2011) revealed similar outcomes to de Jonge et al. (2009). This prospective cohort study collected data on neonatal and maternal perinatal outcomes of 64 538 low-risk women in 142 Health Care Trusts that provided a homebirth service in the UK. Maternal and neonatal outcomes and interventions during labour were compared by planned place of birth at the start of care in labour. Primiparous women who had a planned homebirth or gave birth in other non-obstetric units were more likely to be transferred to hospital in labour or in the postnatal period (36-45% compared with 9-13% for multiparous women), and their babies had higher rates a composite primary outcome[6], than those planning birth in an obstetric unit (in particular, perinatal mortality rates were stated at: adjusted odds ratio 1.75, 95% CI 1.07 to 2.86). Multiparous women's babies had similar outcomes to the hospital cohort. This study's strengths lie in its size and comparability of groups, however, its application to the Australian setting is limited due to the differences in UK health care provision and organisation. Subsequently, a replication of this study is currently underway in Australia.

The next best level of evidence on the safety of homebirth came from a large prospective cohort study by Johnson and Daviss (2005). This study was

[6] The composite primary outcome in this study comprised of perinatal mortality and intrapartum related neonatal morbidities (stillbirth after start of care in labour, early neonatal death, neonatal encephalopathy, meconium aspiration syndrome, brachial plexus injury, fractured humerus, or fractured clavicle).

performed in the United States of America (USA) where homebirth was rare although a recent study by MacDorman et al. (2011) has shown an increase in popularity[7]. Johnson and Daviss accessed the data through the North American Registry of Midwives (NARM) which provides a certified professional midwife (CPM) credential for direct-entry midwives who attend homebirths. In 1999, participation in the study was mandatory for the midwives to gain recertification to practice. This study compared 5418 women who intended to have a homebirth with 3,360,868 women (of all risk levels) giving birth in hospital. The main outcome measures were intrapartum and neonatal mortality, perinatal transfer to hospital care, medical intervention during labour, breastfeeding and maternal satisfaction. Similar to Olsen (1997), the homebirth cohort had significantly less medical intervention (epidural, episiotomy, forceps, vacuum extraction, and caesarean section) which were substantially lower than rates of intervention for low risk women having a hospital birth. Perinatal mortality was not reported for the hospital cohort (an average of several studies was given), but stated as 1.7 per 1000 planned homebirths (planned breech births and twins excluded) for the homebirth cohort. This was consistent with similar studies of out-of-hospital birth low risk women (Anderson & Murphy 1995; Duran 1992; Murphy & Fullerton 1998; Schlenzka 1999; Tyson 1991). However, the homebirth cohort were more highly educated, older and of different ethnicity to the hospital cohort, which may or may not have had a bearing on outcomes.

Weigers, Keirse et al (1996) in the Netherlands took a different approach, and although measuring perinatal mortality rates, they argued that a single measure alone could not indicate the benefits of birth place given the complex process of labour and birth. This prospective cohort study obtained data on perinatal outcomes as well as personal background and social and medical history on 1836 women who planned to give birth either at home or in hospital using a 22-

[7] In the US there are many different levels of midwifery training and usually women choosing to have a homebirth seek the services of either a certified professional midwife (CPM) or a direct-entry midwife (DEM). CPMs are midwives trained by standards set by the North American Registry of Midwives (NARM) and are the only internationally credentialed midwives that require knowledge of out-of-hospital birth places (Midwives Alliance of North America 2011), whereas DEMs gain certification through self-study, apprenticeship, a midwifery school, college or university (distinct from the discipline of nursing) and work primarily in out-of-hospital settings. In the US, less than 8% women are cared for solely by midwives (Certified Nurse Midwives) in hospital whereas 87% women are attended by doctors (Martin et al. 2010). Certified Nurse Midwives (CNM) are midwives who have certification in both disciplines through the requirements of the American College of Nurse-Midwives and work predominantly in hospitals.

item perinatal background index. Their results reported favourable differences in all aspects of pregnancy care, outcome and satisfaction in multiparous women who gave birth to their babies at home, but no relation between birth place and perinatal outcome in primiparous women when obstetric, medical and social background was controlled for. However, consistency of care between participants was questionable as the study included women who were cared for by 97 midwives at 54 different practices within the Netherlands, and homebirth rates varied widely. This was later found to be heavily influenced by individual midwifery attitudes towards birth and levels of cooperation with obstetricians (Weigers et al. 2000). These authors examined 73 midwives care of 4420 women in 42 practices and found those midwives with a more positive attitude to homebirth, and who saw very few non-medical reasons for a hospital birth, had higher rates of homebirth in their practice. Midwives were rated through questionnaires about their background, practice and professional attitudes that indicated their preferences for labour management and their attitudes. Midwives were also rated through a seven-item list on their attitudes towards homebirth and how they collaborated with medical staff. This showed that a positive cooperative relationship with obstetricians was indicative of higher homebirth rates.

The homebirth program at St George Hospital has been the subject of a prospective descriptive study evaluating the first 100 booked women on the program (McMurtrie et al. 2009)[8]. The study's maternal and neonatal outcomes showed appropriate antenatal and intranatal transfers of care, and favourable intervention rates and neonatal apgar scores. The study showed a low proportion of women needing intrapartum transfer to hospital (10%) compared with other studies (Johnson & Daviss 2005; Lindgren et al. 2008; Murphy & Fullerton 1998). This could have been due to careful selection of suitable low risk women, and/or the higher number of multiparous women in the program. Overall, this study showed reassuring maternal and neonatal outcomes facilitated by effective systems of care and back-up, although the sample size was small.

[8] My role in this paper was analysing the data and writing the first draft of the paper. I worked with the team to respond to reviewer comments.

A small number of other studies have shown homebirth in a less favourable light (Bastian, Keirse & Lancaster 1998; Crotty et al. 1990; Kennare et al. 2010; Pang et al. 2002; Wax et al. 2010). In a now infamous study, Bastian, Keirse et al. (1998) studied all births notified to Homebirth Australia, a national consumer organisation, between 1995-1990 (n=7002). They cited a perinatal mortality rate of 7.1 per 1000 planned homebirths which was higher than the estimated rate in Australia of 6 per 1000 (World Health Organization 2006). The authors conceded that women of low obstetric risk had good outcomes whereas the inclusion of the less favourable outcomes of women with high obstetric risk made this perinatal mortality rate artificially high. Women at high obstetric risk included those with multiple pregnancy, breech position, intrauterine growth restriction and preterm or post-term pregnancy. Intrapartum risk factors which contributed to the higher perinatal mortality rate were bradycardia and meconium stained liquour, which the authors stated did not prompt carers to initiate transfer to hospital. Methodologically, the study partly used a national consumer association's register as a source of data, and any statement regarding cross-checking with government birth statistics was absent. The retrospective method of analysis was also methodologically unsound, as the authors may simply have found data to fit their hypothesis. This is a recognised shortcoming of all retrospective studies. Despite this, the research has been consistently used by those opposed to homebirth to argue against its safety (RANZCOG 2008; Sullivan 1999).

An older study by Crotty et al. (1990) studied 799 homebirths in South Australia also included high risk women which resulted in inflated perinatal mortality rates. This retrospective review of case records studied outcomes of women and neonates having a homebirth attended by midwives, General Practitioners, and lay midwives. Results showed 37.5% women were transferred in the antenatal period prior to labour for complications, and 62.5% during labour. The study states the cohort had a perinatal mortality rate that was five times higher among planned homebirths when compared with hospital births (crude rate: 16.2 per 1000 births). This rate included babies who died due to infection,

Sudden Infant Death Syndrome (SIDS) and congenital abnormalities. The limitations of this study's methodology include its retrospective nature, a considerable amount of missing data, and a lack of uniform data collection methods. There were also noted delays in transport to hospital and a low usage of obstetric ultrasound used in the homebirth participants which could have contributed to the higher perinatal mortality rate due to increased numbers of babies born with congenital abnormalities. Women included in the study were also not considered low risk. The study itself declared that 'close examination of the individual deaths led to the conclusion that the majority could not directly be attributed to the place of birth' (p. 670).

In the USA, Pang et al. (2002) studied birth certificate data in Washington between 1989-1996 and concluded homebirths posed more maternal and neonatal risks than hospital births. This study was soon identified as having several methodological flaws, notably the unreliability of birth certificate data, and the inclusion criteria, which included women who had unplanned and unattended homebirths. The inclusion criteria also analysed together women who had homebirths and those that were transferred to hospital prior to birth, which was inappropriate; the latter group should have been analysed within the hospital birth cohort. These data skewed the results to show unfavourable rates of prolonged labour, postpartum haemorrhage, and respiratory distress in babies amongst others.

Another more recent paper reporting unfavourable homebirth outcomes was led by Wax et al. (2010) in the USA. The authors produced a meta-analysis of the safety of planned home versus planned hospital birth and concluded that planned home births were associated with similar maternal outcomes, but with a threefold increase in neonatal mortality (death of an infant up to 28 days). The study has been found to have numerous methodological and statistical analysis errors. These consist of basic numerical errors, a lack of clarity on inclusion and exclusion of studies, a misrepresentation of studies, and logical impossibilities. In addition, the software tool that was used for most of the calculations in the meta-analysis contained inaccuracies that underestimated confidence intervals

(CIs), which may have falsely claimed statistically significant results. Despite this, the research has been used by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) and the American College of Obstetricians and Gynaecologists (ACOG) to support their position statement on homebirth in Australia and the USA (RANZCOG, 2011a; ACOG, 2011). Michel et al. (2011), Keirse (2010), and Gyte et al. (2010) expanded on these methodological inaccuracies in depth with Michel et al. concluding that it was 'incomprehensible that medical society opinion can be formulated on research that does not hold to the most basic standards of methodological rigor' (sec. 7).

An important study from South Australia regarding perinatal safety was a retrospective population-based study by Kennare et al. (2010) spanning 16 years (1991-2006). This study included 1141 planned homebirths (defined as births that were intended to occur at home at the time of antenatal booking) and 297,192 hospital births. The authors found homebirth had similar rates of perinatal mortality to planned hospital births, but a significantly higher rate of intrapartum death and death from intrapartum asphyxia. Many of the results had wide confidence intervals due to the small numbers involved (for example, the confidence interval for perinatal mortality due to intrapartum asphyxia was 8.02–88.83) so interpretation may not be reliable, which was acknowledged by the authors. Upon further exploration, the authors determined that factors that changed womens' status to that of high risk were responsible for the majority of adverse outcomes. These women, who had originally planned a homebirth, were transferred to hospital care appropriately (31% had a hospital birth), but because they had originally booked for a homebirth, their adverse outcomes were recorded in the homebirth cohort. Of the nine perinatal deaths, three occurred in the antenatal period after transfer to hospital, two deaths were due to lethal congenital abnormalities and four occurred after parents' declined intervention after transfer to hospital or refused/delayed transfer. Only two deaths actually occurred at home. Upon further exploration, only three deaths were potentially preventable, two of which had risk factors – one being a woman with a postdates pregnancy who refused fetal monitoring, and the other a

woman with a multiple pregnancy. However, this study was publicised in the media with headlines such as ‘home births multiply death risks by seven’ (Owens 2010 p. 1).

After the publication of Kennare et al. (2010), there was much activity on ‘Croaky’, the health blog of the online news forum ‘Crikey’ (2012). This website published a discussion piece on whether the *Medical Journal of Australia’s* press release to the media misled readers (Owens 2010) and whether the editorial was simply a platform for the Australian Medical Association (AMA) to negatively portray homebirth (Pesce 2010). This was followed by a critique of the study’s methodology and design (Dahlen & Homer 2010) and recommendations to improve hospital environments and conditions so that women do not inappropriately choose to have a homebirth when they have pregnancy risk factors due to fear and mistrust of hospitals. The authors also recommended more inclusion of PPMs into mainstream services which would ultimately help improve safety around situations of antenatal/intrapartum transfer of women from home to hospital.

EVALUATIONS OF HOMEBIRTH SERVICES

As well as research studies examining homebirth, there have been a number of statewide or individual evaluations of programs. In Australia, there have been three evaluations and a series of perinatal reports of programs offering homebirth services in Western and South Australia (Centre for Clinical Effectiveness, 2011; Department of Health 2011; Homer & Caplice 2007; Homer & Nicholl 2008; Western Australia Department of Health 2007). In Western Australia, the Fremantle Community Based Midwifery Program (Thiele & Thorogood 1997) used data from interviews with midwives, project records and consumer satisfaction surveys in its evaluation. The study found high satisfaction rates amongst women who had homebirths, less analgesia usage and lower rates of perineal trauma. Specific survey questions about the influences women had regarding their choice of birth place showed that apart from themselves, their partners, midwives and GPs held significant influence. Despite the small sample size, this evaluation showed cost-effective care and

positive results for women and babies, although it did not engage as many non-English speaking women in the program as anticipated.

In Western Australia (WA), since 2001, the Perinatal and Infant Mortality Committee have provided triennial reports of investigated perinatal and infant deaths. The most recent report, similar to the two previous reports showed a higher perinatal mortality rate in women who planned a homebirth compared to women planning a hospital birth (7.81 per 1000 births vs 2.03). This included women who had homebirths within the publicly-funded program as well as those with PPMs. Upon the investigation of the seven deaths, it was found that three were potentially avoidable (Western Australia Department of Health 2007). This prompted a review of homebirths in WA by Homer and Nicholl (2008) which provided 24 recommendations for practice improvement. The progress of these recommendations was reviewed by the same authors in 2011 (Homer & Nicholl 2011). One of the findings was that the Community Midwifery Program in WA, where the majority of homebirths occurred, had made considerable moves towards policy development and quality and safety issues within their program.

Another evaluated homebirth program in Australia was the Northern Women's Community Midwifery Program (NWCMP), based in the Northern suburbs of Adelaide. This was undertaken by Nixon et al. (2003) who undertook an independent, external evaluation using interviews, questionnaires, focus groups and other records as data. They concluded that the program was successful in caring for Indigenous women, teenagers, and other women of high needs, and although clinical outcomes were similar for the rest of the state, women reported using less analgesia, and there were fewer episiotomies performed. Little data was obtained regarding women's satisfaction with the program, which was stated to be necessary for a comprehensive evaluation.

Women's satisfaction was evaluated by Homer and Caplice (2007) who evaluated the homebirth service at St George Hospital in 2007. This showed that since the service began in September 2005, all women were cared for appropriately, and 88% women who began labour at home had a homebirth. Both the women and the midwives who worked within the service reported

positive experiences with the homebirth model. Later McMurtrie et al. (2009) studied the outcomes of the first 100 women who accessed the service (I was involved in this study). This prospective descriptive study found similar homebirth rates to the previous evaluation (2007), low intervention rates and reassuring outcomes for women and babies.

More recently an evaluation has been undertaken of a publicly-funded homebirth program in Victoria, Australia, (the Casey Hospital Home Birth model) which was established in 2010 (Centre for Clinical Effectiveness, 2011). Qualitative and quantitative data were collected from a range of sources including consumer experience diaries, midwifery homebirth summaries, birth outcome data, interviews of stakeholders and document analysis. This evaluation found a high level of satisfaction from women and midwives working within the model, a compliance with policy, and no safety issues, although it was acknowledged that there were very small numbers of women involved.

Overall, the body of literature reviewed shows that homebirth is as safe as hospital birth and is associated with lower morbidity and medical intervention for women of low obstetric risk when there are good systems of back-up in place. However, studies that negatively portray homebirth often take precedence in the media (Bastian, Keirse & Lancaster 1998; Crotty et al. 1990; Kennare et al. 2010; Pang et al. 2002; Wax et al. 2010) and the task of disseminating this information to the community and key stakeholders (notably GPs and obstetricians), and dispelling unfounded fears surrounding homebirth is difficult. For example, RANZCOG published a brief position statement opposing homebirth in 2008 (RANZCOG 2008). In contrast, in the UK the Royal College of Obstetricians and Gynaecologists (RCOG) and the Royal College of Midwives (RCM) in the UK had a joint statement supporting homebirth (2007). This was succinctly discussed in an editorial by Newman (2008), who compared the scientifically unsupported 2008 RANZCOG stance with the evidence-based RCOG and RCM statement. Newman suggested the lack of mainstream provision of publicly-funded homebirth may be partly resulting in an increase in ‘freebirthing’, similar to Dahlen et al. (2011). Newman explained that to merely warn of the ‘dangers’ of freebirth was not enough; there should be support to

implement homebirth models of care that met women's needs. This was followed by a letter from the President of the National Association of Specialist Obstetricians and Gynaecologists which provided further assessment of the research to show that homebirth was not a safe option (Pesce 2009). Pesce used studies such as the Western Australian review (WA Department of Health, 2007) to state the higher perinatal mortality rate of babies born at home. He failed to break down these cases (in the WA report, there were six babies deaths in a four-year period) to add that four of the six cases had low medical preventability - the preventability scale used by the Mortality Committee of WA Department of Health (WA Department of Health, 2007), and two were unavoidable deaths in utero. In this preventability scale, a low score of 2-3 is defined as 'preventable medical factors in deaths that are considered unavoidable in a medical context' (WA Department of Health, 2007 p.19). Overall, the critique of Newman (2008) by Pesce (2009) appears to 'cherrypick' research and mislead readers by not fully explaining the results of studies in order to reinforce the medical agenda of not supporting homebirth in Australia. The lack of support of homebirth from many medical colleagues remains one of the biggest obstacles to the development of homebirth services, especially when there is a lack of Australian homebirth data showing favourable outcomes.

There will always be women who choose to give birth at home, and some who, in the absence of local homebirth services, will opt to freebirth. This has been studied in Australia by Jackson et al. (2012) who interviewed 20 women who chose to give birth without help from health professionals. She found women felt unsafe with hospital care and wanted to avoid the risk of medical intervention, and subsequently chose to eliminate any possibility of this happening – by having a freebirth. The women essentially trusted their perceptions of risk over the dominant biomedical authority of the health system. The cohort in this study differ fundamentally to my study of women who chose to have a publicly-funded homebirth.

MATERNITY SERVICE REPORTS AND STUDIES IN THE UK

Government reports and reviews are published regularly in most countries predominantly to improve maternity services in line with modern technological advances, research, workforce issues and consumer demand. Homebirth has featured in many of these reports. The reports from the UK will be explored first as these have often influenced Australian maternity care.

In the UK, a landmark report of the Expert Maternity Group, the Changing Childbirth report (Department of Health Expert Maternity Group 1993) was published in response to the Winterton report (House of Commons Health Committee 1992). This set recommendations for National Health Service (NHS) Trusts to put in place more woman-friendly maternity services to improve access and choice for women, including place of birth options.
UK

In 1998, a national audit in the UK found little change in practice, services and evaluation since the Changing Childbirth report (Audit Commission 1998). Years later, other government reports espoused the same messages: that women should be the focus of their own maternity care, make informed decisions, and have access to services to meet their needs (Department of Health 2004; House of Commons Health Committee 2003, Department of Health/Partnerships for Children, 2007). However, the extent to which they were implemented was unclear which led many to wonder about when the rhetoric would meet reality in relation to choice in maternity services, including place of birth (Beake & Bick 2007). The study by Beake and Bick (2007) was a small UK survey of nine NHS Trusts that assessed the extent of the implementation of government policy reform recommendations, and found that most organisations were unable to match expectations, including homebirth options, often due to low staffing levels. A lack of available midwifery staff to provide a homebirth service has also been used as a reason in other areas of the UK (Rogers et al. 2005). This study in the South of England (described later in this chapter) stated that staff shortages may have impacted negatively on the results of the study.

The UK is encouraging more women to have their babies at home. In 2007, some NHS Trusts provided extra tariffs for services that provided homebirths, particularly in rural areas (Department of Health/Partnerships for Children Families and Maternity 2007). Recently, the UK Government released the State of Maternity Services Report (Royal College of Midwives 2011). This was the first of an annual report of the demands on maternity services with a list of the resources available across the UK, and strategies to improve services. One of the main issues reported was a midwife shortage around the UK, and to combat this, an increase in midwife-led units and homebirth was suggested.

Historically Australia has mirrored many advances in maternity care that have originated from the UK. However, it remains to be seen whether the UK push for more midwife-led out of hospital births will be included in these advances. One definite rhetorical issue that is espoused in many reports and studies is the importance of women's choice and control.

THE IMPORTANCE OF WOMEN'S CHOICE AND CONTROL

Birth is a significant physiological, spiritual, and social event in a woman's life, and as such, choice[9] in maternity care is important. The ability to have choice and control during pregnancy and birth relate strongly to maternal satisfaction (Johnson et al. 2003) and this can have long term positive effects on women (Noriko et al. 2007; Schytt & Waldenstrom 2007), her family, and in turn contribute to the general wellbeing and health of the wider community. Page argues that choice in maternity care is a concept closely linked to continuity of care and control (1992, 2004), and defines it as 'a process of informed decision-making in which the woman must have the final say' (Page 2004 p. 27). This rhetoric stems from the UK's 'Changing Childbirth' report (Department of Health Expert Maternity Group 1993) in which the three 'C's' were highlighted: choice, control and continuity. The importance of a woman's sense of control and autonomy was also described by O'Boyle (2006 p. 25) as having the 'right of the

9 The notion of 'choice' in this section relates to the Western industrialised world. In developing nations, women have different sets of priorities and more immediate issues related to the high maternal and neonatal morbidity and mortality rates due to limited access to trained childbirth attendants, and poor health care.

individual to decide upon the integrity of [her] own body'. The next section is an examination of issues including choice and control in maternity care and preference of birth place from the women's perspective.

Numerous studies and reviews, both overseas and in Australia, have stated that women should have choice regarding their care during pregnancy and childbirth (Audit Commission 1998; Department of Health 1998, 2004, 2007; Department of Health Expert Maternity Group 1993; NSW Health Department 2000; Redshaw & Heikkila 2010; Rogers et al. 2005; Senate Community Affairs References Committee 1999). Many of these reports say essentially the same things about the need for women to have choice. This choice is often denied to women, either through lack of information-sharing from carers, an inability to access resources, or lack of facilities.

Choice for women in maternity care and having a sense of control by being involved in decision-making relating to their care promotes respect and trust in caregivers (Sword et al. 2012). In turn, being treated as an individual, and not merely one of many, is fundamental to women feeling confident in expressing their needs to their caregivers, resulting in satisfaction and positive outcomes (Hatem et al. 2008). Having a lack of control over maternity care, and particularly intrapartum care, is associated with a higher incidence of symptoms of post traumatic stress disorder (Czarnocka & Slade 2000; Elmir et al. 2010). Accordingly, satisfaction is higher in women when they perceive control over their birth experience (Fair & Morrison 2012; Hauk et al. 2007; Rudman, El-Khouri & Waldenstrom 2007; Shorten et al. 2005; Waldenstrom 2004).

Satisfaction in relation to control over the birth experience varies when women need to transfer to hospital in labour or the postnatal period. Wiegers, Van der Zee & Keirse (1998) in a survey of 2301 women found that an unplanned transfer to hospital did not negatively affect their birth experience. However, this study was conducted in Holland where it could be conceived that there are more well established referral pathways within their homebirth-friendly maternity system than other countries. Conversely, other studies have shown more negative experiences with hospital transfers (Christiaens, Gouwy & Bracke

2007; Lindgren, Radestad & Hildeingsson 2011). Christiaens et al. (2007) studied Belgian and Dutch women using two satisfaction rating scales. This showed that Belgian women were less negatively affected when transferred from home to hospital than Dutch women, which was possibly because their expectations were different to Dutch women. Another reason for this was that Dutch women also had homebirth as a point of reference more than Belgian women, so were more likely to be disappointed by their expectations not being reached. This study also showed the importance of midwifery care (85% women stated satisfaction with their midwives). Lindgren et al. (2011) also found midwifery care important in Sweden in a survey of 1025 women. The authors found primparous women had a higher likelihood of transferring to hospital from home if there was a lack of midwifery continuity. It then follows that control and choice in maternity and maternal satisfaction are strongly linked to continuity of midwifery models of care (Johnson et al. 2003; McCourt et al. 1998; Sandall, Davies & Warwick 2001) and also to better maternal outcomes (Hatem et al. 2008).

Surveys of women's preferences and information given about choice of birth place have shown conflicting results. In the UK, one older survey undertaken in 1993, identified 22% women would prefer a homebirth and 72% would like more information about birth place (MORI, 1993). More recently, in Australia, a self-reported survey by Gamble, Creedy and Teakle (2007) found that up to 24% women would choose a homebirth given assurance of safety and no extra expense, but when not given the assurances, this figure dropped to 7.9%. The high figure of women stating preference for homebirth in this study may have been inflated as a large proportion of participants had previously had babies in birth centres, were attending a Mother and Baby Expo, and as such may have been more knowledgeable and amenable towards homebirth. Another UK study showed 3% parous women and 11% nulliparous women would prefer a homebirth (Jones & Smith 1996). In Finland, Viisainen et al. (1998) found 6% women would choose a homebirth, and states that (similar to previous studies) the expressed interest was far greater than homebirth rates in reality. In Australia 0.5% women achieved a homebirth in 2010 (0.3% in NSW), although 4.4% women had intended to give birth at home or other settings (Li et al.

2012), but it is not known how many women in Australia would choose a homebirth if given the choice.

Women who choose homebirth do so for a number of reasons. These include feeling safe, having control over their birth and surroundings, to avoid intervention (Viisainen 2001), having a belief in their ability to give birth without intervention or technology, having personalised continuity of carer (Abel & Kearns 1991; Longworth, Ratcliffe & Boulton 2001) and not having to be apart from other children (Andrews 2004). These issues were highlighted in a study by Dahlen, Barclay and Homer (2008) which explored experiences of women having their first birth in Sydney. This study found women chose homebirth (with independent midwives) mainly because their needs were not met by the hospital or obstetrician. The stated needs included the option of giving birth off the bed, having a waterbirth, and having female caregivers. The women in the study were more prepared for their births, were very involved with decision-making, and spent time examining their choices. In contrast, women who chose hospital-based care felt they had fewer options, reported feeling less prepared, and were often disappointed in their birth experience. Close examination of choices by women having homebirths has been found in other studies (Boucher et al. 2009; Hodnett et al. 2007a; Neuhaus et al. 2002; Nolan 2010; Pilley Edwards & Murphy-Lawless 2006; Rogers et al. 2005; Wilde 2006). These choices are based on information from many sources, including the internet, books, DVDs, friends and family, and health professionals.

One setting where women were given choice over their birth place as a matter of routine was the Albany Midwifery Practice in London. This caseload model of care began as a three year pilot and was contracted to Kings College Hospital Trust in 1997. It served the maternity needs of one of the most materially and socially deprived areas of London. This area had high rates of poverty, unemployment, non-English speaking ethnic groups, and had high rates of medical, social and mental health problems (Sandall, Davies & Warwick 2001). Despite this, the practice became internationally acclaimed through their philosophy, the high quality woman-centred care and the emphasis on women having choices regarding their maternity care and a partnership with their

midwife. Evaluation of the practice showed that intervention rates were low despite the demographically deprived sample (caesarean section rates – 16% in 1999) and homebirth rates were high (43% in 1999) (Sandall, Davies & Warwick 2001). Choice of place of birth was discussed with women at the booking interview and throughout pregnancy with the final decision about birthplace made by the mother when the midwives attend her in labour in her home. Particular notice was given to the '36-week birth talk' to women in their third trimester that helped women make plans for birth, discussed pain relief, support in labour and reinforced and built on women's coping mechanisms (Kemp & Sandall 2010). This talk, occurring in women's homes, has been found to be integral to caseload practice, appreciated by women, and built confidence in their ability to have a non-medicalised birth (Kemp & Sandall 2010) which likely contributed to the favourable perinatal outcomes. Despite the disadvantaged population of women, perinatal mortality rates for the practice were 4.9 per 1000 live births in the period 1997-2007 and 11% for other nearby practices (Sandall, Davies & Warwick 2001), whereas the rate in the UK was 7.5 per 1000 total births in 2008, with much higher rates noted for babies of mothers who were black ethnic origin or Asian (Centre for Maternal and Child Enquiries 2010). Leap et al. (2010) have also studied the practice and found the continuity of care and subsequent trust built up through the relationship between the midwives and women, enabled women to give birth without pharmacological pain relief. The Albany Midwifery Practice was closed in 2009 after an audit recommended quality and safety measures be improved. This closure also materialised due to a conflict of ideologies and managerial decisions, much to the dismay of midwives and the community (Davies & Edwards 2010; Edwards 2011; Phipps 2010).

INFORMATION SHARING

As part of their scope of practice, midwives provide information to women during their pregnancies. Often women will seek out further information in the form of books, magazines, and antenatal classes. However, women are not often given choices regarding birth place (Carolan & Hodnett 2007; Chamberlain, Wraight & Crowley 1997; Davies et al. 1996; Hundley et al. 2000;

Longworth, Ratcliffe & Boulton 2001; Madi & Crow 2003; MORI, 1993), or are 'steered' towards a certain option by health professionals (Levy 2006). Longworth (2001) found 58% respondents were not given any information during their pregnancies about alternative locations for birth; particularly for women booked to give birth in hospital. Conversely, the study, a conjoint analysis of women's preferences for intrapartum care, found that women booked for a homebirth were given adequate birth place information. These results were supported by Madi and Crow (2003) who investigated midwives involvement in women's birth place choices and concluded that midwives were reluctant to share full information, especially homebirth options, with women. This was part of a wider grounded theory study in the UK on women's views about influencing factors regarding their choice of birth place. Madi and Crow interviewed 33 women at low obstetric risk in their third trimesters and divided them into two groups: those planning a homebirth and those booked in hospital. One of the main themes in the hospital group was an 'assumption of hospital birth' where women had booked a hospital birth because they had not been told that there was any other option. In addition, participants stated that they would have welcomed being given the choice of a homebirth even though they may not have chosen it as a birth place (Madi & Crow 2003).

The way midwives impart information to childbearing women can influence their decision-making. Levy (2006), in a grounded theory study, explored how midwives helped women make informed decisions about their care. Through taped interviews at booking with women and follow up interviews with midwives, she found that staff directed women to choices available to them through a complex and protective discourse; changing language to suit women's abilities to understand, and tailoring information to the wishes and needs of the individual. This was called 'protective steering', and was determined as the core category in the study.

Midwives and others have been found to be reluctant to offer homebirth as an option, even when the choice is available (Floyd 1995; Hundley et al. 2000). In a UK study, only 5% of nulliparous women stated they retrieved the most information regarding their pregnancy and options for care from midwives or

doctors, whereas the main source of information was gained from written matter (that is, magazines, pregnancy booklets) (Singh et al. 2002). The authors state this possibly reflects the small amount of time health professionals spend with women, and the plethora of information available from other sources, however, it also shows that staff can do more to facilitate information sharing with women.

It is likely health professionals can improve practice to accommodate women's need for information. General Practitioners (GPs) may make assumptions about women's preferences; often referring them for pregnancy care by obstetricians from the outset, and impose their own ideas and biases without fully comprehending the importance of the decision of birth place. Midwives can also display this practice (Levy 2006), and women too, can defer to the advice of health professionals without question (Charles, Gafni & Whelan 1997). Dahlen, Barclay and Homer (2008) reported that GPs sometimes presented alarming and inaccurate mortality statistics, or told women homebirth was illegal to scare them away from choosing homebirth. The importance of GPs in women's decision-making regarding birth place was recognised by Fordham (1997), who concluded that, short of significant changes to their medical training, most GPs continued to dismiss the option of homebirth as a viable option. This is likely due to modern day GPs having little obstetric experience, and even less experience of homebirth (Brown 1994). Brown, in a UK survey of nearly 700 GPs, found that most were unwilling to increase their involvement in intrapartum care due to a fear of litigation, current workload, disruption to personal life, and perceived lack of competence. Those GPs who booked homebirths were three times more likely to offer more intrapartum care to women than those GPs that did not participate in homebirths. The same GPs were also less likely to report lack of confidence, fear of litigation, or their current workload as a deterrent to offering this care to women. Brown reports that only 17% GPs thought they should have a duty of care to be able to provide a homebirth service for women. Thus it can be seen that a lack of experience in homebirth or intrapartum care in general may breed a fear of the practice. This attitude towards homebirth would likely be presented to women by most GPs practices when attending a GP appointment at the beginning of their pregnancies. Despite the age of the study by Brown (1994), it is likely that little has changed regarding GPs attitudes to

homebirth today.

Other researchers have examined the influences on women. Barber, Rogers and Marsh (2006a), in the south of England, investigated the influences of women choosing their birth place in a two phase project. Using questionnaires and focus groups, the authors found that midwives had the ability to influence women the most, but were not exercising their full potential in sharing full and adequate information. Midwives self-selected for the focus groups, and questionnaires were only in the English language, which may have affected the findings. The second phase of the study (Barber, Rogers & Marsh 2006b) introduced an information leaflet regarding birth place choices, change management strategies, and further education to midwives on the issues of informed choice. The intervention resulted in a significant increase in awareness of choice of birth place, and the majority of women felt that written and verbal information given together was the most effective way of assisting them with decision-making. This increased level of information for women has not as yet resulted in a higher rate of homebirth, however, it did show that more women are accessing stand-alone Birth Centres in this area of the UK than at the beginning of the study (Barber, Rogers & Marsh 2007). What this study did demonstrate was the importance of providing maternity choices, and that many women, given the option, will choose an out of hospital birth place.

Perhaps it is the style and type of communication that influences choice of place of birth. Communication between midwives and women has been the subject of a number of studies (Brereton 1995; Carboon 1999; MacKeith 1994; McCourt 2006; Sinivaara et al. 2004). In an attempt to clarify an earlier study by McCourt et al. (1998), McCourt (2006) undertook an observational study which explored the nature of information-sharing, choice given to women and communication skills of midwives in two different models of care and two settings. The earlier study found no differences in quality of information given to women during booking interviews (McCourt et al. 1998), yet when studied more appropriately (qualitative observational instead of case note audit), the authors found midwifery caseload models provided a high quality of information through a relaxed conversational style, rather than a formal, check-list interview. Women

cared for in the caseload model asked more questions, which may have reflected their comfort as most were in their homes with the midwives during the interviews. McCourt et al. described the differences in interview styles as:

> *"In hospital clinics, the focus was primarily on screening, followed by giving information and advice and establishing a corporate relationship. In community clinics, the primary focus was on giving information and advice of a health education type and establishing a team relationship. In caseload visits, the focus was more mixed, across these categories and there was a focus on establishing the midwife-woman relationship." (p. 1313).*

McCourt concluded from her small study that the conventional structure of midwifery care in the UK was not conducive to providing woman-centred care, and that a community-based continuity of care model, such as caseload midwifery, enabled midwives to provide this more effectively. It may be that the same principles hold true in homebirth models as they have more of a community-based focus.

Midwives' relationships with women influence their styles of information-sharing. Health professionals will often unwittingly use power over patients to steer them towards a decision, consciously or not. This has been described in work by Foucault (1979) in his book about the social context of the penal system. He describes the 'steering' as a subtle 'disciplinary power' which can be used to get others to succumb to one's wishes. Foucault studied the relationship between power and knowledge by mapping the reorganisation of the power to punish (likening prisons to schools, hospitals and other institutions), and the development of various bodies of knowledge (the human sciences) that reinforce and interact with that power. Foucault argues that power involves restricting or altering someone's will. For example, prenatal screening tests offered to women are sometimes framed in a way that agreement from women seems a matter of course (Pilnick 2004), when the implications of such tests really warrant far more time and explanation. McCourt (2006) explains that midwives are more likely to work in partnership with women when working in a continuity of care model (such as a homebirth model which has continuity as a

focus) and employ a conversationalist style characterised by listening and 'turn taking' as opposed to a 'professional' or 'disciplinary' style (p. 1315).

It is evident midwives differ in the levels that they (both overtly and covertly) advocate for, and provide information to women, depending on women's particular characteristics and background. Information sharing is also mediated by processes of decision-making and by personal and societal perceptions of risk. This is particularly significant in a decision to have a homebirth and is discussed further in the next section.

DECISION-MAKING AND RISK

Decision-making and the assessment of risk are complex issues used continually within the healthcare environment and have particular relevance for homebirth. Risk is the possibility of unfavourable consequences when following a particular course of action. Throughout pregnancy, labour and the postnatal period, women are often given risk scenarios by midwives and medical staff to aid their decision-making. Women, when deciding to have a homebirth will carefully weigh up the risks of their decision to give birth at home, particularly in relation to the safety aspect. This section will discuss the risks that are presented to women when having a homebirth, women's perspective on risk and attitudes towards decision-making.

Beck (1992) describes modern day as belonging to a 'risk society'; a post modern concept. He describes this as being separate from risks of the pre-industrialised world, in that risks are now largely man-made (e.g. global warming, nuclear weapons, the ability to clone) as opposed to natural disasters, plagues and famines. Beck explains that through modern innovation and technology, and by seeking to control nature, society has inadvertently produced further, more catastrophic risks to humanity. This explanation has similarities to the rapid expansion in modern technologies and practices surrounding birth, where the progression of normal birth is often altered through (often unnecessary) intervention (for example, electronic fetal monitoring). Homebirth is also relevant as it is often seen as against the modern technologies – women are challenged by those inexperienced and/or

uneducated about homebirth about why they would choose not to have ready access to the technology in a hospital (Devine 2009). This is likely to be because women who choose to have a homebirth view risk from a different perspective to women choosing hospital birth.

There is a growth of a 'risk culture' in health care today. This can be seen as a result of litigation and high societal expectations of health care in general. Childbirth can be seen in predominantly two different ways, through a 'biomedical' (or 'technocratic') model or 'social' model, depending on personal philosophy (Davis-Floyd & Mather 2002; Downe & Davis-Floyd 2004). The biomedical model emphasises the elements of danger in pregnancy and birth, whereas the social model philosophy veers towards viewing birth as a more natural physiological event (discussed in Chapter 1). These philosophies have been discussed by MacColl (2009) who demonstrates through vignettes how a lack of collaboration and respect between midwives and obstetricians who possess these polarised attitudes can be to women's health and wellbeing. Similar attitudes to the risks of childbirth are held by both health professionals and women, and as such, can process decisions based on perceptions of risk in quite different ways.

The choice to reject access to hospital technology by having a homebirth can be misconstrued by those more familiar with mainstream hospital care as being a more risky course of action (Devine 2009). In reality, women often feel that they are lowering their risks of problems occurring by avoiding this access to technology, but do not discount that problems can still occur during childbirth (Lindgren, Hildingsson & Radestad 2006). The way women perceive the issue of risk affects their decision-making throughout their pregnancy, labour and birth.

It is not unusual for women to rely on midwives to make decisions for them especially when cared for within a technocratic model (Bluff & Holloway 1994; Too 1996). In her doctoral thesis, Carolan (2005) found many healthily pregnant women over 35 years of age, although keen to be informed, were happy to leave decision-making to their caregivers so as not to jeopardise their so called

'vulnerable' pregnancies. Similarly, a grounded theory study in the UK by Bluff and Holloway (1994) of women and their partners found that there was a strong trust in midwives, and that many care decisions, often not fully explained, were made by the midwives and medical staff. Many women effectively gave their midwives control through a trust in their knowledge and expertise. A similar study today may or may not have different results given the 'woman-centred' care focus of modern midwifery (Australian Nursing and Midwifery Council 2006b; Royal College of Midwives 2008), generational factors, and the promotion of choice for women in maternity care (RANZCOG, 2011b). It is possible that women who choose homebirth have a different approach to decision making as they have usually made very conscious and informed choices about place of birth.

Women who choose a publicly-funded homebirth service do so in the knowledge that the service is hospital-based, policy-driven and they are familiar with the hospital setting should they need to transfer there in the perinatal period. For example, policy would exclude women with multiple pregnancies or breech presentations from booking a homebirth within a publicly-funded service because of the higher likelihood of obstetric complications and higher associated neonatal perinatal morbidity and mortality rates (Bastian, Keirse & Lancaster 1998; Symon et al. 2009). Privately practicing midwives may choose to care for women with multiple pregnancies or breech presentations in their homebirth practice, having discussed the risk factors with the woman and her family, and continue care in the knowledge that there has been an informed choice and decision. This was seen in Symon et al. (2010) in a thematic analysis of independent midwives case notes in instances of perinatal mortality. Women had accepted the potential consequences of their high risk pregnancy and homebirth with their midwives and felt their clinical care was acceptable, despite the tragic outcomes of some of the women with more high risk pregnancies. This was similar to recent Australian research on women who chose high risk homebirths and freebirths (Jackson, Dahlen & Schmied 2012). In this study, Jackson et al. found that women (some with significant risk factors) found it more acceptable and safer to avoid hospital care, often due to a previous traumatic hospital experience.

Women need to make many decisions during the course of their pregnancies. These range from choosing their model of maternity care, to whether to undergo the many antenatal diagnostic tests on offer, although, as previously discussed, agreement is often assumed. This is similar to the often-assumed decision to give birth in hospital, as in Australia, there is little alternative within the public health system. Studies on homebirth have at times been criticised for the 'self-selection' of the women to have a homebirth, and for the similar characteristics they have.

CHARACTERISTICS OF WOMEN WHO CHOOSE HOMEBIRTH

A number of studies have investigated the characteristics of women who choose homebirth. These are useful to review as the type of women who choose homebirth may well have a bearing on the sort of information they seek, their decision making and influences. Bastian (1993), in an older Australian study of 552 women, found that although the majority were of higher educational and occupational status, women could not be stereotyped and came from a diverse range of backgrounds and beliefs. A similarly aged study conducted in Sydney found women having homebirths were older, more educated, more feminist, more willing to accept responsibility for maintaining their own health, and better read on childbirth (Cunningham 1993) than those who chose hospital birth.

Internationally, similar trends have been seen. A Swedish case-control study of 352 homebirth and 1760 hospital-birth women concluded most women choosing homebirth were older, multiparous, and from other European countries apart from Sweden (Hildingsson et al. 2006). Other studies have shown women who choose homebirth are more likely to be having their second or subsequent baby than women choosing hospital births. This is the case in Australia, (Allnutt & Smith 2000; Howe 1988; McMurtrie et al. 2009), UK (Chamberlain, Wraight & Crowley 1997), Canada (Soderstrom et al. 1990) and the USA (Anderson & Greener 1991; Cohen 1982; Littlefield & Adams 1987; Rooks et al. 1989; Schneider 1986). These women also had a high level of education (Cohen

1982; Declercq et al. 2010; Eakins et al. 1989; Hildingsson, Radestad & Lindgren 2010; Johnson & Daviss 2005; Rooks et al. 1989; Schneider 1986; Soderstrom et al. 1990), with up to 75% women having had tertiary education (Jackson, Dahlen & Schmied 2012).

It is possible that the characteristics of women choosing homebirth within a publicly-funded model in Australia are quite different to those from the European studies where homebirth (for the most part) is a more accepted option. Oftentimes, being cared for in a Midwifery Group Practice where homebirth is an option, women initially have no intention of having a homebirth, but through the course of their pregnancy and information from their midwives, change to choose a homebirth later in their pregnancies. A similar phenomena occurred within the Albany Practice in East London where women and their midwives decided during labour whether to continue at home or transfer to hospital (Sandall, Davies & Warwick 2001).

SUMMARY

This literature review has included evidence that supports the safety of homebirth for low risk women and explores issues of choice and control in maternity care, together with decision-making and risk, and the sharing of information. Studies of homebirth indicating the significant benefits of less medical intervention such as epidural analgesia, induction of labour, augmentation, episiotomy and caesarean section for selected groups of women were reviewed. From the literature it was apparent that women choose homebirth for a variety of reasons, and midwives may have had the ability to influence their choice. However, it remained unclear what influenced women accessing publicly-funded homebirth in Australia, and as demonstrated by Barber, Rogers and Marsh (2007), it was necessary to address other factors that influenced women's preference of birth place. This study will help contribute to this knowledge in an Australian context.

CHAPTER 3: METHODOLOGY

INTRODUCTION

This chapter explores and provides a rationale for the choice of grounded theory methodology used in this study. It will also describe how the data collection and analysis were applied using this approach. First, it is necessary to explore epistemologies[10], because of the interrelationship that exists between the researcher's views, their chosen theoretical stance and methodology (Crotty 1998).

EPISTEMOLOGIES

> *Epistemology provides a philosophical background for deciding what kinds of knowledge are legitimate and adequate (Gray 2004 p. 17)*

There are three main epistemologies: objectivism, constructivism and subjectivism (Gray 2004). Objectivist epistemology, which is closely linked to positivism, argues that there is an independent reality in life that is possible to discover and measure. Conversely, constructivism believes that truth and meaning are created by one's interaction with the world; that what exists rests on an individual's perception (Guba & Lincoln 1994). In this way, meaning is constructed, and the same phenomena can vary in meaning between subjects, although many constructions will be shared. In contrast to constructivism, subjectivism argues that meaning does not emerge from an interaction between a phenomena and an individual, but is imposed on the object by that individual.

Objectivism, usually in the form of quantitative research, involves classifying features, and constructing statistical models and figures to explain what is observed. Typically, the results can relate to a population and can reliably determine if one concept, product, package, or treatment is better than the

[10] The assumptions made about how knowledge of reality can be achieved.

alternatives. This is closely aligned to ‘positivism’. Positivism is a philosophical view of sociological theory that objectively looks for causal relationships and explanations in order to make predictions about the world. According to Charmaz (2006), positivism is more aligned to quantitative research theory; it rejects other ‘ways of knowing such as through interpreting meanings and intuitive realizations’ (p.5). Typical quantitative research studies used in healthcare include randomised controlled trials, descriptive surveys, observational studies, case-control studies, and time-series design studies. These provide statistical data as evidence to help establish cause and effect (in the case of RCTs), and can give probabilities and risk ratios. Historically, the more positivistic stance has been the dominant epistemology at the top of the hierarchy of ‘best’ evidence, although there have been arguments for the inclusion of observational studies as well as other heterogenous data in systematic reviews (Dixon-Woods, Fitzpatrick & Roberts 2001). Indeed, changes in philosophies around knowledge acquisition began in the 1940s with discourse on a ‘post-positivistic’ perspective. One important philosopher was Thomas Kuhn (1996 [1962]). Kuhn contested the widespread assumptions of positivism and proposed that ‘no theory ever solves all the puzzles with which it is not confronted at a given time; nor are the solutions already achieved often perfect’ (p. 146). This has led to some disciplines (notably market research) and research methods (mixed methods) combining both positivistic and interpretive methodologies to produce outcomes instead of having conflicting approaches (Davies & Fitchett 2005).

When exploring a phenomenon and finding meaning behind why people behave or think in a certain way, both qualitative and quantitative methods can be used. The best choice of approach needs to fit the research aims and questions, but also resonate with the researcher themselves. Whilst a more positivist quantitative approach perhaps aims to test hypotheses, a theory-producing qualitative approach is often fundamental to studies that aim to find meaning within a social context. This inductively generates patterns and themes through direct quotation and careful description of situations, observed behaviours and interactions.

Interpretivism, often seen as anti-positivistic, is closely aligned to constructivism as it seeks to explore and construct the experiences of people and their perspectives on a particular phenomenon. In this way, theory is not 'discovered' but built through careful examination of the data. In addition, the interpretivist constructivist approach acknowledges that there are multiple realities, and that studies can only capture the phenomenon within the specific context in which they occur. A constructivist approach appeared to fit my research question and personal history of midwifery and homebirth, as it reasoned that there was a close alignment between the researcher and the researched. This has been explained by others (Guba & Lincoln 1994), as well as Charmaz (2006), who uses this epistemology within grounded theory.

GROUNDED THEORY METHODOLOGY

Grounded theory is a qualitative research approach that was developed by sociologists Glaser and Strauss in 1967. It comprises systematic techniques and procedures of analysis that enable the researcher to develop a practical theory that meets the criteria for doing "good" science (Strauss & Corbin 1990). These are: 'significance, theory-observations compatibility, generalisability, reproducibility, precision, rigor, and verification' (Strauss & Corbin 1990 p. 27). Grounded theory is a precise analytic method that can be used as a complete framework for substantive research (Glaser 2002a).

Grounded theory broadly explores specific experiences within society and individuals. Through a series of analytic steps, a substantive theory is revealed that explains how participants processed key issues (Charmaz 2006). Exploring differences and distinctions in behaviours are part of the analysis as each participant interprets their own experiences within their individual contexts. The conceptual theories that emerge will then contain key issues that the researcher constructs, which should resonate with the participants of the study. Grounded theory can assist health professionals with understanding the importance of a phenomenon to people, and show that their ability to manage situations or conditions rests on their own particular social and structural context. Theories

may also be helpful in practice and policy change and development (Wuest 2011).

HISTORY

In the 1960s, Glaser and Strauss developed grounded theory predominantly for use by social scientists. The two men came from differing perspectives on research theory. Strauss's background was one of a traditional stance of research involving 'symbolic interactionism', which was a sociological theory that processed the dynamic interaction between people and created meanings and actions based on language and communication (Charmaz 2006). Glaser had a background in quantitative survey methods. However, despite their background, they merged to create a positivistic ideal of grounded theory. Glaser and Strauss's early work has been described as strongly positivistic with a rigid structure of systematic analytic guidelines. Later this was to evolve and become less so, giving more voice to the participants and becoming 'post-positivistic' in its application to grounded theory (Charmaz 2006; Strauss & Corbin 1990).

Glaser and Strauss's early work consisted of developing a grounded theory around health professionals coping with dying patients. Their book 'The Discovery of Grounded Theory' (Glaser & Strauss 1967) served to help many qualitative researchers make sense of how to deal with their, usually copious amounts of, raw data. However, since the late seventies, Strauss began to develop his own ideas regarding new procedures of verification of data and changed his alignment to the tightly bound comparative methods of ensuring the data and theory were consistent, as defined by Glaser. The difference in opinions mainly concerned the methods of data analysis. Glaser stressed the importance of the emergence of categories from the data, constant comparison with field notes and the development of a core category which underpins a contextual theory. This differed from Strauss in his book with Corbin (1990), who, whilst following the same rules, added a more complex and subjective analysis to the data. One of the differences, for example, is that during axial coding, Strauss and Corbin suggested categories be developed under headings 'conditions, context, action/interactional strategies and consequences' (p. 96).

A few years later, Glaser criticised the original method as being too detailed and cumbersome (1992). Glaser was concerned that Strauss and Corbin were forcing the data into categories and not allowing the emergence of theories to develop (Boychuk Duchscher & Morgan 2004). These diverging philosophies were deemed 'Glaserian' and 'Straussian' by Stern (1994), and this split, and the ensuing debate, possibly provided researchers with a greater understanding of the intricacies of grounded theory. More recently, the interpretive constructionist approach to grounded theory has been proposed by Charmaz (2006). This approach, explained above, was used in my study.

PRINCIPLES OF GROUNDED THEORY

Strauss and Corbin (1990) provide four central criteria for grounded theory. These are: it should fit the phenomenon; provide understanding, and be intelligible to both the persons studied and others involved in the area; provide generality; and control, in the sense of stating the conditions under which the theory applies and providing a basis for action in the area. The objective of grounded theory is that it explains basic patterns that are common in social life. Its major uses are in preliminary, exploratory and descriptive studies, and it is widely accepted as a rigorous analytical process. The data collection, analysis and theory stand in reciprocal relationship with each other and through a series of analytical techniques, the relevance of the area of study is allowed to emerge.

Grounded theory warrants the use of a constant comparative method of analysis. That is, the first interviews are compared for similarities and differences, then coded, compared and clustered, and a category is formed. As more data are collected, it is similarly analysed, and more categories are formed until data saturation occurs (that is, no new data appears). Eventually, patterns and relationships emerge and a general theory about these relationships will be formed. The joint collection and analysis of data is an essential strategy of grounded theory research (Strauss & Corbin 1998).

DATA COLLECTION APPROACH

Data collection was guided by a sampling strategy called theoretical (or purposive) sampling. This is where a need appeared to collect certain data in order to examine categories and their relationships. This ensured complete representation, and also tested, elaborated and verified categories. In this way, there was a certain ability of the researcher to be creative within grounded theory and devise new comparisons and associations. However, every category of comparison needed to be validated within the model. This had to be incorporated with 'theoretical sensitivity'. Theoretical sensitivity is where the researcher was able to use personal and professional experience and literature to think widely around the research topic, analyse words, phrases or sentences through techniques and creative questioning. It enhanced the ability to identify what is important in the data and give it meaning (Corbin & Strauss 2008). When no new data were obtained from the interviews, data saturation was reached, and no new participants were necessary. This has also been defined as a time during the study when concepts are well formed and defined, categories are being developed and the relationships between concepts are beginning to be formed (Corbin & Strauss 2008).

ANALYSIS APPROACH

> The interpretive constructivist approach has been described by Charmaz as placing *'priority on the phenomena of study and sees both data and analysis as created from shared experiences and relationships with participants'* (Charmaz 2000; 2006 p. 130).

Constructivist grounded theory means researchers construct concepts and theories out of data from research participants in their efforts to explain their experiences. This approach was explained by Corbin (2008), and represents a more modern approach to grounded theory as opposed to a 'Glaserian' method, which subscribes to a more classic method (Christiansen 2009). Ardently questioned by Glaser (2002b), constructivist grounded theory has an emphasis on how and why study participants create meanings and actions, and also how the researcher interprets these phenomena. It acknowledges that the studied

experience is revealed within a larger hierarchy of social relationships and that distinctions between participants' experiences and meanings will occur. Charmaz (2006) states that the constructivist approach also acknowledges the social construction of data and analysis; that analysis is put together within a social time and culture.

Importantly, the constructivist interpretation of data rests on the researcher taking a deeply reflexive approach. This reflexivity is important as the researcher examines their own assumptions and viewpoints in order to understand how they individually interpret the data. In this study, reflexivity and my personal philosophical stance have been addressed later in this chapter.

BASIC SOCIAL PROCESS

Throughout a grounded theory approach, there will often be a linking thread that ties categories together, called a 'basic social process'. The basic social process is closely linked to the core category that encapsulates the theory. This becomes apparent later in the study, but serves to give life to data and provide meaning in the form of a dynamic process that occurs across all the categories. For example, a grounded theory study of Human Immunodeficiency Virus (HIV)-positive mothers discovered a basic social (psychological) process of 'defensive mothering' which fit with the way the women had to deal with their health status and the stigma that accompanied being HIV-positive (Ingram & Hutchinson 1999). To inform the basic social process, the authors had categories of 'preventing the spread of HIV and stigma, preparing the children for a motherless future, and 'protecting themselves through thought control'. Defensive mothering was a protective method of caring for themselves and their children, and also a way of maintaining control and planning for the future. Forming a basic social process aligns with a more Glaserian approach (Glaser & Strauss 1967) and Charmaz argues is not always possible in every study, that is, some studies do not have a single defining basic social process that encompasses the meaning of the data (Charmaz 2006).

CODING

The coding procedures allowed theories to be built from the analysis of the data. There are three types of coding; open coding, axial coding and selective coding. Open coding is the part of the analysis concerned with identifying, naming, categorising and describing phenomena found in the text. Essentially, each line, sentence or paragraph is read in search of the answer to a particular repeated question. Axial coding is the process of relating codes (categories and properties) to each other via a combination of inductive and deductive thinking. The final coding, selective coding, is the process of choosing one category to be the core category, and relating all other categories to that category. The essential idea is to develop a single storyline around which everything else is arranged (Glaser 2002a).

Other procedures, memo writing and the use of diagrams, are also incorporated as essential parts of the analysis, as are procedures for identifying and incorporating interaction and process. Credibility for the analysis can be verified through taking the categories back to a number of participants who can assess the accuracy. This was performed by Levy (2006) whose grounded theory research on midwives facilitating informed choice involved participant confirmation of the core category of 'protective steering'. However, Glaser (2002a) differs on this, citing that the data will not necessarily be a reflection of individuals, but rather a generalised abstraction of participants doings or thoughts, and that a 'check' on validity in this way is unwarranted. Charmaz (2006) agrees with Glaser and states 'rather than contributing verified knowledge, I see grounded theorists as offering plausible accounts' (p. 132). In my study I aligned with Charmaz (2006) by not engaging participants in verification of the theory because of the interpretive constructivist nature of the research.

Paradigm (or exemplar) models can be developed throughout the analysis in grounded theory to provide examples of concepts and give meaning to links in categories. These pictorial expressions are described in Corbin and Strauss (2008) and have been used in many studies using grounded theory, for

example, Blix-Lindstrom et al. (2004 p. 107), Levy (2006 p. 116), and Dahlen et al. (2008 p. 24).

MEMOS

Memo notes are written during data collection and analysis. These are notes written to help place the interview in context, and provide more information regarding the participant, as well as thoughts, ideas and questions that may arise for future verification. They provide relevant information that the audio recording alone may have missed, such as non-verbal communication, and serve as a reminder to develop ideas and return to certain issues that need clarification (Charmaz 2006). Corbin (2008) distinguished between memos and field notes by explaining that field notes were data written at the time of data collection (in the 'field') that contain a certain degree of analysis, whereas memos were defined as lengthier texts written after leaving the field containing more conceptual and analytical thoughts. Examples of memo notes are in Appendix 7.

A FEMINIST APPROACH

This study was undertaken through a feminist lens. The participants were women who described their influences that led them to decide to have a homebirth and were the experts about their experiences in their own context within their social world. Hence this study, undertaken by a woman about women's experiences and decision-making of choosing a birthplace, provide a deep reality within the data that incorporate a great deal of emotion, feeling and belief. Gray (2004) states that feminist epistemologies interpret what they know from their social position, and that within feminism, this is from an oppressive standpoint, as opposed to the dominating position of men.

Recordings of feminist thought can be found in many ancient cultures. For example, the 16th century Navajo Indian culture (No author 2005), documents the power of female fertility. More recently, Lake (1999) has provided an Australian history of feminism that described four main periods: pre-suffrage feminism, maternal feminism, equality feminism and liberation feminism. These periods ranged from the first women's campaigns for the right to vote and have

citizenship, to the liberation feminism of today that addressed stereotypes of women as mothers, and demanded equal pay and workforce conditions in a society that is still largely patriarchal. There are numerous feminist theories that have since developed incorporating liberal, Marxist, socialist, radical and post-modern philosophies. These all differ slightly in their emphasis, but overall aim to highlight gender inequality and empower women and give them a voice. This study provides a description of the feminist influence that underpins the nature of homebirth, and the study itself.

Acker, Barry and Essevald (1991) state that there are three principles that underpin feminist research; usefulness of the findings to the participants, a non-oppressive research method, and a method that allows for reflection. Grounded theory, by its methodological nature, is suitable for feminist research, according to Wuest (1995), as it allows the theory to emerge from the data rather than having a notion of what is significant imposed upon female participants. To provide a feminist research method to obtain rich data, it was necessary to examine myself as a researcher through a reflexive process, which was also consistent with constructivist grounded theory methodology.

REFLEXIVITY

> *Personal experience, or member, expertise is at the core of participatory modes of inquiry (Sandelowski 1998)*

All qualitative, and arguably quantitative research, requires researchers to position themselves within the context of the studied phenomenon. Reflexivity is used to help analyse social processes by enabling researchers to acknowledge their role and situation within the research. It is necessary to identify the philosophical stance, or 'personal frame of reference' of the researcher in order to realise motivations behind undertaking the study. These can be internal or external (Higgs, Horsfall & Grace 2009). Internal motivations include a personal interest with a particular topic, and external pertains to the motivations such as salary and maintenance of funding for work-related higher research degrees, and career advancement. Personal philosophical stances are also influenced by the researcher's background; their religious and political beliefs, gender,

knowledge and culture. An understanding of a philosophical stance also lends credibility to the nature of the analysis and the interpretive ability of the researcher.

My history as a midwife and homebirth mother provided me with an internal guideline that assisted with the formation of questions during data collection. It also enabled a deeper understanding of the participant's accounts, and helped them articulate difficult phrases and concepts when the need arose. This has been discussed by DeVault (1990) who suggests helping women clarify and explain 'incompletely said' phrases (p. 67), and differs from 'leading' the participants during interviews. In the same way, care was taken to avoid an over-identification with the participants in which interviewers may miss valuable data through an assumed knowledge.

The dilemma of being an insider or outsider in a research study has been studied (Asselin 2003; Dwyer & Buckle 2009; Simmons 2007). Being an 'insider' researcher means that the researcher is part of that group, and that a language and identity are shared. In my study, I felt being an 'insider' of having had a homebirth enhanced my study through having a shared experiential base with participants, an understanding of the research question, and a commonality with the participants which facilitated the interview process. The benefits of a 'direct and intimate' insider role as a qualitative researcher in both data collection and analysis, has been discussed by Dwyer and Buckle (2009 p. 55). The authors state that this can allow a more rapid acceptance of the researcher by participants which can lead to data of greater depth.

Being an 'outsider' when undertaking research can similarly be argued to be advantageous. In grounded theory, being outside of the knowledge area or 'bracketing' your prior knowledge of a subject can allow an impartiality that may enable a more complete picture or phenomenon. In the same way, a more Glaserian method of not performing a literature review (or 'bracketing your knowledge) prior to conducting the research can allow the emerging deductive theory to be unfettered and unconstrained by the researcher's knowledge.

In my study, I felt able to identify with the participants at possibly a greater level than a non-midwife/homebirth mother would have, but do not feel that the data collected would have varied greatly if I had had a different personal background. At most interviews I did not reveal that I had experienced a homebirth until after the interview was finished, and in doing so I feel this provided an opportunity for women to expand on their explanations of the influences on why they chose a publicly-funded homebirth during the interview. If they had known I had had a similar experience of a birth at home, it was possible participants would have not fully related their experiences because they might have thought I had heard it or experienced it before. Conversely, if I sensed a participant was hesitant to share her feelings and thoughts openly, disclosure of my background helped women to feel a connection with me in order for the interview to flow, which aligns with findings from Dwyer and Buckle (2009) and Asselin (2003). Dwyer and Buckle (2009) discuss the benefits of occupying the space 'in between' being an insider and outsider; that qualitative researchers can never distance themselves completely from their participants, and should strive to maintain a middle ground whereas Johnson (2002) states the necessity to be a current or previous member of the studied group for true reciprocity to occur. Throughout my data collection, I felt I held the middle ground position – and that it oscillated depending on the personalities and interview trajectory with each participant.

As a researcher, I have created the study and actively constructed the collection and analysis of the data. In this way, my approach is integral to the outcome and interpretation of the study. I acknowledge that my personal stance regarding homebirth may have influenced the findings and conclusions. It is now accepted that it is more realistic to include the subjectivity provided by the researcher, rather than seek to eradicate their presence (Finlay 2002) and the concern is how to integrate the researcher's subjectivity within the research and not harm the validity and reliability of the research. Elliot and Lazenbatt (2005) discuss how this can be performed by the use of memos or field notes. By writing notes concurrent with data collection, there can be a cross-checking and notation of personal biases or assumptions, as well as evidence contributing to emerging categories. These techniques of ensuring the quality of the data and theory generation support Finlay and Gough's (2003) statement that 'it is no

exaggeration to maintain that research is, to a large extent, a subjective enterprise kept reasonably in check by a number of more or less general methodological rules and considerations' (p. 40). In my study I attempt to use a variant of reflexivity throughout the analysis and presentation of the findings, as suggested by Finlay and Gough (2003), called 'intersubjective reflection' (p. 8). This involves self- reflection of both the process of data collection and analysis, and the relationship between the researcher and participants.

GROUNDED THEORY IN MATERNITY CARE

There are many studies in maternity care that use grounded theory. These include Blix-Lindstrom et al. (2004), Fenwick et al. (2008), Dahlen et al. (2008), Madi and Crow (2003), Sheehan et al. (2010) and Levy (2006). Blix-Linström (2004) investigated women's satisfaction with decision-making related to augmentation in labour. This study declares a 'modified' grounded theory approach was used, although the modifications were not stated, and cites Strauss and Corbin (1990) in its explanation of methodology. Fenwick et al. (2008), in their study of 28 mothers of infants in Special Care Nurseries, clearly state that a constructivist, interpretative approach was used. Similarly Sheehan et al. (2010) states a constructivist methodology and explained the purposive sampling technique necessity of recruiting younger mothers to ensure heterogeneity of the sample. This study had a core category of 'deconstructing best' which explained the decision-making processes of breastfeeding mothers over the first six postnatal weeks. Dahlen et al. (2008) studied primiparous women who had given birth at home or in hospital in Australia. The paper discusses one of the categories 'Preparing for Birth' that arose from the research and concludes that women planning to give birth at home felt more prepared than those having a hospital birth. The authors state that grounded theory was used and cite Strauss and Corbin predominantly when explaining their methodology (1990). The grounded theory studies by Madi and Crow (2003) and Levy (2006) have been described in the previous Chapter.

The key features of grounded theory are the focus on a 'substantive area' as opposed to a specific research question or hypothesis. Exploring the influences

on women who choose a homebirth fits the grounded theory methodology of being able to generate a theory. The elements of grounded theory, in particular the structured coding methods and concurrent flexibility (and creativity) seemed a suitable approach to facilitate my study. Other considered methods to use in this study included phenomenology (Heidegger 1996), however, this qualitative method focused on an 'inner lived experience' and a broader contextual experience was the aim for this study. It was important to examine the context and process related to women's influences on why they chose a publicly-funded homebirth, and develop a theoretical explanation incorporating women's decision-making processes and all the factors that facilitated the decision.

Grounded theory differs from phenomenology mainly through the differences in data collection and analysis. Ng and Sinclair (2002) used phenomenology to describe the lived experience of women planning a homebirth (n=9). Ng and Sinclair likened women's homebirth experience to the ascent of a mountain and stated eight themes in their study. These included themes around a woman's decision, their perspective on the journey, their approach (to the summit of the mountain [labour]), the peak (birth) and the triumph. In a grounded theory study, analysis would be performed concurrently with data collection and purposive sampling would be used to guide the collection of data, whereas phenomenological methods analyse the data after collection. The purposive sampling enables a grounded theory researcher to focus on particular concepts that arise and test the relevance to the evolving theory through sampling and/or interview questioning. In this way, grounded theory provides a greater depth of focus on a studied subject.

One of the few criticisms of grounded theory approach is that there is a lack of reliability – no two replicated studies will necessarily come to exactly the same conclusion. However, as Chenitz and Swanson (1986) explain, applying grounded theory interprets, understands and predicts phenomena, hence the test for reliability is through the use of theory and its applicability. The applicability of this study will materialise through the future growth of publicly-funded homebirth models in Australia based on this study's findings, as well as further data on maternal and neonatal outcomes from the current Birthplace in

Australia study.

SUMMARY

This chapter has explained the methodology chosen for my study. The epistemological underpinnings and history of grounded theory have been outlined and a reflexive account of my background and placement within the research has been given. After consideration of other qualitative methodologies, a feminist interpretive constructivist grounded theory methodology was chosen for this study because of its flexible style and acknowledgement of the alignment of researcher and analysis. Corbin (2008) states that grounded theorists are a certain 'type' of researcher; interested in making order out of disorder and complexity, with a wish to learn about people, and an enjoyment of serendipity and discovery. This description seems apt of any researcher, but particularly so for researchers using grounded theory due to its serendipitous nature. The ability to study a phenomenon with an evolving, fluid nature, but within a framework of a strong rigorous methodology was also appealing to me and fit the subject and my research interest. The next chapter will describe the methods used in this study.

CHAPTER 4: METHODS

INTRODUCTION

This Chapter explains the methods used in this study. This includes an explanation of the setting for the study. The importance of ethical considerations concerning research studies is stated, and the participants of the study and techniques, content and timing of data collection is defined and discussed. Finally, the methods for data analysis and data storage issues are described.

SETTING

The setting for the research is the Birth Centre at St. George Hospital which is a Level 5[11] metropolitan public hospital and part of the Central Network of the South Eastern Sydney Area and Illawarra Health Service. The Hospital is 19 kilometres from the centre of Sydney. The maternity unit comprises a Delivery Suite, Birth Centre, Antenatal clinic and an Antenatal and Postnatal ward. There are approximately 2500 births a year, 100 of which occur in the Birth Centre, and around 20 at home.

The Birth Centre provides a homely environment, with modern décor throughout to help women and their families feel comfortable; the appearance being more like a room in a house than a hospital room. Women are booked into Birth Centre care at 6-10 weeks gestation. This can be either through referral by their GPs, the antenatal clinic, or often by self-referral through prior knowledge of the Birth Centre by the women themselves (followed by a GP referral). At the time of the study, eight midwives worked within the Birth Centre. Four of these were able to be the primary midwife for women who choose homebirth, having attended at least five births at home, the Advanced Life Support in Obstetrics

[11] In NSW, a Level 5 maternity service consists of midwives, midwifery educators/consultants, 24-hour obstetric, paediatric, and anaesthetic on call staff and onsite accredited medical practitioners. Women with selected high risk factors >32 weeks gestation are cared for, and neonatal nurseries are capable of caring for babies born >32 weeks gestation, but must transfer to a higher level nursery in the presence of complex disease.

(ALSO) course, a rigorous credentialing process, practice review and competence in resuscitative skills, cannulation and perineal suturing.

ETHICAL CONSIDERATIONS

All research requires consideration of ethical practice. For this study, separate applications for ethical clearance were submitted to the South Eastern Sydney and Illawarra Health Service and the University of Technology, Sydney. The main aim of any ethics committee is to protect both researchers and participants from harm, and ensure researchers have considered every aspect of their study. They also ensure that studies are conducted appropriately. My study was given ethical clearance to commence in October 2008, and an amendment to the approval was given to allow interviews of women's partners in April 2010. The University of Technology, Sydney and South Eastern Sydney and Illawarra Health Service Health Research Ethics Committee number of the study was 08/STG/129.

PARTICIPANTS

The study included English-speaking women over age 18 who had given birth within six months, and who had planned a homebirth within the publicly-funded model at St. George Hospital. Included were women who were transferred to hospital care before or during labour. These women had previously made the decision to have a homebirth despite their plans altering through circumstances usually beyond their control. Other participants included two partners of the women, and five midwives who worked within the publicly-funded homebirth program at St George Hospital.

Access to women was gained through the Birth Centre midwives who cared for the women. Through prior agreement, the midwives informed women of the study by introducing the subject during their clinics, gave information sheets (Appendix 1), and placed addressographs of interested women in a designated book. After retrieving the women's details, contact was made by phone after the 6-week postnatal period, where another information sheet was posted if necessary, and an interview was arranged.

Seventeen women, five midwives and two partners were recruited. The final number of participants was determined when data saturation occurred. Data gained from midwives and the women's partners were used to verify concepts that arose. This was in-keeping with a grounded theory approach where evidence is looked for to support or contest a concept by obtaining data from other sources.

DATA COLLECTION

The study involved recording and transcribing interviews with women who had chosen homebirth within the publicly-funded model at St George Hospital. Prior to interview, information sheets regarding the research were given to participants and formal consent forms signed. The research was fully explained verbally to each participant and participants were informed that they could revoke their participation at any time. A semi-structured interview technique was used with a general opening question 'how was your birth experience?' to engage women and create a rapport. Establishing rapport was necessary in order for feelings of trust to occur between participants and researcher allowing a more relaxed approach and sharing of information. This has been discussed by Johnson (2002) who likens effective interviewing to a conversation between friends; the difference being that the discussion will generate data. It was also important to create a non-hierarchical relationship with participants, which is consistent with a feminist standpoint (Oakley 1981). A funnelling technique was used - beginning the interview with general questions, and narrowing down to particular topics (Charmaz 2006; Minichiello et al. 1999; Polit & Hungler 1999), clarification of particular points occurred and encouragement towards a descriptive explanation sought. Care was taken towards an open-ended question technique to avoid loaded questions. Towards the end of the series of interviews, my technique became more focused and selective, having narrowed down the topics and ability to reveal the women's stories and verify prior concepts more efficiently.

The interviews occurred after the women's six-week postnatal period, and within six months of birth. Timing of interviews in postnatal women has been studied in relation to memories of events and levels of pain experienced (Simkin 1991,

1992; Waldenstrom 2003; Waldenstrom & Irestedt 2006) with varying results. Simkin (1992) and Waldenstrom (2003) found that negative events appear to intensify over time, but this was not the case with all women. A further analysis of the large cohort by Waldenstrom (2004) found women who deemed their experiences more negative at one year were more likely to have had more painful labours, caesarean sections, psychosocial difficulties and less support during labour and birth. Early interviews after birth (as opposed to interviews one year after birth) do not necessarily provide a more accurate recall of events (Simkin 1992; Waldenstrom 2003). When interviewing women, I did not request a recall of specific events, but asked for thoughts surrounding their decision-making processes and influences when they chose a homebirth. All interviews took place in women's homes.

Although a semi-structured interview technique was used, I used an interview guide with a list of prompts to ensure focus on the research topic (as recommended by Bryman 2004; Minichiello et al. 1999; Polit & Hungler 1999). These prompts included questions about decision-making, information received, key people and events that led them to choosing a homebirth and prior knowledge of homebirth. During the process of data collection and analysis, it was also helpful to continually ask the question 'what is this data a study of?' (recommended by Glaser 1998) to help maintain and drive the analysis. This helped the meaning of the data to keep on track in relation to the question in my study: what are the influences on women who choose a publicly-funded homebirth?

The questions at interview included, but were not limited to:

- Why did you choose a homebirth?
- What did the midwife (or others) say about homebirth that helped your decision?
- At what stage in your pregnancy did you choose to have a homebirth?
- What was your experience or knowledge of homebirth before this pregnancy?

These questions altered during the series of interviews, and many more questions were added throughout the process to verify concepts from previous interviews - in line with grounded theory methodology (Strauss & Corbin 1990). For example, the first participant stated she felt there was an element of 'blind faith' in her decision to have a publicly-funded homebirth, but could not articulate why she felt this way. In the following interviews I would ask women about their beliefs and faith in having a homebirth, to verify the concept and unravel the meaning. The data eventually led to the core category of *having faith in normal*. The body language of women during relevant periods of conversation was also noted using field notes for inclusion in the analysis. In my study, I used a combination of field notes and memos, with more of the latter written immediately after each interview, and during the transcription process. Demographic data was obtained from the women prior to interview. These data included age, parity, ethnicity, marital status and educational level (see Table 1 in Chapter 5).

Five midwives working in the Birth Centre were invited to participate in the study. The midwives were interviewed in a private room in their workplace after the data collection from women was completed. This aimed to explore the depth and quality of information about homebirth given to women during their pregnancies, and their practices surrounding the facilitation of women's decision-making. Verification of concepts was also sought. Questions asked of the Birth Centre midwives were:

- When do you usually introduce the option of homebirth when talking to women and what do you say?
- Do you approach the subject differently with each woman? If so, why?
- Why do you think women choose to have a homebirth in your program?
- What do women and their partners ask you about having their babies at home?

These interviews were also audio recorded and transcribed, and used to

validate and expand on the women's data.

STORAGE OF DATA

Correct storage of personal data from research participants was ensured. This was concurrent with ethical guidelines, and was reiterated to the participants at the beginning of each interview. All audio data was stored on an NVIVO software program with a non-identifying code and original recordings deleted from the recording devices. The NVIVO software program was located on a password-protected home desktop computer. Once transcribed, the data were similarly stored on the NVIVO program with a non-identifying name similar to the audio recording name - for linkage purposes. During coding, it was necessary to print hardcopies of the data. These were kept in a locked cupboard within my home office. Signed consent forms (hardcopies) were kept separately to the transcripts (Appendices 2, 4 and 6).

DATA ANALYSIS

A qualitative analysis in keeping with grounded theory was undertaken (Charmaz 2006; Strauss & Corbin 1990). This took place concurrently with data collection and included systematic coding and the formation of categories within a grounded theory framework. The analysis also incorporated a feminist viewpoint which is consistent with midwifery and grounded theory (Wuest 1995). This is explained in Chapter 3. The audio tapes were personally transcribed prior to performing the coding procedures, which have been previously described. Audit trails were written to clearly track the coding procedures, similar to the work of Fenwick et al. (2008), and are presented in Appendix 12. Finally, after data collection and initial analysis, selective coding was undertaken. This complex procedure involved tying together the categories to form a core category. The core category had to relate closely to the sub-categories and basic social process to provide an analytic story that emerged throughout the work.

All categories were examined to determine the basic social process and a theoretically sensitive approach was used to synthesise data. Reflexivity was

used to ensure acknowledgement of my role within the research. Being 'theoretically sensitive' is a term used to describe seeing beyond the obvious to the possibilities of different meanings; to challenge assumptions and arrive at new theoretical formulations. Throughout the analysis I continually questioned the data to open up the potential for new categories, and used the field notes and memos gathered during data collection. Examples of the memos created and used in this study are in Appendix 7.

SUMMARY

This Chapter has provided an explanation of the methods used to conduct this study. The next chapter will describe the five categories, core category and the basic social process that comprise the findings of the study.

CHAPTER 5: RESULTS

INTRODUCTION

This grounded theory study set out to investigate the influences on women who chose a publicly-funded homebirth. The core category was *having faith in normal* with an overall basic social process of *validating the decision to have a homebirth.* The categories were: *feeling strong and confident, doing it my way, protection from hospital related activities, having a safety net, selective listening and telling, and engaging suppor*t. These categories all linked to the core category *having faith in normal* which will be expanded upon at the end of each section describing the results of each category. The relationship between the core category, the categories and the basic social process are shown in Figure 1. Overall, the basic social process was *validating the decision to have a homebirth*, which will be explained at the end of this chapter.

This chapter provides the demographic data of the participants, and describes the categories, highlighting the core category and the basic social process.

DEMOGRAPHIC DATA

The 17 participants came from similar backgrounds with similar ethnicity (Table 1). They all lived within the St George local health district (see Appendix 14) - one of the conditions of booking for a homebirth was that women had to live within half an hour's drive of the hospital. Of the 17 women interviewed, 13 were born in Australia. The other women were born in Bosnia, New Zealand, Ireland and Malaysia. All spoke English as their first language.

Women's ages ranged from 21 – 40 years, and most were aged between 30 – 35 years. The majority were married with four in a de-facto relationship. Four women had Masters degrees, three had Bachelors degrees, one had a post-

graduate diploma, four had Diplomas, one had a Certificate 4[12], two had Higher School Certificates, and one woman's educational level was unknown. Two women had three previous children before booking a homebirth. One woman had two previous children, seven had one child, and there were seven for whom this was their first baby.

TABLE 1: DEMOGRAPHIC DATA OF WOMEN PARTICIPANTS

No	Birthplace	Age	Parity at time of interview*	Marital Status	Educational level	Country of Birth
1	Hospital	30	1	De Facto	Higher School Certificate	Australia
2	Home	40	1	Married	Masters degree	Australia
3	Home	31	1	Married	Masters degree	Pacific
4	Hospital	32	1	De Facto	Bachelors degree	Australia
5	Hospital	38	1	De Facto	Masters degree	Australia
6	Hospital	33	1	Married	Bachelors degree	Australia
7	Hospital	25	1	Married	Post Grad Diploma	Australia
8	Home	35	2	Married	Masters degree	Northern Europe
9	Hospital	26	2	Married	Diploma	Australia
10	Home	21	2	Married	Diploma	Australia
11	Home	33	2	Married	Bachelors degree	Australia
12	Home	25	2	Married	Diploma	Eastern Europe
13	Home	31	2	Married	Higher School Certificate	South East Asia
14	Home	31	2	Married	Bachelors degree	Australia
15	Hospital	NR	3	Married	NR	Australia
16	Home	39	4	De Facto	Diploma	Australia
17	Home	34	4	Married	Certificate 4	Australia

*Placed in order of parity; 1 = has given birth to their first baby; 2 and greater = has given birth to their second, third or fourth baby; NR = not recorded.

[12] A certificate 4 is a level of education as noted by the Australian Qualifications Framework, which involves up to two years study and results in graduates attaining theoretical and practical knowledge and skills for specialised skilled work.

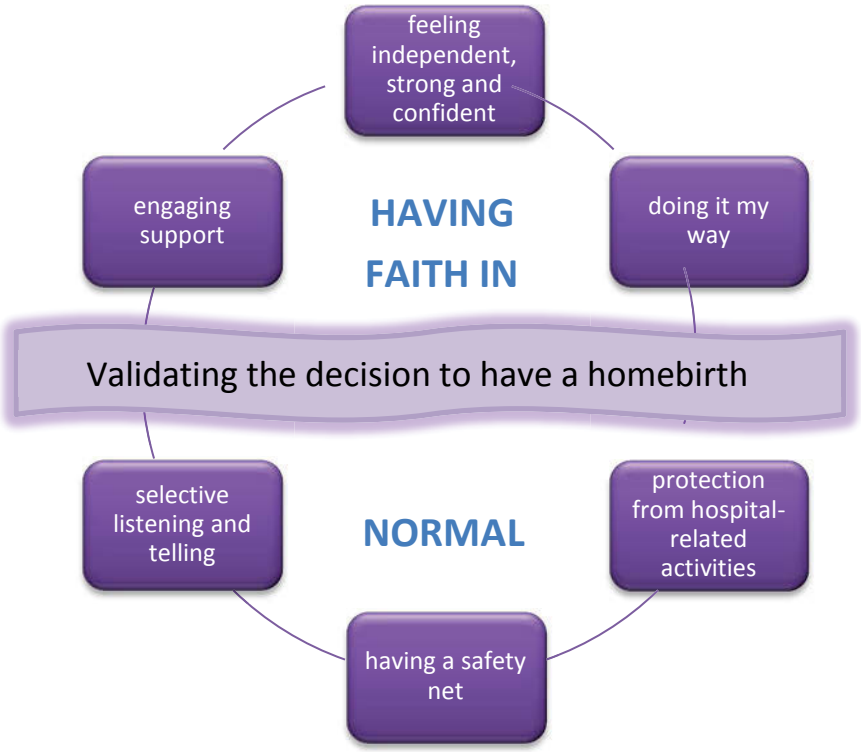
OTHER PARTICIPANTS

Interviews were also conducted with five midwives who worked in the Birth Centre and the homebirth program, and two male partners of the women participants. In total there were 24 participants. These data have been integrated into the results to validate the categories and provide strength to the concepts discussed.

THE CATEGORIES

This section will describe and explore the categories. These were: *feeling independent, strong and confident, doing it my way, protection from hospital-related activities, having a safety net, selective listening and telling, and engaging support*. The names for the categories emerged from coding the data, and as such are often women's own words. This process has been previously described. The relationship of each category to the core category: *having faith in normal* will be explained in each section. Lastly the basic social process: *validating the decision to have a homebirth* will be discussed. Due to the small sample size in this study and the chance of identification of participants, quotes have not been linked to participants in-text. The numbers have been removed to protect anonymity.

FIGURE 1: THE FINDINGS: A MAP OF CATERGORIES AND THE CORE CATEGORY



FEELING INDEPENDENT, STRONG AND CONFIDENT

Feeling confident and having a strength to be able to give birth at home was a strong theme expressed by all participants. Women used a number of phrases to articulate their strength, independence and confidence including *'I knew that my body was capable', 'If I think a certain path is the right way... I will do that',* and *'I just felt so confident and supported'.* Women reported being independent assertive decision-makers who felt they did not need drugs during labour, and were physically and mentally well. Women believed in their body and their midwives, and felt their belief and confidence would enable them to give birth at home.

Women often felt that their independent nature contributed to their feelings of strength, and attributed it to one of the reasons they chose to have a homebirth. One woman stated: '…*I'm very independent, fiercely independent, I don't like to*

be told what to do'. This statement also related to her feeling that she needed to be in control, which is a category that will be expanded upon on within this chapter.

When asked how they made decisions in their life, most explained that they were very involved in decision-making in all aspects of their lives. One woman described the strength of her decision once it was made; she said: '…*Once I'd made my decision, that was my decision, and I'd thought about it enough to make a very confident decision'.* Another woman described how she discussed decisions with her partner, but within her partnership, she retained her independence and individuality. She said:

> *We certainly make decisions together and always discuss things together, but definitely – I am not one to rely on a partnership, and make decisions for me or not make decisions because of somebody else, so I've always done what I've wanted*

While care and support from partners was critical, the sense of being responsible for one's decision and having the confidence to make it was strong.

Most women decided to have a homebirth independently of their partner, and then had to help them understand the reasons behind their decision. Women often described their partners as being 'led' by them. One woman describes this:

> *He was just led by me basically; he said 'well if you're comfortable with it and you think it's the right thing' then he was happy with it*

Women were assertive when discussing the ways they made decisions. Due to societal and often health professionals' disapproval of homebirth, women had to be assertive in order to arrange, and carry out their plans for a homebirth. The disapproval of homebirth by some health professionals was present despite the homebirth they were planning being a hospital-based program.

The Birth Centre has a limit on the numbers of women able to be booked each month (women have to be booked into the Birth Centre to access the homebirth service). Women who try to book for Birth Centre care beyond 8-9 weeks gestation often cannot be accommodated. Hence women seeking a homebirth had to be able to negotiate the system, know where to seek advice that met their needs, and have the assertiveness and determination to do so. One woman explained that her age and past experience enabled her assertiveness:

> *I think when you are older you learn to say 'no' more because when you are young you just want to please everyone and the more kids I have and the more I have to do, its like 'no – can't do that' and 'don't want to do that'*

To experience the intensity of childbirth without analgesia involves strength and tenacity. A homebirth in Australia means that women have no option of having pharmacological medications in labour compared with the United Kingdom for example, where Entonox, and Pethidine can be used. The women in this study who discussed ways to manage pain during labour believed they would not need medication, and were mostly planning to use heat packs and water. This did not differ between primparous and multiparous women. Women saw medication for pain in labour as a medical intervention, and something that was only necessary if there was a problem. One multiparous woman explained the way she managed her labour pain in the past:

> *I've seen what you have to do to get through it and I just had it in my head that it's not about the pain that I'm going to physically experience, it's about getting my head above that pain and I can do that, I'm strong enough to do that*

It was not only the multiparous women who felt the confidence and strength to experience childbirth without analgesia. One primiparous woman relayed her certainty that she would not need pain relief:

> *Never thought about whether I would need it or not, or whether I would change my mind half way through labour and want pain relief*

> *because I just knew I wouldn't. I know that I'm saying that in hindsight, but even now I just remember thinking that I just won't need it, I just won't need it unless there is something wrong*

Women felt that they were strong, and this meant that they perceived that they were fit, healthy and mentally able to cope to give birth at home. This provided confidence and reassurance that they had the best chance at achieving their aim, and that their risk of complications was minimal. Many sought natural remedies before seeking conventional help when ill, adding weight to their view of health and wellness. These women related that this perspective on health fitted their philosophy of giving birth at home. Some of the comments from women explaining this include:

> *I would consider myself a healthy person, I exercise, eat balanced meals, I think it's important*

> *I was very much in that 'wellness perspective'*

> *I think if your mind is set and you are mentally stable enough to do it then… go for it*

> *I just know mentally I was strong enough to do that*

The 'wellness perspective' mentioned by one of the women above is a description of a state of mind depicting an overall default feeling of being well in her pregnancy and in herself. This was a powerful and meaningful way to view oneself, especially when planning to have a homebirth. Most women described their lifestyles as being centred around keeping fit and well, either through their exercise regime, diet, alternative health practices, or a combination of these. In this way, women had a perspective of wellness that reassured them that they were highly likely to have a normal natural birth. This was linked strongly to the core category of *having faith in normal*.

During data collection I wrote memo notes that prompted further exploration of the concept of 'wellness' (see Appendix 7). Upon further questioning of participants, this concept was greatly strengthened and reinforced.

Most women discussed personal values and beliefs in relation to their decisions around place of birth. These all centred on what they considered to be normal and natural, and often stemmed from their other life experiences. One woman described her healthy family lifestyle, and another listed the non-toxic cleaning products she preferred to use around her house (connecting her 'green' natural-focused lifestyle with having a homebirth). Three women were alternative health practitioners, and related their work philosophies to having a homebirth. Another woman had previously worked in a developing country and described the overall 'normal, natural process' of women having their babies in small clinics there as an 'amazing experience'. All these women described elements of their lives that fit with having their babies at home (having a natural, normal birth), as opposed to a birth in a hospital environment, which they deemed more likely to be 'unnatural'. Being natural and keeping normal gave women confidence to have a homebirth.

In relation to the women's comments about feeling mentally strong to have a homebirth, it is likely this also related to their emotional strength. Only one woman described this explicitly in relation to her profession in an alternative health discipline, which clearly played a large part in her general philosophy. She said:

> *Western medicine doesn't help everything, they [women who choose homebirth] tend to be people who choose alternative health care models like chiropractors, osteopathy, acupuncture, they tend to have a broader view of health and don't just see it as being physically healthy, they have a big concept of having their emotional well-being as well…*

Many explained their confidence through depicting their strength in other areas of their lives and relating it to the ability of their body to give birth normally. This was more often from the primiparous women, whereas the multiparous women

had their previous childbirth experience from which to draw confidence and strength. One primiparous woman described her resolve to have a homebirth through knowledge that she could cope with similar intense experiences. She said: '*Other people I know, certain things I've been through, they say 'wow, you've come through that' so I know that I have a strong tenacity to go through things'.*

Multiparous women explained their personal strength needed to give birth at home in relation to their previous birth experience. All these women, except one who had a vacuum-assisted birth, had previous normal births. They anticipated a normal birth for this birth – and aimed to improve on their previous experience by giving birth at home. They had not had the confidence to plan for a homebirth with their first babies, mainly due to their articulated fear of the unknown, but also through lack of opportunity. Below are two examples of women describing the development of confidence in their bodies between having their first and second babies:

> *[I] didn't go ahead with the homebirth the first time mainly because I was scared and didn't know what to expect*

> *I had thought about it [homebirth for my first baby] but there was a hesitancy within myself of 'can I completely do this?' and 'would I feel comfortable' and I guess I was reassured by being at the hospital, if something goes disastrous I'm only a few feet from help whereas after [my first baby] it was 'I can do this' yeah, its very much something that I'm involved with - its my body doing it - I didn't necessarily need any intervention or help*

Women did not talk about 'personal strength' as such, but described how they felt about their physical abilities to give birth at home by using terms and phrases that, similar to the quote directly above, depicted a very individual strength. The women were well aware that ultimately it was their own abilities and strength that were going to see them through being able to give birth at home.

Past experiences were important when considering having a homebirth. Experiences mediated the way women viewed their world in general. In relation to childbirth, multiparous women directly took their previous experience of birth and related it to how their future experience would be. One multiparous woman discussed her initial worries about having a homebirth. She had had three previous children, and had experienced an induction of labour with one, and augmentation with syntocinon and epidural anaesthesia with another. Her views this time were '*I did think about homebirth, but it was a matter of 'could I do it or not?' that was my own thought 'could I do it if I was at home?' or do I need to be in the birth centre to do it?'* Her third baby was born precipitously (very quickly) on the way to hospital in the car. This was simultaneously encouraging (regarding her ability to give birth without intervention) and something that she wished to avoid for her next birth. Her choice of homebirth for her fourth baby was based on practical reasons of safety; it was safer for her to stay at home than to have a repeat experience of having a baby in a car, and she had confidence in her body's ability to do this through her previous birth experiences. Later in the interview she said:

> *I knew I could have a homebirth due to going through the stress of having a baby in a car, and knowing that I wouldn't need to have epidurals and gas and all of that*

Primparous women often described their strength and confidence to give birth at home more in terms of being mentally prepared for the experience, rather than having knowledge of a previous birth. They spent time discussing their values behind choosing homebirth, whereas multiparous women added issues to do with the practicalities of having their babies at home. It was also apparent that women also needed their birthplace choice to suit their philosophy. For example, one primiparous woman explained how she felt: '...*I'd really like to do that [have a homebirth], it resonates well with me, it fits in with my personal beliefs'.*

Women had an innate confidence in the ability of their body to give birth at

home. Multiparous women, after having a previous normal birth, would often unpick and process their experience (especially if there was intervention) in terms of interruption to normality. For example, one woman had labour augmentation and a vacuum extraction for her first baby. In the months afterwards she developed an understanding of why her labour slowed (posterior position of the baby, lack of mobilisation due to augmentation and epidural) and why the treatment in hospital (which she described as 'unnecessary') led to the assisted birth. She believed that her body was capable of giving birth without this intervention and chose to have a homebirth with her second child. Her labour experience at home was similar to her previous labour in hospital, but despite having another baby in a posterior position, her positioning and patience during her labour enabled a normal birth at home. She said: *'… I think all that was unnecessary because the same thing happened pretty much exactly with [homebirth baby] – we just took a bit of time and eventually he turned…'*

In the absence of a previous birth experience, women having their first baby relayed their confidence through a belief that their bodies were 'made to have babies'. One primiparous woman expressed this through the analogy that her body had created a baby without conscious input and the same body should be able to give birth without intervention:

> *It didn't make sense to me that my body could know how to make a baby, this miracle, grow its eyes and ears and all these wonderful magical things without me doing anything, I didn't even have to sit back and go 'oh hold on, its week what is it, ok, ears go!!' it just did that, how could I entertain the view that my body didn't know how to give birth to this baby? That didn't make sense to me that I [would] need help, or my body didn't know how to give birth to this baby*

The above view was strengthened throughout pregnancy by attending both hypnobirthing and Calmbirth®[13] classes, which concentrated on the normality of birth. This particular woman engaged the services of a doula and obstetrician, as well as the midwives in the Birth Centre. She had a strong faith in the normality and ability of her body to give birth, and refuted the notion that all women needed intervention in order to be able to give birth. All the women in

[13] Calmbirth® is a childbirth education program that focuses on the normal birth process.

this study shared this attitude.

Another concept in the category of 'feeling strong and confident' was that women had confidence in the midwives who were caring for them. It was very important for both women and their partners to feel that their midwife was able to facilitate the homebirth and deal with any unexpected occurrences. The trust women developed in their midwife deepened throughout the pregnancy as the personal relationship developed. For the women's partners, most women describe how their confidence strengthened after the 36-week visit. During this visit, the midwives brought the homebirth kit to the woman's home and explained its contents to the support people. The midwives also discussed unexpected outcomes and the measures they would take to deal with emergencies. This logical discussion about why and how transfer to hospital happens, together with details about the expectations of support people served to increase trust and confidence in the midwife. One woman described her partner's feelings after this visit.

> *My husband had to be here for that [36-week visit] and that really set his mind a little at ease, because they went through all that stuff. They went through what happens if you had the baby here by yourself, what to do, or if he's here, what he should do... and what happens with various different things, and what equipment they would leave here and how would they use it and all that sort of stuff*

Another woman appreciated the 'team' (comprising midwives and support people) she had around her to help facilitate the homebirth, and described her sense of personal empowerment and strength:

> *They [midwives] came out to the house as well, and that was really nice, they came out a few weeks before and that was a time when everything was at the peak of coming together, like yes, I've made the right decision, and all the support team that were going to be there like my doula and my partner and I just felt so empowered and strong and like this is going to be a beautiful birth process, I'm so looking forward to this, I thought it was a really great thing*

All women created a ‘team’ of support around them – this is explored more in the category of ‘engaging support’ (p. 25). It was apparent that women appreciated having care based on a partnership model with their midwives – and having midwives visit them in their homes augmented this. Having the midwives as ‘guests’ in their homes at antenatal visits, as opposed to the more powerless feeling of being a ‘patient’ in a hospital antenatal clinic, gave women more strength and conviction in their homebirth decision and confidence in their midwives as part of their support team.

Throughout pregnancy, women described the confidence and trust that built between them and their midwives and how this built their own personal confidence. A necessary intimacy developed between women and their midwives that was pivotal to the women’s confidence. This was nurtured throughout pregnancy by the midwives by spending quality time with women, being honest and clear about their practice, and activating women’s strength and inner resources to cope with their labor and birth. One woman described how her close relationship with her midwife made her feel:

> *They make you feel really good. Like they become like your family because you see them so often. My last visit with [midwife] was really sad – like I felt I was losing a family member or something [laughs]*

Another woman gained tremendous support from the midwives during a difficult pregnancy that, although remaining low-risk, had more extreme pregnancy-related discomfort/illness. She said:

> *They were really reassuring – I had a really tough time with being so sick and for six months, and then I had extreme heartburn, like I really hated my pregnancy, and so I went through – I kind of – my depression was through my pregnancy so I found it a hard time, but they were really great – I used to come back and feel uplifted every time I came back*.

Trust in the skills and care of the midwife was paramount to women being able to process their worries about problems occurring during labour. Through

having trust, women felt more able to express their fears to the midwives, which, in turn, enabled both a relief at having fears allayed, and an increase in intimacy and trust. For example, one woman explained her fear of the consequences of being told she had a big baby (that there might be a long protracted labour, or that the baby would have shoulder dystocia), and how even though she realised the possibility of problems was small, she trusted the midwife to deal with any problems that may have arisen. This woman appeared to relinquish the decision-making and partnership with her midwife in this respect; her decision to have a homebirth was more based on avoiding a repeat of unpleasant occurrences in hospital than the need to take more responsibility for her birth. She said:

> *I got scared for a little while, just because I was having my first and I thought I was having a big baby, and I did have a reasonable sized baby, I think I was really worried about things, the shoulders getting stuck or silly things like that and then I just thought that there is such a small chance that that would happen, and its not my job to think about that – it's the midwife's job to think about that, so I really tried to let that go, all that scary stuff*

At the same time, women took personal responsibility for themselves and their choice to have a homebirth. They felt they did not need to be in hospital. One woman describes the hospital as being superfluous to her needs:

> *I really did appreciate that support and having it there, but having done that the first time [hospital birth] I felt I didn't need any of that the second time with my second baby, so taking that out of it, what did the hospital provide that really – I didn't need anything that the hospital provided, so I didn't really see the need to go to hospital*

Women felt confident with themselves, their midwifery care, and their support team. Women displayed a personal strength and confidence in their own bodies to have a homebirth. These were qualities that linked fundamentally to their belief in normal birth and also served to lessen women's stress during their pregnancy, labour and birth. The women expressed an underlying knowledge

that they would benefit in many ways by having their babies at home, and by doing so, increase their chances of having a natural, normal birth. Women stated the independent and assertive elements of their personalities and their overall health and wellness as being factors in their strength to have a homebirth, and having the ability in itself to make the decision to have a homebirth, served to lessen their stress. The mental strength to follow through their choice of birth place when confronted with opposition from friends and family was something that women also expressed as important. All the elements of strength and confidence described in this category were a strong force in women's ability to follow through with their fundamental *faith in normal* (the core category). In turn, this belief in their personal strength, their related confidence to have a normal birth and the trust in their midwives, were major issues as women were *validating their decision to have a homebirth* to lessen their stress during pregnancy, labour and birth at home (the basic social process).

DOING IT MY WAY

'Doing it my way' was a category born out of the need for women to have control and power over events in their pregnancy and labour. Different women described varying levels of need regarding their midwives and the levels of responsibility and control they wanted. Some women wanted a great degree of control, whereas most wanted a partnership with their midwives regarding their care, and a few women appeared to want very little from their midwives.

One primiparous woman explained that she felt she would not have a 'voice' if in hospital, and felt she would not be 'in a position' when in labour to advocate for herself. She said:

> *It was a big thing [deciding to have a homebirth]. I felt like I wasn't going to have the level of input or control or a voice [in hospital] in a way that I would in my own home in that environment… just being told what's going to happen to you and not being given an option, I just thought 'crikey, what chance have I got'*

All of the women in this study discussed their desire to have control over the course of their pregnancy, labour and birth as a major reason for choosing a homebirth. Most women described elements of their care or previous birth/s that they wished to have more control over for their present birth. The women did not use the actual word 'control' very often, but expressed this in other ways including discussing their wishes surrounding the birth environment, their desires for a family-focused event, and their fear of powerlessness. Concepts in this category consisted of seeking empowerment, being in control of their own space and who was with them, and avoidance of drugs, intervention and de-personalisation (watching events, but having no control over them). All these issues led them to actively pursue what they perceived as a better birth experience for themselves, their partners, and their babies, that is, a homebirth.

Multiparous women described previous experiences in hospital where they did not feel they had control, and were keen to avoid the feelings of powerlessness and restriction by having a homebirth. Many women expressed that they were able to avoid a sense of disempowerment in hospital by having a homebirth. In this sense, disempowerment meant simply to have personal power taken away. Women wanted to avoid feeling obligated to conform to the hospital's ways – for example, being a 'patient' in an unfamiliar environment and feeling that the hospital staff and organisation were dominant in the relationship. This need to be able to have control over events/decisions when in labour was important to the women in the study, and was one of the main reasons they chose a homebirth. For example, one multiparous woman expressed her clear desire to have control with her last baby. She said: '*having very different births with all of them – I wanted to do it my way the last time. Knowing it was my last, I wanted to do it my way from start to finish'.*

Women also wanted to be able to feel that they could do whatever they liked when in labour. They felt that being able to move around at home and be in their own space contributed to their wellbeing and feelings of relaxation. They felt they would not necessarily have the freedom to do this in hospital, and this would lead to an increase of stress. One woman said '*I felt much happier having my baby at home, being able to do what I liked'.*

Another strong concept from women was the desire to control who was around her at the time of labour, birth and the postnatal period. Often, women would describe the busyness of the postnatal ward after having their previous baby, and how they wished to avoid this happening again. One woman expressed how she felt:

> *Just staying together as a family that was the main thing... I thought how nice it was not to go back to a hospital room, with another lady and her baby, because the room I shared... she had about five family members there and they were in and out and you know, the last thing you want is strangers around you after going through something like that.*

Avoiding medications in hospital was a topic women often described during interviews. They wanted to avoid being subtly coerced into taking analgesic medication during labour, and to avoid taking medication simply because it was available and accessible. Women knew that if they were in hospital they would feel less power in themselves to be able to decline medication if it was offered. By having a homebirth, women avoided this 'hospital-induced passivity'. One woman describes this as being '*snowballed*' which indicates she thought that if in hospital, she would be more likely to passively agree to a number of suggestions regarding the management of her labour, including having medication, due to the loss of power she felt she would have in hospital. She said:

> *I thought it was pretty inevitable to be snowballed in hospital, and to have people suggest things, and I think too in that respect, having spoken to some of my mother's group who would plan to have a natural, no pain-killers birth, but then once it happens I think being in hospital and having that option available – you take it! I mean definitely there were probably times when you know 'I can't do this!' and it was so painful, but there were not drugs in the house, so it wasn't an option, whereas I'm sure if they were just right there, and somebody was saying to me 'look you can have something if you want it' – 'giving in' is probably the wrong phrase, but it would sort of be easier to go down and say 'OK fine!'*

Being able to ‘have a voice’ in pregnancy and birth was not only related to planning what would happen, it was also a way of avoiding what women perceived might happen in hospital. Some multiparous women wished to avoid unpleasant experiences they had previously had, and for primiparous women, the possibility of intervention. The underlying construct of this is that hospital birth often incorporates medical intervention as a standard practice in normal labour and comes from a perspective of risk. For example, there is a technocratic medical attitude that labour is only thought to be normal on retrospect, whereas by having a homebirth the philosophy shifts to a belief in normality from the outset. One woman explained her concerns, similar to the ‘snowballing’ concept above:

> *The concern is the minute you set foot in the hospital there are all these parameters put on you, time frames… that then lead to intervention and once you start that roller coaster, 9 times out of 10 intervention leads to another ‘Oh let’s just use some [Prostaglandin] gel to get things going... Oh let’s do an episiotomy... Oh dear me’*

Multiparous women sometimes had experiences of poor treatment in hospital during their previous pregnancies. This led them to decide to have a homebirth in order to eliminate this as a future possibility; they wanted to ‘have a voice’ and improve their next experience. The next quote shows how one woman was ‘managed’ by the hospital staff without being consulted, as though her baby and labour were separate to herself, and her welfare was under their control, and she was merely a ‘passenger’. She said:

> *I had gestational high blood pressure and I found I was being induced when I read my file – I wasn’t actually told. I found out a week before because I was sitting in clinic and just looking through my file, and then I realised that I was being induced and I didn’t want to be induced and I wasn’t consulted about it and I felt like I was a passenger, not so much in charge of what was happening so I didn’t like that, so that was the main thing*

This category relates how it was important for women to feel in control and

'have a voice' during their pregnancy, labour and birth. By staying in their own space, women were able to feel more empowered, in control and, this in turn, lessened their stress. Women knew they would not be able to feel the same power and control during their labour and birth in a hospital environment. Women felt they would be more stressed in hospital and many expressed that having to travel to the hospital, especially while in labour, was a stress they wanted to avoid.

Controlling who was with them during their labour and birth and to have a more family-focused event, was important to women. Even though these things could be accommodated in a hospital environment, women knew it would involve negotiation and permission, and could easily be altered by staff changes or a lack of communication. Women felt the only way they could ensure they had control over these things was to give birth at home. One woman expressed this need:

> *I wanted to do the homebirth because it was my little boy's baby as well, I wanted him involved, I wanted him there and I wanted it to be a family thing, a family affair*

Women's strong *faith in normal* (the core category) was a justification for their need for control, although both are circular in concept; that is, women needed to have control to help themselves get the best chance at achieving a normal birth, and vice versa: that in order to have the best chance at having a normal birth, women needed to have more control.

HAVING PROTECTION FROM HOSPITAL-RELATED ACTIVITIES

Women chose to avoid hospital-related activities by booking to have a homebirth. Those who had previous babies (all multiparous women in the study had had previous hospital births) described experiences that ranged from being very satisfying to wholly negative. Those who were satisfied with their previous hospital experience chose a homebirth to simplify, and improve on their experience of childbirth by removing the source of potential stress (the hospital) and the activities that occur within the hospital system.

By simplifying their experience of care during pregnancy and birth women firstly chose a model (the Birth Centre) that enabled continuity of care from two midwives. This enabled women to directly contact their midwives should they need to, and have personalised care from a known midwife. This is opposite to care in an antenatal clinic, where women usually have no direct telephone numbers of midwives to call, and care is likely to be more fragmented between staff within the clinic, and women often see different midwives at each antenatal visit. Essentially, the care of midwives within the homebirth program was of a more personal and individual basis, and women had a central point of contact for their care, rather than a larger antenatal clinic scenario, where communication breakdowns are more likely. Secondly, by choosing a homebirth within this model, women eliminated the need to go to hospital when in labour which simplified their birth experience, and in turn lessened their stress.

The ‘activities’ in hospital that women described as wanting to avoid were many and varied. The ‘activities’ encompassed the hospital environment, as well as the general level of service the hospital gave. Comments from women about what they wanted to avoid included negative interactions with staff, strangers coming into the room, hospital visiting times restricting partner access, travelling to hospital, not having access to a waterbirth, having epidurals and other medical interventions, restrictive protocols, feeling unable to resist pain relief medication, the ‘cascade of intervention’, infection, and separation from their baby.

Multiparous women described intervention that they felt was unnecessary after reflection, and wished to avoid this with their next birth. For example, one woman reiterated how being transferred from home to hospital late in her labour because of having prolonged labour in retrospect prevented her from the likelihood of having an epidural and a syntocinon infusion which she would have had if she had been planning a hospital birth. She stated that her choice to have a homebirth was responsible for the lack of medical intervention during her labour (she had a normal birth in hospital). Another woman who was transferred to hospital care in the antenatal period for high blood pressure realised after her

normal birth experience in hospital that the care she received was inferior to that offered by the homebirth midwives, and felt cheated, knowing that she could have been more comfortable at home, with more attentive midwives, albeit with blood pressure monitoring and oral antihypertensive medication. She said:

> *they wanted me to be monitored then when I booked into the hospital, the nurse [midwife] booked me in and then the night nurse came on and they just left me alone, they didn't check on me all night and it was just [husband] and I by ourselves as I was in labour, and I could have been at home basically… no one had monitored me the whole time yea so I would have actually been better off at home I think cos I would have had 100% attention – I mean, she [baby] was fine straight away, but...*

Those women who had unpleasant experiences (often involving suboptimal communication with staff) had tangible memories of stressful situations that they actively wished to avoid for their next pregnancy and birth. One woman described being 'scarred' by a lack of sensitivity and care by the midwives during her first labour and birth in hospital:

> *All she [the midwife] did was come in and give me some negative comment and then leave and send a student in to check on the baby's heartbeat, and I remember her saying as I was walking through my contractions, she said 'oh that's nothing, wait till you start breastfeeding, then you'll see what pain is like'. She was really negative and I was kind of scarred to be honest, I was scarred by the experience.*

Unlike multigravid women, primigravid women did not have a previous experience in a maternity unit that prompted their homebirth choice. Despite this, they all discussed their desire to avoid hospital-related stress. This view was gained either through their work experience (three primiparous women had worked in nursing, physiotherapy or midwifery), conversations with other mothers, DVDs, and reading books and websites. In addition, the knowledge of the hospital's policies and restrictions on visitors, for example, did not fit with

their wishes for unrestricted family involvement and attendance.

Another primigravid woman explained how she wished to avoid any possibility of having an unpleasant experience in hospital after reading other women's stories about their hospital experience:

> *I started reading about homebirths and especially as it was the second-time mothers, and how all these women had had terrible first births. I didn't want to be like that, so I wanted to learn from them and I don't want to have to be the one that says 'I had this awful experience in hospital, so therefore I am going to have a homebirth next time'. I was kind of 'we'll just have a homebirth this time!*'

One primigravid woman explained her negative feelings related to the antenatal tests she needed to have as part of the homebirth program. Upon exploration, she discussed her frustration with the 'universal' policies of antenatal testing of all women, and not individually risk-assessing those with a higher need for investigation. She classified herself as a very healthy, low-risk woman who did not feel she needed to be tested for gestational diabetes and Group B Streptococcus. Similar to another participant, she used research evidence to support her views. She said:

> *I would go in and say to the midwife 'what about this study or that study' and she would say 'yes, I get it, but you have to understand this is hospital policy'… I didn't think [the tests] were appropriate for me*

Another primiparous woman accredited her confidence to plan a homebirth on the experience and knowledge she gained through her recent nursing training. She wanted to avoid the negative elements of hospital care that she had seen during her training, hence the confidence she describes is more related to the certainty in her decision to avoid hospital. She explained: '*I think perhaps training as a nurse I was more confident... I think that definitely influenced me – just to stay away from hospitals, infection and intervention*'.

The wish to avoid travelling to hospital in labour was a major concept in this category. Travelling to hospital was necessary if women had booked a hospital birth, and as such, women found great comfort in being able to eliminate this difficulty. There was a strong desire for women to 'stay in their own space'. This was essentially a way to lessen stress. One woman explained:

> *The hardest part of my first baby's birth was leaving home! We came from our apartment, in the lift, to the car, got every red light and I guess it's OK, but 'I'm out of my space'… but to take that out of it – to be in your own space, your own bed*

Most women in the study were aware of the higher rates of medical intervention in labour in hospital compared with home, and expressed that this was something they wished to avoid by having a homebirth. Many women expressed that they felt if they were in hospital, their 'normal' labour would be interfered with because of the routine interventions that occur in hospital, which would be exacerbated by the discomfort they had with the environment itself. This discomfort would possibly lead to anxiety, which would cause more problems in their labour such as the need for pain relief, which women thought would then lead to more intervention. This fear of a spiraling series of events in hospital (the cascade of intervention) which stemmed from their anxiety with the environment was enough for women to strongly believe it was safer for them to plan to have a homebirth.

Often, the multiparous women, after contemplating their previous birth experience in hospital, described what happened to them and questioned the need for interventional practices such as artificial rupture of the membranes, induction/augmentation of labour, and epidural and other analgesic use. One woman described how the different management of her labour, possibly helped by the inability to have augmentation and analgesic medication at a homebirth, eliminated intervention that would have likely been offered if she was in hospital. She described a very similar course of labour to her first labour in hospital with fundamental differences in management by the midwives during her homebirth that enabled her to avoid an assisted birth, pain relief

medications and syntocinon augmentation. She also discussed the loss of power she felt in hospital, which was a concept many women alluded to, and wished to avoid. She said:

> *With [first son] he was also posterior [position in labour]… they said we'll have to give you a Syntocinon drip to pump up your contractions, so you'll need an epidural because they'll be quite painful, then I had to have a catheter and by the time he had turned, my epidural hadn't worn off so they had to suction him out and I think all that was unnecessary because the same thing [posterior position] happened pretty much exactly with [homebirth baby] - we just took a bit of time and eventually he turned… I guess when you're in hospital, you lose all power basically… and I knew that it wasn't all necessary… if none of it's around, it can't be used*

Another woman described intervention in hospitals as being the 'risk': '*And that's the other thing about going to the hospital – they have a much higher rate of intervention, although the Birth Centre does have a lower rate, but there is always that risk'.* Many women expressed sentiments that showed they essentially felt safer at home than in hospital. They recognised that this was the reverse of what most women (and the wider society) in Australia think in relation to birth and place of birth and risk.

Many women also expressed the wish to avoid being cared for by midwives and medical staff they had not met before. This was more prevalent from multigravid women who had had the experience of a hospital birth, where many staff were involved in their care. It became important to women that the midwives who were caring for them during their pregnancies and labour knew their history and shared their philosophy and faith in normal birth. This continuity of care and carer enabled women and their families to feel comfortable and safe; women valued getting to know their midwife. In hospital, women knew such continuity was not possible, hence this was a hospital-related factor that they wished to avoid by having a homebirth. One primigravid woman explained her experience of working within a maternity unit and the contrast with her care by the homebirth midwives:

> *.. at [a large maternity unit] women would see one midwife for the birth, 8 hours later you would get another midwife, postnatally you would get another, and there wasn't a single continuity of care, and [talking about her experience of homebirth] we really got to know our midwives and I had faith in both of them*

A few women in the study talked about the hospital as being a place for the sick and unwell. They described hospitals as being 'germy', full of infection and intervention, which did not fit with their perspective on normal healthy pregnancy and birth. Their decision to have a homebirth was related to an avoidance of a birthplace they viewed as unhealthy. One woman was influenced by what happened to her partner, she said:

> *I really don't like hospitals – you go there to die or when you are really ill and my partner had a staph, a very bad staph infection when he had an operation on his hand... and he almost lost his arm, almost died, so I think its [the hospital is] very germy*

All the women were certain they would be more relaxed and de-stressed at home; and their emotional well-being would be protected and safe by having a homebirth. The reasons women gave to avoid hospital-related activities were given as a way of *validating their decision to have a homebirth*, and served to lessen their stress surrounding birth. This centred around women's *faith in normal birth*, the core category, which was the basis for their justification.

HAVING A SAFETY NET

Another category was one of women feeling they had a safety net. This describes the ability of this homebirth model to be based in a hospital, and have links to hospital care should it be necessary. Most women felt reassured by this. They weighed up their healthy status and the possibility of problems occurring with their plans to have a homebirth, and concluded that firstly, they were at negligible risk of obstetric complications (their perspective), and secondly, that they could rely on the systems for hospital transfer should complications arise unexpectedly in labour.

One woman describes how she felt the hospital was in the background as a 'safety net', although her midwives took precedence:

> *I think it was possibly that it was a bit of a safety net at the end of the day, but it wasn't a major thing, I had these two experienced passionate midwives, which was more important.*

The logistics of what would happen if complications in labour occurred were discussed during pregnancy by the midwives caring for the women. There was flexibility with many issues of care (e.g. women could have their babies in the Birth Centre if they chose to before or during labour), but at the same time, there were definitive situations where transfer to hospital was recommended. The flexibility to give birth at home or in the Birth Centre was appreciated by many of the women, as they did not know how they were going to feel when in labour (in particular the primigravidas), that is, they may have changed their mind about where they wanted to give birth. In reality, none of the women in this study decided at the beginning of their labour to transfer to hospital for this reason. Only one woman transferred to hospital because of difficulties with childcare (she did not want her children awake and aware of her labour or birth – and it suited her wishes in this respect to give birth in the Birth Centre). One woman, who at first was a little apprehensive about having a homebirth said:

> *Yes at the time I was a bit worried, she [the midwife] said you can always come back through the Birth Centre which was the best thing that she said rather than push me into having a homebirth*

Another woman expressed her feelings of safety about the ability to transfer to hospital care, '…*So the option to actually go to the hospital at any time that I felt unsafe or insecure or whatever, so that was beautiful like it didn't frighten me at all knowing that I had back-up'.*

Another woman expressed a great faith in her midwives in relation to her safety:

> *Felt very safe, in that I had absolute faith in the midwives that if something wasn't going right that I would be transferred to the hospital – I wasn't far away so there was never any doubt as to safety for me*

There were some women who felt being cared for by a hospital-based publicly-funded homebirth program was safer than being cared for by a PPM. This was not based on the fact that independent midwives had no professional indemnity insurance, or a lack of professional skill, it was more related to the women's perception of their lack of strong links with the hospital system. When describing feelings of safety with the homebirth program, some women distinguished between their idea of how PPMs operated and the safety they felt being cared for by a publicly-funded system. One woman described this '…*I wouldn't have thought of going independently to have a baby. I like the security of the hospital – just being able to go there if something was to go wrong'.* Most women in this study had briefly investigated care by a PPM, but expressed their fortune to have been able to book in a publicly-funded (free) service, and not have to pay for private care.

There was an acknowledgment that the midwives working on the homebirth program had to adhere to hospital policies and for these women this enhanced the perception of safety. One woman thought the hospital protocols were stricter than the protocols used by PPMs. It was apparent that a number of women in this study felt more reassured by the back-up and links with the hospital and that they felt this structure was missing with PPM care. One woman said:

> *I kind of felt reassured that I had this big back-up system behind me and I had a kind of a protocol that was kind of a bit tougher than if you went independently, like I really had to tick the boxes and jump through the hoops and that*

Women explained that their families were also reassured by the hospital back-up, should complications in labour warrant a transfer. One woman said: '…*Just more safe – and I think it helped with the family as well – they knew that the care was going to be there'.* Another woman described how her mum felt

reassured after being given information to read about the homebirth program and issues surrounding homebirth. This extended the feeling of having a safety net to the wider family. She said:

> *My mum was very negative at the start - she was really not certain about the whole thing, she was like 'I know that's what you want but do you really think it's the best idea?' and what if, what if, what if... kind of thing, what if something goes wrong, what if - you know - all this sort of stuff - so I think for her she felt good about reading the information they gave out and just seeing the birthing pool and seeing the set-up and things like that, then she felt OK about that*

Knowing that the homebirth program had safety structures should complications arise was very important to the women and their families. These included hospital policies to cover antenatal and intrapartum transfer criteria for the homebirth program, links with the ambulance service and the ability to seamlessly access the hospital facilities. Throughout pregnancy, and especially at the 36-week visit, the midwives discussed the situations and parameters of normal that, if breached, would necessitate a transfer to hospital. Only one woman felt her transfer to hospital was unnecessary due to rigid hospital policies – she had a prolonged rupture of membranes – but proceeded to have a normal birth in the Birth Centre shortly after arrival. She said:

> *when my waters broke and I didn't go into labour… their policy – I'm pretty sure its 16 hours [time until an induction of labour is recommended] I'm not sure, so the next day, I went in to be checked by the girls [midwives] and they were sort of mentioning induction and things like that which I was sort of totally against at that stage … and I just was really spun out*

After transfer to hospital and a normal birth, the woman accepted the decision the midwives made to transfer her to hospital due to hospital policy. She said:

> *well we knew something like this might happen and I did choose to have a homebirth within the hospital system, so I chose to do this, so*

> *I've just got to go with it and we had a beautiful birth anyway, we were very lucky*

By feeling safe during labour and birth, it possibly follows that women would feel less stress. This was enhanced when the women's family (parents/siblings) also felt safe. This category relates to the core category *having faith in normal* through women having the knowledge of the structure and safety set-up of the publicly-funded homebirth program, and feeling they would be cared for in the event of an emergency, whilst at the same time having a strong belief that this was highly unlikely.

SELECTIVE LISTENING AND TELLING ABOUT THE CHOICE

All women in this study carefully chose certain friends and family to talk to about their choice of a homebirth. Women came to know which people in their lives they were able to talk to about homebirth, and those they had to avoid. This mainly came about through trial and error, and knowledge of people's background, including their birth history. There was also an element of generational selectivity – i.e. it was assumed from some women that the older generations were more likely to be opposed to homebirth. Similarly, women listened to and digested information from certain people in their lives about birth, and chose not to do this with others. This 'selective listening and telling' was predominantly a behavior that served to protect the choice women had made to have a homebirth, by not allowing opposing, and sometimes frightening scenarios being presented by people who often had no experience or balanced knowledge of homebirth. Women needed to remain clear and positive that they had made the right decision to birth at home, and avoided people with negative, ill-informed, or alarmist opinions. Different women displayed different needs in this respect – some needed to belong to homebirth support groups, attend Calmbirth® and other groups supportive of normal birth, and some kept a small tight-knit support group of their own that they gained all their strength and validation from.

Women and their partners consciously elected not to tell certain people (sometimes even their own mothers) of their plans to have a homebirth for fear of stressful conversations, confrontation, disapproval and negativity. One woman described her selectivity by choosing people to talk to about her plans to have a homebirth who were not going to give her a 'negative vibe'. This essentially meant a person fundamentally disapproved of her decision, which was apparent in the discourse. She said '…w*hen it got closer to the time I told a few other people who I felt weren't going to give me that negative vibe'.* Another woman described a 'drama queen' reaction from certain people, which meant they raised issues of drama, negativity and danger in relation to homebirth, possibly related to their overall view of birth and personal experiences. She said '…*I had a few friends who were a bit drama queenish - I just didn't talk to them, and mainly spoke to the friends who had had the good experiences'.*

One woman articulated clearly that she would have been more anxious if she had told her immediate relatives about her plans to have a homebirth because of their predicted response. She described how it was important to trust the people who were aware she was having a homebirth. Her lack of trust in some of her relatives dictated who she told about her homebirth plans. She explained that she thought her anxiety would have deepened over time with reinforcement of negative conversations:

> *You know the saying, we have that in our culture, the more someone says something, the more you believe it, the more you think its true, even though there is no way in the world it can be true... I said 'I gave birth here' and they were like 'what?' because I didn't want to tell everybody because I knew people would be against it and they would always keep ringing to see if I had had the baby and things like that so only my husband and me knew, and my auntie I could trust, that's about it.*

The descriptions that women gave regarding their reluctance to talk to family or friends about their plans to have a homebirth show the marginality of homebirth within society in Australia. It demonstrated how women were not only aware of this, but were aware of the power of the majority opinion in society, and how it

may negatively affect them. However, being self-protective was not always the reason women limited telling people about their plans. Sometimes women felt they needed to protect others. This woman explained that she tried to prevent her relatives from worrying unduly about her plans to have a homebirth:

> *Because I didn't want them to worry or be given the opportunity to think about it too much, and try to talk to me about it and even my partner's family were worried, over-worried, over-cautious and they had a lot of questions about it – because they are from a nursing background too*

Women often gave explanations about why they thought their friend or relative did not understand or accept homebirth as a viable birth place. The woman quoted above felt her partner's family's nursing background influenced their degree of worry over potential problems occurring at a homebirth. Nursing is often related to a more risk-averse philosophy; the training lent itself to a feeling that pregnancy and birth were medical events that should be managed in a hospital. Conversely, one primigravid woman related how her nursing training helped her decide to have a homebirth. She had recently completed a nursing degree and came to dislike hospitals to a degree where she felt safer to have her baby at home. In this instance, it was related to witnessing suboptimal practices on postnatal wards. This woman's views were quite separate to the other women's views in this study who had experiences working in maternity wards (two midwives, two paediatric staff); the others did not display such an extreme need to avoid the hospital. She said:

> *I think probably my nursing training and that I had an understanding of the bigger picture and how the medical system works, and having worked and done all my prac [practical] and stuff in hospital it's just kind of – I don' t like them*

One woman had particularly worried relatives who thought there would be catastrophic consequences without obstetric-led care. This attitude led her to minimise the contact she had with them during her pregnancy. She explains her

relatives' fears:

> *'But where is the doctor? Where is the doctor?!' They thought the birth centre was crazy enough, not to mention a waterbirth in the birth centre, they thought that the baby would die and I was insane*

The same woman went onto describe how she felt after hearing this, and how reassurance from her midwife alleviated her fears. This came in the form of reiterating that she could give birth in the Birth Centre if there were any problems, or if she changed her mind. One of the midwives explained this:

> *it's a very flexible model… if you change your mind at the last minute… and want to go through the birth centre, you can*

Other women had families who openly opposed their decision to have a homebirth, and tried to scare them into changing their minds. One woman describes how her confidence was shaken after her brother-in-law (a General Practitioner) indirectly said she was risking her baby's life '…*The first thing my brother-in-law said to my sister was 'please tell your sister not to go ahead with the homebirth, its you know, too many deaths' just basically trying to frighten her and frighten me I think'.* This was around the time that newspapers around Australia had alarmist headlines about neonatal deaths at homebirths (predominantly freebirths) (for example, see Devine 2009) and shows how health professionals were ill informed about the differences between freebirth and publicly-funded homebirth services. The brother-in-law in the above quote had both power as her relative and a health professional, which temporarily affected the confidence in her decision to have a homebirth.

It also became tiresome and frustrating for women to repeatedly explain their choice for a homebirth to people. This led to women limiting the number of people they spoke to. One woman describes this:

> Y*es I was open about telling people at the beginning… and people's reactions would be so 'oh shock horror'… it got to the point where I*

> *was a bit negative towards them, not towards the homebirth, but thinking 'just stop being so naïve! Just wake up and realise that its normal!'*

One of the ways women lessened their stress and validated their decision was by censoring who they spoke to during their pregnancies about their plans to have a homebirth. This was something women acknowledged as acceptable and it was seen as an expected by-product of wanting to do something unconventional that many people thought was unsafe. Explaining that the hospital could not provide the level of comfort and emotional safety they required was hard to convey to friends and relatives who believed these issues were of secondary importance, and that the presence of medical help took precedence. Women felt that their emotional and physical safety were inextricably linked, that by having trust in their carers, and feeling relaxed and secure (feelings of being emotionally safe), had a strong influence on their physical safety and the course of their labour. These feelings, which include a release of tension, have a basis in physiology, however, this was difficult for women to impart to others, so more often they had to defend their decision to have a homebirth on issues of physical safety, which was a more understandable and solid concept for most people to comprehend. This meant women had to explain more tangible things to people such as how the homebirth program worked, who was present at the birth, and what would be done in the event of an emergency. For example, one woman said '…*I told them there would be two midwives there and the whole hospital knows that I'm labouring at home and … the hospital is only five minutes away… yea I think the fact that I was so close to the hospital and I had midwives there no-one was too concerned'.*

Other women tried to justify their decision to have a homebirth to others through research findings *'…all the family and friends thought I was absolutely crazy so it was so nice to have some real hardcore evidence and statistics to tell them'.*

Talking and listening to those who would be supportive and positive about normal birth (not necessarily homebirth) was a strategy all women in this study

put in place to lessen their stress, and *validate their decision to have a homebirth*. Again, the basis to this behavior was that women had a *faith in normal birth* and they wanted to keep, and build on this faith by selective listening and telling.

ENGAGING SUPPORT

Women described how they engaged a support network around them during pregnancy. This usually consisted of a small number of people who were family members or friends, and the Birth Centre midwives. The way women went about engaging support involved having careful discussions with support people, provision of media in the form of books, research papers, homebirth DVDs, and, more rarely, attendance of homebirth support groups. All these activities were essentially to allay the fears and answer any questions they or their support people (in particular husbands and other family members) had about the safety aspect of giving birth at home. It was also a means of providing education to themselves and their support people in this respect, as well as a validation of their decision to have a homebirth.

Another issue women had to contend with was the non-conformity of having a homebirth; that having a homebirth was not a normal, mainstream birth place choice in Australia. Depending on their starting point, women had different levels of effort to go to in order to engage support, and combat this viewpoint from their support partners. Most had to convince their support partners in some way, for example, one woman explained: '*As soon as I showed hubby the DVDs he was like, yea let's do it, and I was feeding him different things, statistics and things'.* Some had friends and family who had no prior experience of homebirth and were very fearful of potential problems of childbirth in general, and others had a network which was more accepting and had either firsthand experience of homebirth or knew women who had had one.

Women gained the most support from their partners. Often women would describe how their partners were initially very skeptical and fearful of homebirth. For example, one woman said:

> *He was concerned about health problems if things go wrong, if things don't go right and then we are heading down a not-so-great path – what happens? He was really worried that something could happen to me or the baby*

When partners or support people felt this way, women described taking them to meet their midwives to be given information on safety processes, policies, and for general reassurance of the care they would receive. This provided relief from fear, and greatly helped to strengthen women's support team through their improved confidence in the midwives and knowledge of the homebirth service, as well as the 'safety net' of the hospital back-up.
Women describe this:

> *I really educated him about it as well, and he got into it really well, which was nice, but I think he had the questions all about the safety and the 'what ifs'*

> *He kind of relaxed a bit when he realised that they [midwives] were actually really competent and things would be OK*

Partners needed assurances of safety and how the system worked should problems occur. One woman had to reassure her partner that she would comply with advice should she need to transfer to hospital:

> *I took him along to one of the meetings with the midwives and I just reassured him that it would be OK and had to let go of the fact that if things didn't go right, and we had to transfer to hospital, then it is OK. I had to reassure him that I wouldn't dig my heels in and [I would] be compliant if I had to go to hospital*

Often women stated that their partners were supportive, and trusting of their decision to have a homebirth from the outset; they were led by the woman's decision. One woman described this:

> *He'd already sort of just decided that I knew what I was talking about so all of his understandings were through me*

One woman booked for a homebirth very late in her pregnancy because she initially thought her age (40 years) was outside the criteria for the program. Throughout pregnancy, she researched birth intensively and eventually came to think homebirth was what she wanted. This involved engaging a doula, talking to obstetricians, and gradually introducing material to her husband about homebirth to help him understand it as a viable option. She appeared to wage a subtle persuasive process through introducing key people and educational courses that involved helping her husband come to the same conclusions about birth and birthplace that she had. She explains her process of engaging the support of her husband:

> *As we went through that education process, my husband got his confidence about birth so he was then saying to me 'this is nuts, why do we have to – you're going to be in the middle of giving birth to our baby and we've got to get in the car and go somewhere, this is insane, it seems against how it should be' and so I said 'that's kind of what I'd been thinking all along'*

This worked well for her and she expressed the happiness with her support team:

> *I had my doula, who I had absolute faith in, she was just a perfect fit for me and also having my partner so I suppose with a support team I felt confident with and also with the women from St George Hospital, there was no doubt, I just felt so confident and supported and they were fantastic*

Most women used persuasive means to engage support from their partners and selected friends or family members. Other women were more direct with their partners about their decisions to have a homebirth. One woman stated that she would go ahead with her plans to have her baby at home whether her partner was there or not. She said:

> *'… he didn't like it, he was really overwhelmed and actually said no to begin with and I said that it's my vagina, it's my choice… he watched some DVDs about homebirth and just kind of did some research and*

> *then became more open to the idea, because I told him I was going to do it anyway, with or without him'.*

Women used many ways to engage support from people who were close to them. They showed them DVDs of homebirths and books on the subject often borrowed from the Birth Centre, or their antenatal class facilitator. Some women would view these books and DVDs themselves first to validate their decision to have a homebirth before sharing the resources with their partners, friends and family. A few women used the internet to read material from natural birth chat rooms, and homebirth sites. One woman describes how she appreciated the booklet generated for fathers-to-be by her antenatal class facilitator. This was an overview of normal birth, and what it meant to be a father. She said:

> *Seeing all the videos, reading all the books, and [antenatal class facilitator] gave us stuff as well, she does one especially for fathers – a booklet – she gives one for the mums and one for the dads because there is a lot of information in there just for the women*

A few women in the study described a particularly helpful resource that helped reassure their partners about the decision to have a homebirth. This was a book of personal stories, written for men, called 'Men at Birth' (Vernon 2006) consisting of accounts of the events of their partner's homebirth and fatherhood. This helped both the women and their partners through the similarity of their situations that were described in the text. For example, one of the men whose stories were printed said he felt that the idea of homebirth '*freaked [him] out'* and he had prevailing worries about '*what if something goes wrong*?' (p.46). These sentiments were very similar to those the partners expressed at the beginning of their 'journey' towards becoming engaged as a support person to the homebirth woman. Further along in the text, the same father discussed how he realised his fears were based on the unknown, explained his anguish over the pros and cons and likened it to '*mates arguing over Ford versus Holden'*[14] (p.47). The readability of this book, and the personal accounts of wrangling with how they came to feel good about their partners having a homebirth, was of great help to women engaging support. One woman describes this:

[14] Ford and Holden cars are thought to be quite different by some, but very similar by others.

> *He asked our midwife the questions when we first went to see her, and kind of really nailed her on what was going to happen. He actually read a book called 'Men at birth' which was lent to him by our midwife and that really put his mind at ease, and he knew everything in that book, and I read it as well*

Another woman described the importance of the various influences on her when deciding to have a homebirth:

> *Meeting the midwives and learning more about the program and doing my own reading through the books, the DVDs, having my [relative] birth naturally, those kind of things are more primary source of relevance to me than what I read in the media*

Most women in the study did not read research articles on the safety of homebirth on the internet. However, those that had worked in health did access the research databases, ostensibly to validate their decision, and share information with their partners. Published information on homebirth, in the form of books, research papers, DVDs and information booklets, all held kudos as sources of information with authority on the subject. The information also reinforced the conversations that women had with their partners and family. One woman, a nurse, said:

> *I'd get on NSW Health [Department] website and CINAHL[15] and all those databases and I read a few books, you know, birth stories and stuff like that, which were the ones my husband read*

DVDs were a very powerful medium for conveying information about homebirth. This was because women and their partners could identify with the women who were filmed giving birth; they could see that women were able to give birth in a calm home environment which helped them visualise their own experience. Most women borrowed these from the Birth Centre, and a few saw home videos of their friend's homebirths. All but one woman in the study watched DVDs on homebirth and waterbirth during their pregnancies and described these as

[15] CINAHL® is the Cumulative Index to Nursing and Allied Health Literature; a resource for nursing and allied health literature.

helpful and encouraging. One woman described how a more political birth film affected her decision to homebirth before pregnancy:

> *I also went and saw 'The Business of Being Born'. Yes I went and saw that, that was before I got pregnant. So after that I was even more convinced that I really would love a homebirth*

'The Business of Being Born' was a film made in the USA by a well-known actress and talk-show host, Ricki Lake (Epstein et al. 2008). It described intimate birth stories with surprising historical, political and scientific insights and shocking statistics about the medical intervention rates embedded in the maternity care system in the USA. It describes the marginalisation of homebirth and midwifery care in the country, and how routine medicalisation was normal practice in most maternity units in the USA. Translating this into an Australian context, it was apparent that it was a powerful film for a woman to watch when deciding whether to have a homebirth. In this instance, the woman used the film to reinforce and support her decision to have a homebirth – even before she was pregnant.

It was important for women to gain support from their partners and selected friends and family to feel cared for during their pregnancy and birth. All women need both physical and emotional support. However, due to the rarity and controversy surrounding homebirth, when women chose homebirth, emotional support is not always automatically there at first from their partners, friends or family. This is mostly due to them knowing little about homebirth, and needing support themselves in order to understand and feel comfortable - predominantly with the safety aspect. Therefore women had to actively engage this support by educating and persuading their partners and family members or friends to think differently about homebirth. By succeeding in this, women lessened their stress by actively engaging a support team around them in preparation for their birth. During this process, women were strongly reiterating their *faith in normal birth* and *validating their decision to have a homebirth* – to themselves and to their support team, ostensibly to enable, reinforce and keep their support.

THE CORE CATEGORY - HAVING FAITH IN NORMAL

Essentially women had a faith in the normal natural course of events, and this was an important influence on them choosing a homebirth. *Having faith in normal* became the core category building on data from women, and linking concepts within the categories. After exploring the relationships between the concepts, it became evident that *having faith in normal* was a strong reoccurring theme that pulled together all the strands, and offered an explanation for the behavior and feelings of the women.

Having a faith in normal, natural processes was a constant theme. It served to act as a comfort for women and their partners to have this reiterated in conversations with their midwives, antenatal facilitators and through books and DVDs. For the partners who, at first, did not have a strong faith in normal, the same things served to strengthen and awaken this belief in themselves and the process of normal birth. This category consisted of concepts: natural as the norm, having faith in the decision, and feeling that risks are negligible.

The faith women had in their decision to have a homebirth was strong and often something they found hard to articulate. Often women would say ‘it felt right’, that they were ‘meant to have a homebirth’ and they had ‘strong beliefs’ in homebirth. As well as researching homebirth and finding out the issues relating to safety and process, women also had a part of their decision-making that was based on a belief system that was not fully explainable. Upon questioning women in later interviews if the feelings of *faith in normal* were felt during pregnancy, or if it was stronger on retrospect, women expressed that it was clearly a faith present during their pregnancy. Women would often relay experiences or events during their pregnancies that strengthened their resolve in the normality of pregnancy and birth. Often this was early in the course of the interview, and was seen as the basis for their reason for choosing a homebirth. For example, one woman was given a book that had a section on homebirth that sparked her interest *‘…I was informed by luck, because of the book that I was given, that was the source of it’.* A number of women had pivotal people in their lives, or met them during their pregnancies which influenced their decision

to have a homebirth. One woman had a friend who showed her the video from her own homebirth, she said: *'…my good friend had one at home with a waterbirth which she found really positive – it was her second child... she really enjoyed the homebirth, showed us the video, and was very open about it all'.*

All but one woman interviewed for this study watched homebirth videos/DVDs during their pregnancies. This was likely a way to reinforce their belief in normal birth, and may have helped them visualise and imagine that they would have a similar experience. For example, one woman said:

> *…there was this amazing DVD that I borrowed about waterbirths and it was probably one of the most beautiful birthing stories that I have seen on film and … they really touched me and I thought that's what I want for myself*

One woman expressed the inexplicable nature of the faith she felt, and her grapple with the concept:

> *I guess at some point during the pregnancy I would have had a few thoughts and doubts, probably because the way I made the decision wasn't so much research based it was more blind-faith based in a way, that every now and then I would think, am I being a bit too 'blind faith' here? Should I really be considering doing this in hospital or is it the right thing and I would just think 'for God's sake!' you know, again – blind faith!*

Another woman described her faith in normal birth and expressed a 'surrender' to the unknown, which indicates an acceptance of a course of labour and birth that she could not fully predict. She said:

> *I had to let go of the outcome I guess in a sense that it could have gone pear-shaped, so there was a trust and a faith, but also a surrender*

Because of their faith in normal birth, and their perception of themselves as being healthy, women felt their risks of problems occurring during labour and birth were small, and that they were highly likely to have a normal birth. For example, one woman said: *'...I had been really healthy throughout and didn't really think there would be too many risks'.* As described earlier, they saw themselves as healthy women who had every chance of having a healthy baby, which was enhanced by avoiding the possibility of intervention in hospital. This view was reinforced by other factors (DVDs, midwives, friends who had had a homebirth) throughout pregnancy. One woman said:

> *It doesn't necessarily, doesn't at all need to be medicalised, its just a normal process that happens and you don't really need all that high tech wizardry around you… I'm healthy, why wouldn't the baby be healthy?'*

Most were aware of being deemed 'low risk', and had this reinforced by having blood tests and swabs throughout their pregnancies that were within normal limits. Few women used this term to describe themselves, although those that did used the label of being 'low risk' as a positive thing, and something that contributed to their ability to remain on the homebirth program. The antenatal screening was welcomed by some women, who saw it as a confirmation of their health, but others thought of it as unnecessary. One woman who appreciated the close screening to be able to feel more secure in her decision to have a homebirth describes this:

> *I knew that if I was well monitored in my pregnancy, then I could have one [a homebirth], 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 my 28-week gestational diabetics 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.*

Another woman in the study challenged the need for tests, such as the Group B Streptococcus (GBS) swab and the Glucose Tolerance Test. This was on the basis that she would refuse antibiotics if she was GBS positive, and wished to be tested for gestational diabetes only if there were clinical indicators. This woman was particularly knowledgeable about her low levels of risk with these potential problems, and had the confidence, not only in her own health and body, but to challenge the midwives and Birth Centre obstetrician on these issues.

Memo notes written after data collection from this particular woman centre upon her taking control over her own clinical risk and taking an active part in decision-making. This prompted further validation of the concept of control, and how women worked to ensure their care was tailored to their needs and beliefs (see Appendix 7).

A number of women spoke about their own mother's birth experiences. This was in relation to the hope that their experience was going to be similar. One woman who, as a child, saw her siblings born at home said:

> *Mum's always had such beautiful, positive birth experiences so I just didn't ever have any kind of fear of it, there was just the unknown, but nothing like 'its going to be awful it was all just very positive*

Women described their family values stemming from their childhood. These values included a more natural attitude to solving health problems and a lifestyle of embracing more natural concepts. The women had an imprint of normal and natural, which likely came from maternal and/or paternal influence. For example, one primigravid woman described how her chronic respiratory disease as a teenager led her to try alternative treatment methods that had great success in relieving her symptoms. This influenced her ability to investigate and embrace homebirth when she became pregnant. She said:

> *Its probably since early teens 13-14 years… having had some experience with my health that really was a challenge… standard*

> *avenues weren't helping, and stepping outside the box and then getting better and getting the chronic bronchitis sorted out… that really made me then start to question just being told what to do, especially health wise and made me look outside the box for some other answer*

Another woman described the influences from her own mother that encouraged her independent thinking and preference for more natural practices: '…*She [my mother] was always more of a 'think for yourself' and 'do things naturally if possible' person'.*

One woman articulated the differing levels of risk, and the need to be able to differentiate between large and smaller risks. They also felt the risks of problems occurring in labour during a homebirth should also be discussed at an individual level taking into account their personal histories, attitudes and health status. For example, a few women in the study wanted to be able to make the choice to deviate from or discuss aspects of hospital policy when the risks were very small. They essentially wanted to have their philosophy of normal, and their 'low-risk' status taken into account. One woman described this:

> *Certainly I think women who choose homebirth... are so flexible about transferring in when there are problems, very real problems... they are OK with that... they want the help, but when there is a risk, we are talking about small risks here, they want to be able to make the choice and the decision*

A level of faith and belief beyond the concrete knowledge of statistics or their own 'low-risk' status, was something that many women in this study expressed – which lessened their stress. By virtue of being booked to have a homebirth, women were deemed 'low-risk', meaning they were healthy, the progression of their pregnancy was within normal limits, and they had no medical/obstetric history that could affect their pregnancy or birth. Ostensibly, being 'low-risk' meant women on the homebirth program were more likely to have a normal birth, and less likely to need intervention. However, women described an additional factor in their decisions to choose a homebirth – a 'faith' – which was

itself an acknowledgement that they felt their low-risk status was not the only factor that made them believe they would have a normal birth. There was an acknowledgement of an 'unknown' factor in the course of their labour and birth which these women chose to feel was very likely to be positive; they had faith that everything would be normal. This faith in normal, when found in others, or activated in friends and relatives after receiving information, was itself a reassuring, comforting concept, especially when backed-up by knowledge of their own mother's normal birth history, or their own previous normal birth. Multiparous women in particular, having experienced a normal birth, believed that they would experience a similar birth and had less stress through their faith in the normal. One woman expressed this:

> *I think we [woman and her partner] both had that blind faith that's it a very natural thing to do, so why wouldn't you do it at home and also that it had gone so swimmingly well with my daughter that we just expected more of the same*

THE BASIC SOCIAL PROCESS - VALIDATING THE DECISION TO HAVE A HOMEBIRTH

The behaviours described in the categories above are all linked to the Basic Social Process (BSP), which was: *Validating the decision to have a homebirth* during pregnancy, labour and birth. The BSP became apparent through the process of coding and the formation of categories. Within the activities involved with each category, women were constantly validating their decision to have a homebirth throughout their pregnancies and labours. Most of the validating was done early in pregnancy, although some women worked towards their decision before pregnancy, but it varied depending on when women were exposed and receptive to the idea of a homebirth. At times, women engaged in an intense process of validation – to themselves and to others – whereas at other times, or at the latter stages of pregnancy, there would be less activity in this respect, as there was more certainty and solidity in their decision and plans. Hence it was a dynamic, changeable process. This process was essentially a strategy to lessen their stress regarding their decision to have a homebirth by reinforcing already-

held reasons (e.g. their strength and ability to have a normal birth) and beliefs (e.g. their faith in normal, natural processes).

Women felt strong and confident in themselves and their ability to have a homebirth, and developed confidence and trust in their midwives to care for them. They cited their strength and confidence often when giving reasons why they chose a homebirth. This self-belief of strength, backed up by their healthy status and negative screening tests reinforced their ongoing confidence that they would have a normal birth at home, and served to lessen their stress in this respect. Women would validate their decision to have a homebirth by using their healthy, 'low-risk' status as a reason and ongoing justification to pursue a homebirth. This was reinforced by those multiparous women's experience of a previous normal birth. In the same way, the confidence in their midwives that grew during pregnancy also was a means of validation as they became more knowledgeable of their midwives role and professional competency to deal with any difficulties that might arise in labour. Hence, women's confidence in themselves to have a normal birth at home and their midwives ability as their support was a great source of validation to lessen stress not only for the women themselves, but to their wider family and friends. Other aspects of validation came through the various tests performed during the antenatal period. In particular, a normal Glucose Tolerance Test and negative Group B Streptococcus swab were necessary to remain booked to have a homebirth. Some women found this reassuring, but others who believed there were minimal levels of risk involved with these issues, did not.

To maintain the certainty women felt about their decision to have a homebirth, women undertook a 'selective listening and telling' approach that strengthened their values surrounding birth. Being selective in who women talked to about their plans to have a homebirth ensured they remained positive about their decision. By avoiding conversations with people who disapproved of homebirth, and by not reading anti-homebirth articles, women lessened their stress by eliminating any opposing views that may have caused doubt over their decision. This was an inverse way of validating their decision to have a homebirth i.e. by actively not engaging with opposition and negativity, and surrounding

themselves with like-minded, pro-homebirth people, women stayed firm in their decision to have a homebirth. This was also a way in which women avoided stress related to the controversies related to homebirth. Simultaneously, by not talking to people who women thought were likely to be against their decision to have a homebirth, this helped validate their decision by eliminating negativity and stress that was related to the controversies surrounding homebirth.

The other categories of 'doing it my way' and 'protection from hospital-related activities' lessened women's stress by them being able to have more control over the course of their pregnancy and birth. Women validated their decision to have a homebirth by what they felt was their right to be heard in relation to their own body and birthplace. Multiparous women in particular had previous hospital experiences to draw from, but all women discussed the different levels of control they would have in hospital versus their home. By having more control over events, and choosing to avoid the hospital environment, and in particular medical intervention and medication, women enabled their control. When discussing medical intervention, either through their previous experience, or through other knowledge of hospital practices, women were validating their decision to avoid this 'trauma' by having a homebirth. The feeling that they would have less control in hospital led women to express a need to avoid hospital-related activities that would naturally flow from being considered a 'patient' in a hospital, and conforming to what is normal practice within a hospital environment. All women validated their reason for choosing a homebirth by describing hospital-related activities that they wished to avoid. For example, most women explained how even avoiding the car journey to hospital was a big relief to them. In addition, through having a 'faith in normal' women also facilitated feelings of control and confidence in their decision. The philosophy of normal and natural birth underpinned their overall desire for a homebirth, and served to lessen women's stress through a strong belief that it was highly likely they would have a normal birth.

Women discussed how reassuring it was for them to have the hospital back-up as a safety net, although they thought they would not need it. The reassurance and the process of engaging support in the form of friends and family similarly

provided women with a feeling of safety through having a supportive team. This team encouraged and cared for women throughout pregnancy, labour and birth, and was pivotal to helping women validate their decision to have a homebirth and reducing stress for them at this time. By choosing who they talked to, women also engaged support for their decision. Some women were happy to have very few people in their 'support team', whereas others engaged doulas, obstetricians, midwives, family and friends. Each woman engaged support for her decision to have a homebirth from various people during pregnancy, which considerably lessened their stress. This meant women reinforced their decision through dialogue with certain individuals who made up her 'support team' for her homebirth. Even though they had a strong belief in normal birth and their abilities, they described the reassurance they felt by having the hospital's 'safety net' around them, should they need to access it. This was something they discussed with their families to gain support for their plans for a homebirth.

Similarly the last category of 'having a safety net' in the form of the hospital back-up was a feature of publicly-funded homebirth that women and their families appreciated. Knowing the structures in place should an emergency occur served to lessen stress, and relieved women of the complete 'responsibility' of their homebirth being with them; it gave the hospital the ability to 'rescue' the women if they or their babies needed emergency care. Again, women would use the knowledge of this aspect of the structure of the homebirth program to validate their decision within themselves and to others in their support team.

Throughout pregnancy women constantly validated (i.e. reaffirmed or justified) their decision to have a homebirth. This was apparent through discussions with selected people, watching DVDs showing homebirths, reading books promoting natural birth, reading material on the internet or participating in homebirth chat rooms, and by reaffirming their low-risk profile and eligibility. Women also spent time visualising their experience and organising who would be present, their environment for the homebirth, and looking forward to an exciting family event. All women spent time processing their decision to have a homebirth, but some women spent more time validating their decision more than others. Most of this

work was done by the women, whereas their partners, once reassured of the safety aspect and the structures in place during labour and birth, did less, and were mostly led by the women in this respect. When engaging the support of friends and family, women simultaneously were justifying and validating their decision to have a homebirth. This process often solidified their plans, as educating their support partners through using media such as books, DVDs and introducing them to their midwives or doulas served to not only bring on board a support team, but equally gave strength to the plans and conviction of the women to have a homebirth, and enhanced their trust and confidence in their midwives.

The categories found in this study all link directly with the basic social process of women *validating their decision to have a homebirth*, which was essentially to lessen their stress. By explaining the decision-making processes they made to have a homebirth, it became apparent that women were continually validating their decision and going to some lengths to prove to themselves and others that their decision was the right one for them. This was predominantly by believing a homebirth was as safe as hospital birth, would lessen their stress, and in turn be a better experience for themselves, their babies and families. This occurred intensely throughout pregnancy, especially during the time of making the decision to have a homebirth, but did not disappear fully in the postnatal period and beyond. The women who achieved a homebirth had their experience to draw upon, however the women who did not achieve a homebirth remained positive about their choice and continued to validate their decision in the postnatal period. For example, the women in this study who did not achieve a homebirth remained very clear that their choice to have a homebirth was the right one for them, and reiterated many of the reasons described above; i.e. they were still validating their decision. Regardless of birth place, women in this study validated their decisions to have a homebirth in similar ways antenatally and postnatally, and this was modified to be in line with their own birth experience.

SUMMARY

In summary, the influences women had when choosing to give birth at home within a publicly-funded homebirth model of care centre on the facilitation of a normal process. Women felt that their choice of birthplace was pivotal to their and their baby's safety and wellbeing, although they were grateful that there were links with the hospital, should they have needed emergency care. Women articulated a need to feel in control of their care and their birth environment in order to support their wellbeing, and they had a confidence and strength to take responsibility for their choice of birthplace. Other strong influences were women's previous birth experiences, the trust and confidence built in their midwives, and their overall sense of their own health and subsequent low risk status. This was enhanced by reading books and websites, watching DVDs, and having a personal philosophy that rejected non-emergency medical interventional practices, and embraced normal, natural things.

This chapter has examined the six categories, the core category and basic social process found in this study. Through using a grounded theory methodology, there has been a process of constantly comparing concepts, linkage of emerging themes and hypothesising about relationships within the data. Using this method, and formulating an understanding that is 'grounded', the categories found and described above were *feeling independent, strong and confident, doing it my way, protection from hospital-related activities, having a safety net, selective listening and telling,* and *engaging support*. The core category was *having faith in normal* and the basic social process was one of *validating the decision to have a homebirth.* The next chapter discusses the issues arising from the results.

CHAPTER 6: DISCUSSION

INTRODUCTION

The aim of this study was to explore the influences on women who chose a publicly-funded homebirth at St George Hospital. The methods used to conduct the research involved semi-structured interviews with 17 women, two partners of the women and five homebirth midwives, using a grounded theory methodology. This is the first doctoral study of publicly-funded homebirth in Australia.

Six categories emerged from the data that described the influences women had when they chose to have a publicly-funded homebirth. These categories were *feeling independent, strong and confident, doing it my way, protection from hospital related activities, having a safety net, selective listening and telling,* and *engaging support*. The core category was *having faith in normal* which linked the categories and was the dominant attitude women had towards themselves, their pregnancies, labour and birth. The basic social process was *validating the decision to have a homebirth*. This was a process that women undertook principally to lessen their stress regarding their decision to have a homebirth by fortifying their personal beliefs and knowledge about homebirth.

The findings show women have a strong faith in normal birth and through this, they mediated and justified their needs. Women regarded pregnancy and birth as a normal process and did not believe they necessarily needed to be within a hospital to give birth safely. In fact, women thought it was more likely that their pregnancies would remain straightforward and healthy by avoiding the hospital system as much as possible. At the same time, and what makes this study different from other studies of homebirth, is that most women gained comfort from the fact that the publicly-funded homebirth midwives worked within the hospital system and emergency care was accessible through this link.

The findings revealed that women found particular issues important when describing the influences they had when choosing a publicly-funded homebirth. This chapter discusses the issues raised by the findings. This includes examining the type of women who choose to give birth at home, and socioeconomic factors, their decision-making processes and perspectives of risk. The issue of selective telling and listening will be discussed together with women's choice and control in maternity care and the desire to avoid intervention. Women's faith in normal birth, and the use of evidence are considered, and the importance of the relationship with caregivers is discussed. Recommendations for enhancing maternity care to incorporate the wishes of women who choose to have a homebirth are given at the end of the chapter, and the limitations and conclusions to the study are stated.

UNIQUE CONTRIBUTION OF THIS THESIS

The unique finding in this study was that women appreciated the safety net of the hospital-based homebirth program. Other studies of homebirth have had similar findings relating to women's desire for control in their maternity care and avoidance of medical intervention, (Boucher et al. 2009; Lindgren & Erlandsson 2010; Morison et al. 1998; Viisainen 2001), selectivity on discussing their plans to give birth at home (Lindgren et al. 2010) and processes of engaging appropriate support (Sjoblom et al. 2006). However, the critical difference in this work is that women appreciated the ability of the publicly-funded homebirth program to provide emergency care in the hospital maternity unit, in a seamless manner, should it be necessary. Women felt this was a 'safety net' within the homebirth program and were happy to have the hospital, and obstetric care, as a back-up if necessary. This differs from the recent qualitative study of women who chose to have a freebirth in Australia (Jackson, Dahlen & Schmied 2012); these women mistrust and fear hospitals and feel these institutions are the opposite of a 'safety net'.

A seamless transfer into hospital to access the 'safety net' was experienced by seven women in my study. The women were briefed during their pregnancies

about the types of complications that would necessitate a transfer to hospital and upon transfer, the homebirth midwives remained the lead carers. Recent unpublished data suggests good maternal and neonatal outcomes in relation to publicly-funded homebirth in Australia (Catling-Paull et al. 2012), although the numbers are small. This includes outcomes of women and babies who were transferred to hospital in labour.

TYPE OF WOMEN WHO CHOOSE HOMEBIRTH

The women in this study were well educated and of high socioeconomic status. Other studies have shown similar trends in women who choose a homebirth, both publicly-funded and private (Ackermann-Liebrich et al. 1994; Bastian 1993; Cunningham 1993; Neuhaus et al. 2002). Women in my study were also very aware of the importance of their role in their own health, and described a proactive approach in keeping themselves and their family healthy. This fits with the findings of a study carried out by Wardle and Steptoe (2003) who found healthy choices were more likely to come from people of a higher socioeconomic bracket, including less likelihood to smoke, and a higher chance of eating more fruit and vegetables and exercising each day. Those in the lower socioeconomic bracket had less health consciousness and stronger beliefs in the influence of chance on their health. The women in my study, being of a higher socioeconomic status, felt that they had a lot of control over their health outcomes by choosing a homebirth, but were aware that there was a small chance of negative outcomes that was beyond their control. Wardle and Steptoe (2003) discussed their findings in view of the fact that the socioeconomic differences and related health attitudes and lifestyles are likely to be a result of variations in life opportunities, and exposure to hardship and ill-health. These factors were not studied in relation to the women in my study, although there were two women who may have suffered hardship in their lives: one had a Bosnian background, and was present during the 1992-5 war, and the other was a Malaysian refugee migrant.

SOCIOECONOMIC STATUS AND SENSE OF CONTROL

There are differences in the levels of control women exert, which have a relationship to their socioeconomic status. For example, primigravid women have been found to exert more control over their birth experiences if they are middle class[16] (Zadoroznyi 1999). This early Australian study by Zadoronznyi (1999) described how working class women tended to be more fatalistic regarding their first birth; that is, they put their faith in the health professionals caring for them, and did little towards extending their knowledge about birth to help decision-making and directing their care. Middle class women did more to control their labour and birth environment, by either choosing a natural approach to birth, or by planning to control their labour and birth by embracing intervention and a 'pain free' experience (for example, having an epidural or elective caesarean section). Interestingly, both social classes of women did become more active in preparations and levels of control for their second and subsequent births. In particular, proportionally more working class than middle class women took greater steps to change and control aspects of their second and subsequent births; they had become more knowledgeable and clear about what they did or did not want – likely trying to improve on their previous experience. Similar to the women in the St George Homebirth Program, a previous birth experience gave women (all of similar socioeconomic status) the confidence to shape their subsequent maternity care (Catling-Paull, Dahlen & Homer 2011).

Women of lower socioeconomic status appear to have less control over their pregnancy care, labour and birth. Similar to Zadoroznyi (1999), Lazarus (1994) also found poor women had limited access to birth knowledge, and little desire to increase their knowledge. This, in turn, affected their ability to control aspects of their care and birth. Their choices were limited to care under the USA public hospital system, and as such were subject to a lack of continuity of care, and they often had communication difficulties. Lazarus explains that this powerlessness to access anything other than fragmented antenatal care may

[16] 'Working' and 'middle' class in this study was defined by a broad assessment of women's demographic data and material circumstance

have led some women to be noncompliant and not attend appointments – which is a type of control behaviour in itself. This can likely be generalised to a number of countries with similar maternity systems of care. One limitation of my study is that the women were from very similar socioeconomic demographics and one geographical location in NSW, and because of this, issues relating to status were not studied.

Other authors have found differences in socioeconomic status of women related to levels of control. In her study of middle class professional women and birth, Davis-Floyd (1994) described the 'centrality of control' (p. 1130) that was a strong belief that lives are controllable, and such control equated to happiness. For example, women controlled their bodies through exercise, and their destinies through career success. This control extended to their pregnancies and birth. David-Floyd explains how women with a more technocratic approach had a 'self/body split: pregnancy and birth were out-of-control'; their bodies were described more as 'vessels'; a means to an end, with which they grappled for control. This often resulted in a highly medicalised birth which was welcome and sought after by these women as something they felt they could control (as opposed to their 'unreliable' bodies). In contrast, women in the study with a more holistic approach to birth spoke of letting go of control of their bodies but spent time arranging their birth environment. They saw their pregnancies and body integrated as one, and the emotional needs of the mother and safety of the baby being closely linked. By choosing the best nurturing environment for themselves (home), the women felt they were 'naturally' doing the best for their babies. Davis-Floyd explains that both sets of women, those embracing the technocratic approach, and the natural 'homebirthers', had one thing in common: they both needed to control aspects of their birth.

SOCIOECONOMIC STATUS AND SATISFACTION

The similar attitudes towards childbirth in my study (that is, having faith in normal) should be seen in the context of the attitudes of all childbearing women. Hodnett (2002), in a systematic review of satisfaction in childbirth found little or no relationship between women's socioeconomic background and their levels of satisfaction with their care, which was in contrast to studies of general

satisfaction in health care. Nearly thirty years ago, Nelson (1983), in the USA, suggested that middle-class feminists were not considering the needs of 'working-class' women when espousing their new vision of childbirth, which embraced the swing back to normal birth practices. She argued there were different attitudes and expectations towards childbirth in both groups of women, and as such, a singular vision of the best way forward regarding childbirth was not taking into account these variables. In other words, not all women thought that childbirth was a normal process, and believed that a degree of medical intervention was necessary to enhance its safety. Despite these differences, Hodnett (2002) did find that there were consistent themes in her review from all women regarding the importance of caregivers attitudes and levels of support.

DECISION-MAKING AND RISK

Decision-making was a critical component of the findings. In this study, women made decisions about giving birth at home in relation to perceptions of their wellbeing, their wish to avoid unnecessary intervention, and their strong faith in their ability to have a normal birth. Decision-making and the assessment of risk are complex issues used continually within the healthcare environment and have particular relevance for homebirth. Risk can be defined as the possibility of unfavourable consequences when following a particular course of action, or the 'possibility of loss or injury' or 'someone or something that creates or suggests a hazard' (Merriam-Webster 2012). Throughout pregnancy, labour and the postnatal period, women are often given risk scenarios by midwives and medical staff to aid their decision-making. In this study, the women made firm decisions to have a homebirth on the basis of their perception of risk, which often differed from the perceptions of those around them, and certain health professionals they met.

BEING DECISION MAKERS

Women in my study described themselves as decision-makers, which incorporated being assertive and independent. They wanted to make their own decisions and not rely on health professionals to decide for them. However, it is not unusual for women to rely on midwives to make decisions for them

especially in a technocratic model (Bluff & Holloway 1994; Too 1996). In her doctoral thesis, Carolan (2005) found that many healthy pregnant women over 35 years of age, although keen to be informed, were happy to leave decision-making to their caregivers so as not to jeopardise their 'vulnerable' pregnancies. This was not found in relation to the older women in my study; they described an independence of decision-making, and more of a partnership with their midwives regarding their care. The ages of women who chose a publicly-funded homebirth were between 21-40 years, with most between ages 30-35. The two primparous women in this study over the age of 35, who could theoretically feel that their first babies were 'vulnerable' due to their age did not feel they had put their babies welfare in jeopardy by choosing to have a homebirth.

Women who choose homebirth seem different to those who choose hospital birth in relation to decision-making. For example, Longworth (2001), in a conjoint analysis of women's preferences for intrapartum care, found the homebirth women highly valued their ability to make their own decisions about their labour and birth, whereas women in hospital valued a system where 'healthcare professionals [took] decisions about labour and delivery in the best interests of the mother and baby' (p. 406). This demonstrated the differences in women's perspectives on power and control when cared for in hospital as opposed to the home. It is possible that women who choose homebirth have this different approach to decision-making as they have usually made very conscious and informed choices about their proposed place of birth rather than going with the dominant paradigm.

Similar to Carolan's thesis, a grounded theory study in the UK by Bluff and Holloway (1994) of women and their partners found that there was a strong trust in midwives, and that many care decisions – often not fully explained – were made by the midwives and doctors. Many women effectively gave their midwives control through a trust in their knowledge and expertise. A similar study today may or may not have different results given the more 'woman-centred' care focus of modern midwifery, generational factors, and the promotion of choice for women in maternity care.

TRUST AND DECISION-MAKING

Trust was seen to be pivotal to women's feelings of safety in Pilley Edwards (2005). She stated 'there is an inherent paradox in obstetric ideology focusing on safety and at the same time decreasing safety by placing obstacles in the way of trust developing between women and midwives' (p.186). This Scottish study of homebirth demonstrated the lack of ability for women to build a relationship with their care-givers due to poor continuity of care. This impacted on women's feelings of confidence and safety during their maternity care. In my study, women expressed a trust and confidence in the midwives caring for them which was enabled by the continuity of care program (this is discussed more later in this Chapter). This alignment and trust appeared to enhance and ease women's decision making.

REASONS, INFORMATION, RISK AND CHOICE

Another perspective on women's decision-making is seen by Kirkham (2004) and Leap and Edwards (2007).These authors discuss that an 'informed' choice is not always the case, as the health professional providing the 'information' and then the 'choice' is often doing so within a more powerful position which influences women's behavior. In addition, there are often limited choices given, and women are likely to be steered towards a decision that suits the organisation, rather than being truly involved in the process. This was seen in a grounded theory study in the UK by Levy (2006). In her study, the interactions between midwives and women were examined and 'protective steering' emerged as the central theme. This meant that women were guided towards decisions in a manner that would protect both the midwife and the woman. For example, information was shared with women regarding antenatal testing for fetal abnormalities in a way that would not frighten women, but also it acknowledged the midwives' biases on the subject (that is, that they wished them to have the test). Hence the decisions women make about their maternity care can often depend on the way information is presented, as well as the relationship they have with their midwife/health carer.

Decision-making and risk perception have a close relationship (Williams &

Noyes 2007) and trust in caregivers greatly influences women's decision-making and engagement in their care (Neuhaus et al. 2002; Sword et al. 2012). Pilley Edwards and Murphy-Lawless (2006) discuss the rise of technology and the greatly expanded perception of risk around new science and treatments for women in maternity care and how this relates to decision making. They state 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). In this instance, probabilistic logic is a system of logic that puts forward a structured argument based upon probability, or degrees of truth, that is, the medical definitions of risk are only degrees of probability that differ with each individual woman, and as such are logically flawed. Women choosing homebirth will often come up against the more conventional obstetric, and often ignorant views of risk and safety, and be forced to defend their decisions not to give birth in hospital (Nolan 2010). Interestingly, given the positive outcomes of homebirth for low risk women, there remains a reluctance on the part of some health professionals and the wider community to dispel fears around homebirth. It is likely that the negative way Australian homebirth data is framed when reporting outcomes of women and babies at all obstetric risk levels (for example, Bastian, Keirse & Lancaster 1998; Kennare et al. 2010) is responsible for many health professionals' opinions on homebirth. That is, dramatised headlines are taken literally - for example 'homebirth triples neonatal death risk: study' (No Author 2010), instead of unpicking the data to reveal the study's true meaning. Full understanding of women's wellbeing in relation to their risk factors and chosen birth place would enable health professionals to give more accurate information to aid decision-making.

Information for women when deciding on maternity care is often given as a statistical risk ratio. Most women are given a statistical risk to their baby's wellbeing when asked to make decisions about antenatal tests (e.g. women considering amniocentesis are often told risks of miscarriage associated with the test are 1%). This can sometimes be inappropriate and unhelpful for less numerate women who may rely on emotions, mood states or factors of trust to make decisions (Peters 2008). Often a list of advantages and disadvantages are given to help women decide upon treatments. However the interpretation of

risk can differ between women. For example, some women believe the risks involved in having a hospital birth outweigh those of having a homebirth (Neuhaus et al. 2002), although the majority believe hospital birth to be safer, with more effective pain relief methods and more ability to rest (Fordham 1997). These differences of perceived risk are discussed by Williams (2007) who feels the concept of real risk in health care concentrates on physical risks and neglects important issues such as psychological and social impacts. These issues, such as having relatives/children present at birth and having trust and confidence in themselves and their bodies, are often discussed by women choosing a homebirth as being very important to them (Catling-Paull, Dahlen & Homer 2011; Pilley Edwards 2005). Andrews (2004), in a small qualitative study in the UK, interviewed eight women who had a planned homebirth and found women processed a number of issues when deciding to have a homebirth. These were based on previous birth experience and social circumstances, the desire to maintain normality, and a calm atmosphere. Decisions were also influenced by women's medical history, ethnicity, religion, socio-economic and educational status, and their own personality style (Flynn & Smith 2007).

A DIFFERENT RISK PERSPECTIVE

Women interviewed in this study thought they had a high likelihood of a normal birth, and that there was a low risk of encountering complications; in effect they had a lowered risk perspective. This philosophy has been found before in women who choose Birth Centre care (Coyle et al. 2001), and differs from that of others who believe there is an enhanced risk of negative outcomes, simply by being pregnant (Fisher, Hauck & Fenwick 2006). The perspective that childbirth carries inherent risks of death and disability needs to be balanced by the knowledge that these events are quite rare. Beck (1992) describes modern day living as belonging to a 'risk society' as a post modern concept. He describes this phenomena as being separate from risks of the pre-industrialised world, in that risks are now largely man-made (e.g. global warming, nuclear weapons, the ability to clone) as opposed to natural disasters, plagues and famines. Beck explains that through modern innovation and technology, and by seeking to control nature, society has inadvertently produced further, more catastrophic

risks to humanity. This explanation could be applied to the rapid expansion in modern technologies and practices surrounding birth, where the progression of normal birth is often altered through (often unnecessary) intervention (for example, electronic fetal monitoring). Homebirth is also relevant as it is often seen as something women do which is against the benefits of modern technologies – women are challenged as to why they would choose not to have ready access to the technology in a hospital (Devine 2009). Such choices are often not understood by a wider society.

RISK AROUND BIRTH AND DEATH

The willingness of women to forgo modern technology when giving birth at home also has parallels with the other end of the life continuum. In a similar way, terminally ill people can elect to forgo technology, and die at home if this is their choice (Betteley 2012). However, within a hospital environment, there is often a reluctance on behalf of the relatives and the medical/nursing staff to stop active treatment of the terminally ill, even if the side effects of the treatment may lower the dying person's quality of life. To be seen to be 'doing something' to try to fix a particular ailment is a strong urge, particularly as the technology and medicine is available (Rothschild 2007). There are also issues of litigation and the possibility of being called to court for negligence – that can lead to over-treatment and 'defensive medicine' (Studdert et al. 2005). In maternity care, health professionals often consider that disciplinary panels and courts would assess a childbearing women's quality of care to be higher if medical technology is used (Stapleton, Kirkham & Thomas 2002). Similarly, it is mistakenly thought that neonatal deaths in hospital occur after the use of all possible technology and medicine, whereas a death at a homebirth is often assumed to be associated with negligence (Beech 2009).

AN ALTERED PERCEPTION OF LOW RISK

Perceiving risk to be low requires a particular decision-making process. Weinstein (2000) suggests that people manage by deciding on the perceived likelihood and perceived seriousness of a certain risk. For example, in considering the risk of a postpartum haemorrhage (PPH), a healthy pregnant woman may believe that given a PPH rate of 6 per 100 births of women in NSW

of all risk levels (Ford et al. 2007) is firstly lower for her as she is of lesser obstetric risk than a population sample, and secondly, that the likelihood of the risk is very low overall. She may also be influenced by her midwife's explanation of the management of a PPH in the home setting. Indeed, a recent observational study in the UK suggests that women who have a homebirth are at significantly lower risk of having a PPH than those planning to give birth in hospital (Nove, Berrington & Matthews 2012). This has also been studied in Australia in relation to holistic physiological care compared with active management of the third stage (Fahy et al. 2010). Consideration of these factors together influences individuals to have an overall view of a situation, and the level of perceived seriousness of such risks may be altered. When factors are thought of as both severe and probable, it is likely the situation is thought of as filled with risk (Weinstein 2000).

Women in my study believed their risk status was very low and that it was extremely unlikely any complications would occur when in labour. They took responsibility for their birth by choosing to give birth at home, and appeared, on the whole, to justify their decision to have a homebirth by personalising their individual risk status and seeing issues through a wider lens. This means that they made choices in consideration of the safety and needs of their baby, and also themselves and their family. This was seen by some women in my study who challenged the rules regarding the tests necessary during their pregnancy. By questioning the midwives, women articulated well their need to be treated as an individual who could take responsibility and weigh up certain decisions regarding their care. This was due to their overall risk perspective; they identified with being healthy, normal and altogether low-risk. This attitude towards their personal risk status was at the core of women's decision-making to have a homebirth, but is at odds with many other attitudes towards risk in the 21st Century.

There is a growth of a 'risk culture' in health care today. This may be as a result of litigation and high societal expectations of health care in general. As discussed in Chapter 1, childbirth can be seen in predominantly two different ways, through a 'biomedical' (or 'technocratic') model or 'social' model,

depending on personal philosophy (Davis-Floyd & Mather 2002; Downe & Davis-Floyd 2004). Similarly, MacColl (2009) describes different philosophies in Australia as 'mechanic' and 'organic' to characterise different attitudes of health professionals. The women in this study predominantly held a social view of childbirth, and whilst knowing there were risks involved with childbirth, these were perceived as minimal, with the other risks involved with hospital birth being seen as far greater.

SELECTIVE LISTENING AND TELLING

This study found that women only considered information regarding homebirth when it came from people they knew to be knowledgeable and pro-homebirth. Women also only told selected people about their plans to give birth at home. One of the strategies Lindgren (2010) found women used to deal with perceived risk in childbirth was 'avoidance'. This meant that they avoided the perception that homebirth was inherently risky, and preferred to concentrate on the belief that they would have a normal birth. This was done by avoiding discussions about the risks of homebirth with health professionals not directly involved in their care, or friends and family that they felt would not be supportive of their birth place decision. In my study, all women displayed a similar 'selective telling and listening' behaviour with health professionals, friends and family as a way of avoiding difficult conversations about risk and safety with those less informed about homebirth or those who felt women were only safe in a hospital when giving birth. In my study, women avoided talking to people they thought to be unsupportive of homebirth, but were receptive to discussions regarding risk and safety issues with their midwives, and others who they knew provided balanced information based on experience and knowledge.

In a way, by selectively listening and telling people about their choice to have a homebirth, women developed their own specific decision-making strategies. That is, they streamlined their decision-making by reducing the amount of variables in their knowledge that may have diluted their decision or judgement. This can also be defined as a cognitive bias, as discussed by Simon et al. (1999) and can parallel the way business entrepreneurs 'simplify their

information processing to diminish the stress and ambiguity associated with the decision to start ventures' (p. 117) (although it is acknowledged that risk in childbirth and business have very different consequences). Simon et al. hypothesised that the illusion of control and decision-making after obtaining limited information led to a reduction in the perception of risk. In their study, businessmen's propensity for taking a risk on a venture was dependent upon their risk perception, which was mediated by their particular cognitive bias. In a similar way, women deciding to have a homebirth limited their input to mostly positive information relating to homebirth in order to simplify the effort they expended in decision-making, but also to maintain the validity of their choice and reduce the feeling that they may be putting themselves at risk.

HAVING FAITH IN NORMAL AND USING EVIDENCE

The core category in this study was *having faith in normal.* Having faith, or a belief in something implies a trusting reliance upon something, future events or outcomes (The Free Dictionary 2009) and does not rest on logical proof or evidence (Merriam-Webster 2011). As well as their stated 'belief' in homebirth, a number of women described that the research evidence of good outcomes related to homebirth was something they were reassured by. Hence there were two very differing influences that women related to their decision to have a homebirth: research evidence and a personal belief. In regards to the belief women had, they also appeared to acknowledge that there were factors that were beyond their control, and that it was better, and less stressful for them not to dwell on negative outcomes that were very likely not to come to fruition. This was reinforced from women's past life experiences and their strength, health and confidence; it was part of an overall philosophy of 'normal' that women had in their lives.

In this study, women had an overall perspective of themselves as healthy, which influenced their lean towards a natural, normal birth process. They described their lifestyles as healthy (incorporating a balanced diet and exercise), and their health approach as being one that embraced natural remedies, before conventional 'western' medicine. Women's past experiences

and family attitudes were important in shaping their views and beliefs in this respect, and possibly contributed to the confidence they had in themselves to give birth at home. Women believed that their healthy lifestyle would contribute to the likelihood of a normal birth. Women essentially had an imprint of normality in childbirth that stemmed from their life experiences and learned attitudes. It is known that past experiences influence decision-making (Dietrich 2010; Juliusson, Karlsson & Garling 2005). These experiences likely mediate women's courage, strength and confidence to have a homebirth.

A BELIEF IN THE NORMAL

In most conventional western medicine and arenas of health care, science is the predominant and prevailing authority. As such, this belittles the idea that having faith in a given situation should give reassurance of an outcome. However, faith has been seen to have positive effects, for example, patients given a placebo drug can show significant improvements in their health when they know they have been given drugs without active ingredients, as opposed to a control group who knowingly did not get a placebo (Kaptchuk et al. 2010). Similarly, scientific testing of homeopathic remedies have discounted their efficacy (Linde et al. 1997), yet this remains a very popular form of alternative medicine; possibly because of the placebo effect, and the belief that it works (Shang et al. 2005). It is likely that, in the way women weigh up the factors for and against having a homebirth, both the evidence, incorporated with personal faith in normal birth, serve to reassure and support decisions. However, women found it difficult to articulate their faith in any depth, and when probed, mostly referred to their healthy status and overall perception of normality as reasons for their faith. For example, a number of women said *'…it felt right',* and one woman described her feeling as a '*blind faith'* regarding her decisions to have a homebirth. Another woman expressed that '*if I have that belief, I feel comfortable and safe*'. Such phrases are similar to expressions of religious faith. These feelings are likely to be misunderstood by many health professionals and the wider society who rely on science and proof to induce the same level of comfort and surety, however, it is necessary to understand that decisions are made through a complex mix of logic, values and instinct. This has been acknowledged by Merry and Merry (2011), who state 'few decisions in life are

predicated on hard logic firmly grounded in facts. People function through a complex mix of rationality and instinct' (p.70). Similarly, people are often selective in their use of evidence in keeping with their own values. This is seen particularly in maternity care (Homer & Broom 2012; MacColl 2009).

Essentially, having a faith in normal birth, and having an imprint of normality which may well stem from past life experiences, although not evidence-based, was the main factor in women's decisions to give birth at home. This was something that could not be measured, or completely explained.

THE IMPORTANCE OF CHOICE AND CONTROL IN MATERNITY CARE

Issues of control in pregnancy, labour and birth are often identified as important to women. Many studies have recognised control as being linked to women's satisfaction with their care (Christiaens et al. 2009; Fleming et al. 1988; Goodman, Mackay & Tavakoli 2004; Green & Baston 2003; Simkin 1991). This can mean different things to women depending on social class (Davis-Floyd 1994; Lazarus 1994; Zadoroznyi 1999), or choice of birth place (Cunningham 1993; Viisainen 2001).

Birth is a significant physiological, spiritual, and social event in a woman's life, and as such, choice[17] in maternity care is important. The ability to have choice and control during pregnancy and birth relate strongly to maternal satisfaction (Johnson et al. 2003) and this can have long term positive effects on women and their families (Noriko et al. 2007; Schytt & Waldenstrom 2007), and in turn contribute to the general wellbeing and health of the wider community. Page argues that choice in maternity care is a concept closely linked to continuity of care and control (or the three 'Cs') (1992, 2004), and defines it as 'a process of informed decision-making in which the woman must have the final say' (Page 2004 p. 27). This promotes a sense of control and autonomy described by

[17] The notion of 'choice' in this section relates to the Western industrialised world. In developing nations, women have different sets of priorities and more immediate issues related to the high maternal and neonatal morbidity and mortality rates due to limited access to trained childbirth attendants, and poor health care.

O'Boyle (2006 p. 25) as having the 'right of the individual to decide upon the integrity of [her] own body'.

Numerous studies and reviews, both overseas and in Australia, have stated that women should have choice regarding their care during pregnancy and childbirth (Audit Commission 1998; Commonwealth of Australia 2009, 2010; Department of Health 1998, 2004, 2007; Department of Health Expert Maternity Group 1993; NSW Health Department 2000, 2010; Public Health Agency of Canada 2009; Rogers et al. 2005; Senate Community Affairs References Committee 1999). This choice is often not available to women in Australia and overseas, either through lack of information-sharing from carers, an inability to access resources, or lack of facilities.

Choice for women in maternity care and having a sense of control by being involved in decision-making relating to their care promotes respect and trust in caregivers (Hardin & Buckner 2004). This care, more often seen in midwifery-led care models is fundamental to women feeling confident in expressing their needs to their caregivers, resulting in satisfaction and positive outcomes (Biro et al. 2003; Waldenstrom et al. 2000). The feeling of having control over maternity care, and particularly intrapartum care, can occur even if women have a highly medicalised birth experience (Behruzi et al. 2011). This is also apparent when women who are booked for homebirth need transfer to hospital in labour (Viisainen et al. 1998); contrary to popular thought, women often remain positive about their birth experience, and the midwives looking after them (Behruzi et al. 2011; Homer & Caplice 2007). It then follows that control and choice in maternity and maternal satisfaction are strongly linked to continuity of midwifery models of care (Biro et al. 2003; Hatem et al. 2008; Johnson et al. 2003; McCourt et al. 1998; Sandall, Davies & Warwick 2001) .

CHOICE OF PLACE OF BIRTH

Surveys of women's preferences and information given about choice of birth place have shown conflicting results. In the UK, a 1990s survey identified 22% women would prefer a homebirth and 72% would like more information about birth place (MORI, 1993). In Australia, a survey by Gamble, Creedy et al. (2007)

found that up to 24% women would choose a homebirth given assurance of safety and no extra expense, but when not given these assurances, this figure dropped to 7.9%. The high number of women stating preference for homebirth in this study may have been inflated as a large proportion of participants had previously had babies in Birth Centres, and were attending a Mother and Baby Expo; as such they may have been more knowledgeable and amenable towards homebirth. Another UK study showed 3% of parous women and 11% of nulliparous women would prefer a homebirth (Jones & Smith 1996). In Finland Viisainen et al. (1998) found 6% of women would choose a homebirth, and states that (similar to previous studies) the expressed interest was far greater than homebirth rates in reality.

It is apparent that women who choose homebirth do so for a number of reasons. These include feeling safe, having control over their birth and surroundings, to avoid intervention (Viisainen 2001); having a belief in their ability to birth without intervention or technology, having personalised continuity of carer (Abel & Kearns 1991; Longworth, Ratcliffe & Boulton 2001) and not having to be apart from other children (Andrews 2004). Dahlen, Barclay et al. (2008) explored experiences of women having their first birth in Sydney, Australia. They found women chose homebirth (with privately practising midwives) mainly because the hospital or obstetrician did not meet their needs. These women were more prepared for their births, and spent time examining their choices. In contrast, women who chose hospital-based care felt they had fewer options, reported feeling less prepared, and were often disappointed in their birth experience. The women who chose homebirth needed to be very involved with decision-making. This was also the case in my study, and has been found elsewhere (Hodnett et al. 2007a; Neuhaus et al. 2002). In particular, it was apparent that women in my study expressed that the hospital was not able to meet their needs of facilitating an intimate family-oriented birth, comfort with surroundings, familiarity with caregivers, and control over decision-making.

FEELING IN CONTROL

There is a multiplicity of meaning for the term ‘control’ and it is often poorly defined (Namey & Lyerly 2010). The authors, drawing on data from the large

USA ‘Good Birth Project’, analysed women’s experiences of birth in all settings, and their meaning of ‘control’. Nearly half the sample spontaneously mentioned the word ‘control’ during interviews, which showed its importance to women. However there were quite different meanings – the authors’ coded five broad domains of meaning: self-determination, respect, personal security, attachment, and lack of control. Self-determination largely related to women making decisions about birth related to body and environment; respect meant to be acknowledged and listened to; personal security related to having a sense of order through planning and organisation for the birth; attachment was a feeling of trust in carers; and lack of control was a theme described by not having the control during birth, and that a feeling that perhaps carers had more control. Namey and Lyerly found 13% of women expressed that having control was not important to them, and 19% discussed a ‘surrendering’ to the experience rather than trying to affect the course of the birth. This study also discussed how issues of control can predispose women to feelings of shame or guilt – that is, when women want to have a tight control over their birth place/environment/tests and events do not go to plan, they may feel guilty (in retrospect) for making possible ‘wrong’ choices. The authors suggest that, rather than precipitating a conflict of power, where women feel they need to have more control than their caregivers, there should be more emphasis on creating a shared agency between women and carers and a focus on improving women’s self-determination, respect, knowledge, attachment and personal security. The shared responsibility between midwives and women, or ‘partnership’ model of care has been prevalent in the development of many midwifery-led continuity models of care in Australia in recent years (Dahlen, Barclay & Homer 2010; Johnson et al. 2003; NSW Ministry of Health 2012). This is explained more fully at the end of this Chapter.

There are also many other studies that describe what women mean by having ‘control’. These include Slade et al. (1993), Fox and Worts, (1999), Lavender et al. (1999), Green and Baston, (2003) and Ford et al. (2009). In surveys of 1146 women, Green and Baston (2003) examined issues of ‘internal’ and ‘external’ control. In this context, having internal control meant having control over personal behaviour, whereas external control pertained to the behaviour and

actions of others. The authors found that women were less likely to report feeling in control of the staff (39.5%) than they were of their own behaviour (61%). Conclusions were that caregivers had great potential to affect women's childbirth experience; the way they help women to deal with labour had a strong effect on women's internal control, and, in turn, the extent to which women felt cared for affected their external control. Both types of control were significant in contributing to the satisfaction and emotional wellbeing of women (that is, multiparous and primiparous women had lower scores on the Edinburgh Postnatal Depression Score [EPDS] if they felt more control in labour and birth). Women's length of labour was not a significant factor in their responses and birth at home or hospital also did not provide different results. Not surprisingly, this study showed multigravid women felt more in control of their labour and birth than primigravid women. Similarly, in my study, women described how their previous birth experiences strengthened the confidence in their ability to display internal and external control.

Another way women achieved the control over their maternity care was through actively resisting being cared for within a medicalised environment. This has been discussed by Pilley Edwards (2005) in her study of homebirth in Scotland, where women expressed a loss of control when faced with medical technology. In Canada, a qualitative study by Parry (2008) about women's choice of midwifery care, found eight aspects of resistance to medicalisation that women were utilising by choosing midwifery care. One of those was 'personal control', which described how women desired a control over their experiences through shared decision making in midwifery care, as opposed to being directed and not given choices by their carer. This was seen in my study, where women displayed and discussed their assertive nature.

Several authors have sought the meaning of control through development of assessment tools (Ford, Ayers & Wright 2009; Hodnett & Simmons-Tropea 1987; Wallstone 1989). Ford et al. (2009) developed and tested a questionnaire to assess support and control in birth. The pilot study identified two main dimensions of control – internal and external control – similar to previous studies discussed above. Ford et al. also distinguished between support and

control in labour as being different, yet similar concepts, and cites an example of women being able to feel supported, yet not in control of events (for example during an emergency caesarean section). In my study, most women talked about 'support' in terms of their support people, and a few used the term to describe the care their midwives and/or doulas provided.

CONTROL LEADS TO POSITIVE EXPERIENCES

My study did not explicitly examine satisfaction per se, however the findings clearly indicated positive experiences from this cohort. The concept of satisfaction in maternity care should be thought of as 'humanistic', as discussed by Black and Jenkinson (2009). The authors called for greater emphasis on issues such as dignity, respect, privacy, information and being disadvantaged (for example, by waiting or being delayed within hospitals) – or the 'humanity of care'. In my study, many of the women described experiences relating to these types of issues that were very important to them – often in relation to a previous hospital experience - that influenced their decision to have a homebirth.

Women's satisfaction with their birth experience is strongly linked to their feelings of control (Goodman, Mackay & Tavakoli 2004; Green & Baston 2003; Johnson et al. 2003; Lavender, Walkinshaw & Walton 1999). In qualitative data from a larger RCT, Lavender (1999) found women mostly talked about self-control and external control in relation to their satisfaction. Women found comfort and pride in the fact that they had exerted personal control, yet appreciated their caregiver's control over situations that necessitated specific intervention. This was similar to the findings of many other studies (Fleming et al. 1988; Hart & Foster 1997; Knapp 1996; Mackey 1995; Simkin 1991, 1992; Waldenstrom et al. 1996; Zadoroznyi 1999). In the USA, Goodman et al (2004) described survey results of a study of 60 low-risk women. They found that personal control and having expectations met was highly important for birth satisfaction, but satisfaction per se was multidimensional. Women could have negative and positive feelings that coexisted about differing aspects of their labour and birth. However, the most significant aspects found were that it was important for carers to facilitate women's needs regarding personal control and their expectations during labour and birth.

Another important aspect of women's satisfaction over their birthplace relates to how midwives facilitate the birth environment (Fahy, Foureur & Hastie 2008; Fahy & Parratt 2006). Fahy and Parratt (2006) propose that optimum support in labour and birth is given when midwives create a woman's 'Birth Territory' (p. 45), and enable women and their support partners jurisdiction over the space. The authors of the concept of Birth Territory (Fahy, Foureur & Hastie 2008) suggest that the role of the midwife in facilitating this care in a hospital setting is paramount to promoting normal birth, satisfaction with care, and an easier transition into the postnatal period. It is likely that midwives facilitating a homebirth have less to do in this regard, as women are already in their own territory. In my study, one of the main influences on women when choosing to have a publicly-funded homebirth was that of wanting to stay in the comfort of their own homes, and not have the possibility of hospital care providing feelings of disempowerment, which has been found in other studies (Andrews, 2004; Boucher, 2009; Lindgren, 2010; Morison, 1998).

FEELING IN CONTROL WITH CONTINUITY OF CARE

Other studies have found that higher levels of control in maternity care, labour and birth were related to the ability of women to let go and relax within their labour (Ford et al. 2007; Lindgren & Erlandsson 2010; Parratt & Fahy 2003). One Swedish study describes this as 'rest[ing] in acceptance of the process' (Lindgren & Erlandsson 2010 p.311). It has also been discussed in an Australian study by Parratt and Fahy (2003). These authors found through an analysis of models of maternity care, that there was a higher likelihood of women who were able to experience a release of mind and body during labour within a midwifery model of care than in a medical model. The state of 'relinquishing mind control' (p.18) during labour, and women having enough trust in their carers to facilitate this, enhanced empowerment in women and was a positive experience for women. This was explained by women as having the ability to focus on themselves during labour, and not be concerned about the external environment. Women in my study also felt a strong sense of control over their care, and trust and confidence in their midwives that would possibly have enabled the same ability to 'let go', although this was not studied.

Women have reported a higher sense of control and satisfaction when cared for in caseload and woman-centred care models (Johnson et al. 2003; Parratt & Fahy 2003). Continuity of midwifery care has also been found to be important in a more recent Australian meta-ethnographic study of women who had traumatic births (Elmir et al. 2010). This study identified that a lack of control was a major factor in the trauma experienced by women, and that this was more likely to occur within a medical model of maternity care. The authors concluded that continuity of midwifery care had the potential to enhance women's feelings of control, and would therefore create a more positive birth experience. Similarly, the St George Homebirth Program focuses on being woman-centred with carer continuity. The women in my study, although not asked about their satisfaction with the program specifically, were all very positive about their experience and many expressed that they would book onto the program for future pregnancies.

A number of multiparous women in my study, having experienced labour and birth within a hospital, were able to express their different perceptions of hospital and home. Often this would be related to the level of control they felt they had, in particular the control over medications for labour pain. The feeling of being in control during labour and birth has also been linked to satisfaction with midwifery care (Christiaens et al. 2009; Magee & Askham 2008). Set in the Netherlands and Belgium, Christiaens et al. (2009) found that personal control interacted with labour pain, that is, the more control a woman felt in her labour, the more satisfied she was with her midwife, even if she was experiencing strong labour pain. By feeling in control, women felt empowered even if they had a very demanding birth experience. This was a study of satisfaction testing a model of four social psychological determinants; personal control during labour and birth being one of them. Central to greater personal satisfaction of women were issues of control and decision-making. This study found that the empowerment of women during their labour and birth (through having personal control), as opposed to the management of labour (being given medications to dull the pain) was significantly associated with higher rates of satisfaction (Christiaens et al. 2009).

CONTROL, CHOICE AND PLACE OF BIRTH

One of the most overt ways to have control over events during birth is to choose a homebirth. This enables parents to construct the environment, and have family or friends present, without having to 'ask permission' of hospital staff. In Western Australia women have been noted as choosing to have a private homebirth in order to receive midwifery continuity of care due to the lack of available options (Homer & Nicholl 2008). Morison et al. (1998) describes this as parents assuming control by displaying assertive behaviour necessary to control the birth environment, rather than the birth itself. My study also found women's past negative experiences with health professionals contributed to their need for control. Morison et al. (1998) state that encounters with carers who held the view that pregnancy was a disease process and health professionals were the 'experts', did not align with the homebirth women's philosophies. Women who have a homebirth generally have an alternative view: that pregnancy and birth is normal and carers need to facilitate this, and work in partnership, in a nurturing mode, to facilitate self-reliance. My study showed women and their partners have differing issues of control. Women were seen to instinctively know how to give birth which added to their perception of control, whereas partners acknowledged that women were the focus, and that they felt powerless at times to control the birth but overcame these feelings through doing what they could and acceptance. One of the fathers interviewed said '*my wife was in the field* [she was a midwife] *so I was led by her basically'*. This verified data comprising the *engaging support* category; that women's partners were led (by the women) to understand and accept homebirth as a viable birthplace.

One woman in my study described her previous hospital experience in terms of being powerless. She described herself as a 'passenger', with important decisions regarding her labour and birth being taken without her consultation. This experience affected this particular woman so much that she trained to be a doula, and devoted much of her time to improving women's maternity rights and choices. This behaviour is an isolated example related to the concept of 'reflexive modernity' (Beck, Giddens & Lash 1994) which describes how society

changes itself after examination. The authors describe the dynamic nature of today's society, and the ability to reform and adapt to suit new ideas and beliefs. This can be seen in my study where the women and their partners who chose homebirth tended to challenge hegemonic institutions and understanding and have faith in themselves to create their own birthplace within their homes.

Different cultures of birthplace appear to have differing levels of control and power in relation to staff and women. This was discussed by Dahlen et al. (2010), who found the discourse from postnatal women showed well defined differences in the way they perceived their levels of control related to birth place. Women who had a homebirth spoke of their labour and birth in terms of what they did/chose/planned (using 'I' as the first person), whereas those in a Birth Centre would speak about shared decision-making (using 'we'). This differed from the discourse where women had babies in a Delivery Suite. These women discussed events occurring *to* them; the power and control being very much in the hands of the staff (using 'they'). Through the discourse analysis this study showed that there were clear practice issues related to environment regarding control. Staff exerted control within the hospital Delivery Suite environment, there was a more shared control within Birth Centres, and at home, women were strongly in control of the events surrounding labour and birth.

Most multiparous women described a level of previous suboptimal and impersonal care within hospital maternity units that did not take into account their individuality and emotional concerns. This was supported by statements from the partner participant data, and contributed to the strength of the *protection from hospital related activities* category.

CHOOSING A HOMEBIRTH TO AVOID UNNECESSARY INTERVENTION

One of the reasons the women in this study wanted to have a homebirth was that they wanted to avoid unnecessary intervention during their labour and birth, and they felt this would be more likely to happen in hospital. Women thought

interventional practices were something that were necessary only if there were complications in labour, and that they should not be employed as a routine practice, which they believed was the case in hospital. Women also believed they would lose the power within themselves to challenge the routine work of the hospital staff, and believed they would be 'snowballed' into accepting interventional practices because of this. This is similar to findings from other studies (Janssen, Henderson & Vedam 2009; Lindgren et al. 2010; Pilley Edwards 2000; Pilley Edwards 2005). Lindgren et al. (2010), found women felt a loss of autonomy when cared for in hospital. They felt that by having their baby in hospital, the birth process was being taken out of their control, and they were far more likely to experience unnecessary medical interventions.

Women were aware of the hospital's culture of intervention and risk management focus. This, and the proactive characteristic of needing to 'do something to' patients (and women) when in hospital, made it difficult for health professionals to comprehend the 'less is more' approach, explored by Leap (2010), and the ability of healthy women to be able to give birth without intervention. It is therefore understandable that most health professionals are challenged by the whole concept of homebirth even though it is associated with better outcomes for low risk women.

TAKING RESPONSIBILITY FOR BIRTH

By choosing a homebirth women put an emphasis on their own ability to give birth without the technologies and pain relieving medications provided in hospital. In effect, they take responsibility for their decision regarding birthplace and its consequences, possibly more so than women in a hospital setting. In this study, women who chose a publicly-funded homebirth displayed this level of responsibility, although they expressed a comfort that the hospital was an integral part of the service, should they need to access it. As Bailes and Jackson explain, 'the woman is endowed with the power to give birth, but she also benefits from the support of others who amplify her power to do so' (2000 p. 542).

Not all health professionals support women who take responsibility for giving birth at home (American Congress of Obstetricians and Gynecologists 2011; Chervenak et al. 2012; Hoang et al. 2012; Royal Australian & New Zealand College of Obstetricians & Gynaecologists 2011a). This was demonstrated recently by de Crespgny, Walker and Savulescu (2012) who discussed the lack of ethical or legal rights of fetuses, and felt that maternal autonomy in choosing to give birth at home overlooked neonatal health risks. Citing the negative outcomes from freebirths and homebirths with unregistered personnel of women with obstetric risk factors, the authors did not distinguish between birth with maternal or fetal risk factors present, freebirth, and that of selected women cared for by health professionals with systems for transfer in place. However, it remains that the women with risk factors who chose to give birth at home outside of a publicly-funded homebirth service have a right to choose this option, as recently mandated by the European Court of Human Rights (2010), although this ruling has yet to be tested by the Australian legal system.

The results from this study support the notion that women choose a publicly-funded homebirth to retain personal control over their labour and birth, in addition to having support from midwives who they trust and have confidence in. This type of collaborative 'partnership' care has been seen to be the most effective and satisfying way to experience maternity care (Bailes & Jackson 2000; Kennedy et al. 2004; Walsh 1999) and can lead to more positive outcomes (Benjamin, Walsh & Taub 2001). However, there was an element of care and guidance from the midwives that was expected and appreciated in this study. Women who chose a publicly-funded homebirth, for the most part, relied on the support of their midwives to care for them in the way they came to know would be in their interests. During pregnancy, women described the trust and confidence that was built up with their midwives. This was achieved through sharing philosophies of normal birth and ways of practice, so that women and their families felt comfortable to take advice from the midwife, should any unexpected deviation from normal occur. On the same premise, Bluff (1994) found a strong willingness for women to concede to their midwife's knowledge and practice, even if this contradicted their wishes; they did not find differences in primigravid or multigravid women in this respect. The study by Bluff, set in a

large UK maternity unit, may show that women are more likely to give over control in a hospital environment; a concept that has been explored by Dahlen and colleagues (2010). In my study, the awareness of this possibility influenced women's decisions to give birth at home.

THE PRACTICALITIES OF HAVING A HOMEBIRTH

Women described a number of practical reasons why they chose to have a homebirth. These came mostly from the multiparous women, due to their previous birth experiences and the knowledge of how they could eliminate complications and enhance their experience. Reasons given included those of not wanting to be separated from their partners, wanting to avoid the car journey to the hospital, and incorporating the needs of older children. For example, one woman said '…*So I was thinking well why don't we eliminate that tricky bit of getting in the car and going and just get people to come to us instead, it will be lovely'.* A similar reaction from a small number of women was found in Borquez and Weigers (2006) in a study comparing experiences of women giving birth in a Birth Centre and having a homebirth, and also by Boucher et al. (2009). This can also be interpreted as women wanting to stay in their own space during their labour and birth experience. The power that a place exerts on women has been studied by Lock and Gibb (2003). These researchers examined women's experiences of early discharge from hospital, and concluded that women felt a disempowerment in hospital, and that their home was associated with feelings of security, freedom and support. Succinctly, Lock and Gibb state that by choosing a different birthplace '… the rules of the institution no longer exerted powerful control over the activities of these women' (page 135). This is likely to be similar to the reasons women choose a homebirth.

RELATIONSHIPS WITH CAREGIVERS

All women described the importance of their midwives, and the activities they employed to engage the support of their partners, friends or family to complete their 'support team'. Some women had an immediate team without much difficulty, and others had to educate themselves first, then transfer the

knowledge to their support team and use persuasive methods to change their attitudes - which took a longer period of time. This was accomplished with the help of their midwives, with whom the women became very close over the course of their pregnancy, labour and birth.

Women described an overwhelming confidence and trust in the midwives and a deepening of this over time, due to the continuity of caregiver in this homebirth model. In Australia, only 2.2% of women are reported to be cared for in a Birth Centre (Li et al. 2012), and is anecdotally estimated that up to 10% women are cared for within a midwifery-led continuity of care model, although accurate figures are unknown.

Similar to Janssen et al. (2009), the continuity of care and carer women received in my study enabled them to feel emotionally supported. They expressed that they trusted their midwives to be professionally competent to deal with any difficulties that might arise during their labour. This in turn allowed women to relax when in labour, which may have had a bearing on their outcomes, although this was not studied. Women who have homebirths do have better outcomes than women of similar risk status and demographic (Davis et al. 2011; de Jonge et al. 2009; Hutton et al. 2009; Johnson & Daviss 2005; Olsen & Clausen 2012), but it is not known whether a higher level of emotional support is a factor in this. Studies that focus on the benefits of support in labour include Hodnett et al. (2007b) that define emotional support as giving continuous presence, reassurance and praise, and state it may decrease anxiety, and the adverse effects this creates. A systematic review of non-pharmacological measures to reduce pain by Simkin and O'Hara (2002) had comparable results, however, none of these studies focused on women having a homebirth.

Women in this study described good relationships with their midwives that reflected a partnership philosophy of care. Caring for women in partnership is a collaborative method with the ability to deliver effective high quality care to women during pregnancy and birth (Bailes & Jackson 2000; Benjamin, Walsh & Taub 2001; Casey 2008; Freeman 2006; Freeman & Griew 2007; Kennedy et

al. 2004; Walsh 1999). Partnership involves collaboration with the woman and her family and this is the basis of how midwifery students are currently taught to relate to women (Rolls & McGuinness 2007). This care ensures midwives and women set goals and discuss options of care together, and that women are active participants in the process. This in turn improves a woman's knowledge about herself, her body, baby and the birth process as well as the homebirth program itself. Working in a partnership provides women with a sense of dignity, self-respect and self-responsibility as well as a sense of self-determination and control during pregnancy and birth (Leap & Pairman 2010).

HAVING THE SUPPORT TEAM AT HOME

Without necessarily knowing the importance of support in labour in relation to outcomes, in this study, women who chose a publicly-funded homebirth worked hard to engage the help and support of their partners, friends or wider family during their pregnancies. This was often more to provide support for their decision, than to necessarily give support in labour itself. In contrast, women who have hospital births do not have to do this. When having a baby in hospital in Australia, it is an automatically assumed notion that partners or significant others will accompany and support women in their choice to give birth in hospital.

In this study, women often spoke of the importance of their 'support team', which, depending on the woman, meant their partners and midwives, or these people plus wider family, friends and privately-employed doulas. Most women had a strong, constant support team by their side. Also, due to the structure of the St George homebirth program, there were always two midwives with women in labour at home, so it was likely that they had consistent, quality support during labour and birth. This has been shown to contribute to the satisfaction women feel from having a homebirth (Borquez & Wiegers 2006; Christiaens et al. 2009; Hildingsson, Radestad & Lindgren 2010; Sjoblom et al. 2006) as it is well known that support in labour is associated with good outcomes and satisfied mothers (Hodnett 2002; Hodnett et al. 2007b; Kashanian et al. 2010; Leap et al. 2010; Lundgren 2010).

Women appreciated the flexibility within the publicly-funded system to make the final decision about where they wanted to give birth when in labour. The Albany Practice in London also provided the same flexibility of birthplace choice to women throughout their pregnancy and labour; hence women wishing to have a homebirth could change their minds at any time about where they gave birth if they wanted to (Sandall, Davies & Warwick 2001). In this study, only one woman requested to transfer into hospital for her birth, and this was for childcare reasons, not safety concerns. In effect, there was an equal decision-sharing relationship (or partnership model) with midwives who facilitated situations where women's experiences could be tailored to their individual needs.

HAVING WOMAN-CENTRED CARE

In my study, woman-centred care was apparent throughout the data and is closely linked to women feeling they have more control in their pregnancy and birth (Johnson et al. 2003; Leap 2009). One example of this was described by a woman who was transferred to hospital for an emergency caesarean section for delayed progress in labour. She, her partner and doula had planned to chant to the newborn at birth. Despite the birth occurring in the operating theatre, this wish was facilitated by her homebirth midwife, who was aware that it was an important thing for her and her partner to do.

Woman-centred care appears to give equal weight to the emotional and physical wellbeing of women during pregnancy and birth. Incorporating and recognising the emotional wellbeing of women is often overlooked in busy antenatal clinics with fragmented models of care. Women choosing homebirth may also feel their emotional health to be of equal importance – and either knowingly or un-knowingly choose care that facilitates this. This was apparent in my study, where a number of women would describe the importance of their emotional health in their maternity care.

Caring for women's emotional needs is an important aspect of midwifery. This care can be facilitated well in a midwifery-led continuity of care model (Severinsson, Haruna & Friberg 2010), and is important to women (Kirkham

2010). For example, a Norwegian qualitative analysis by Severinsson et al. (2010) found midwives placed importance on caring for women's emotional needs within a continuity of care model, and that this was facilitated by clinical midwifery supervision and leadership. Pilley Edwards (2005), in her Scottish study of homebirth, also found women needed emotional care just as much as they needed the physical care from their midwives. In her study, Pilley Edwards found this aspect was lacking at times, which could have been because the midwives in this study did not work predominantly within a continuity of care model, which was a barrier to developing a relationship with women. Additionally, the midwives in this study also had a more technocratic, medical-oriented approach.

SUMMARY: CLOSING THE HOSPITAL-HOME DIVIDE

The desire for a level of control during pregnancy, labour and birth is present for most women, regardless of birthplace. What makes women who book for a homebirth different is that they have an ability to pursue and create their birthplace environment enhancing the level of control, confidence, power and responsibility for their own birth experience. This all centres on their faith in themselves to have a normal birth, which this study found as a central category: *having faith in normal*.

Having control over pregnancy and birth is a common theme in my study, with many other studies reiterating this as important to women. In view of this it is important that hospital maternity services develop models of care that facilitate a partnership approach in order for women to have more control over their care. This would serve to increase the satisfaction levels of women regarding their care, and indirectly may have a bearing on outcomes through women feeling more relaxed and in control during labour and birth. It may also reduce the number of women with more complicated pregnancies (for example breech presentation, multiple pregnancy) to feel more comfortable within a hospital environment and not pursue a private homebirth or freebirth and risk adverse outcomes for themselves and their babies. However, public and private hospital maternity services in Australia are frequently running on full capacity, are

understaffed and under-resourced (Pugh et al. 2012), hence the time necessary to spend with women to facilitate the 'partnership' is often lacking. In addition, midwives working within these organisations, even if newly graduated and versed in the importance of this way of caring for women, may become disillusioned with the constraints of the workplace culture and succumb to the status quo in order to cope and 'fit in' with their more senior colleagues. This disillusionment has been cited as a reason for the high number of newly graduated midwives who leave the profession (Buchan & Seccombe 2005; Curtis, Ball & Kirkham 2003).

The women in this study expressed a relief to be able to have the choice of a homebirth and to not have to go to hospital. In Australia, most women have their babies in hospital, so it could be assumed that there was less stress for these women to have their babies within a hospital environment, and that they would be possibly more stressed by giving birth at home. However, this is not known, and there may be large numbers of women who are highly stressed by giving birth within a hospital maternity unit but do not have the resources or ability to investigate other choices of birthplace. What is known is that when homebirth services are supported and available, women will choose this option and homebirth rates rise (Pilley Edwards 2005; Sandall, Davies & Warwick 2001). This is likely to be the case with an increase in development of publicly-funded homebirth programs in Australia.

LIMITATIONS OF THE STUDY

The limitations of this study are that the setting is restricted to one publicly-funded homebirth program in the south eastern area of Sydney, and women interviewed were all English-speaking and of a similar demographic profile. Hence, the findings have limited generalisability. This study could have had different findings if set in, for example, rural Australia.

Women who agreed to participate in this study may have been somewhat motivated to do so, and as such have a more positive attitude to homebirth. This may have had a bearing on the mostly positive views found in this study.

As with most studies of homebirth, there are accepted limitations regarding the self selection of women who choose to give birth at home. For example, results may have been affected by unmeasured characteristics and attitudes of these women. The restrictive inclusion criteria of the publicly-funded homebirth program was also a limiting factor in the type of woman that was recruited to this study.

This study did not include women who chose to have a homebirth with privately practising midwives as I chose to focus on those women within a publicly-funded homebirth program. The finding of the safety net would probably have been different if I had included these women.

In addition, it is acknowledged that researcher bias is possible with grounded theory, however throughout the study I have endeavoured to be aware of the need for reflexivity, and have used my personal stance and experience in relation to homebirth to increase theoretical sensitivity and enhance interpretation of the data. Data were also observed by, and the formation of the categories and findings in this study were discussed with my doctoral supervisors. However, the qualitative nature of this study is a limitation, due to the subjective nature of the methodology.

CONCLUSIONS: THE FUTURE? COLLABORATION, CONSENSUS AND CHOICE

This study found that the influences on women that chose a publicly-funded homebirth were multifactorial. Women expressed that they were strong, assertive and independent, and healthy and able to have a baby at home without medical intervention. They had a solid belief in the normal process of birth, and spent time during their pregnancies validating their decision by engaging support and disclosing and discussing their plans with selected people. All women expressed a strong wish to have a high level of control over their maternity care, labour and birth, and they felt they could not do this in a hospital setting. Women had deep, trusting relationships with their midwives, and this confidence in their carers enhanced their experience within the

program. They also wished to avoid the possibility of medical intervention, and felt the surest way to achieve this was to give birth at home. The unique finding in this study was that the women conveyed a reassurance (for themselves and their family) that the publicly-funded homebirth program caring for them created a safety net with easy links to the hospital, and that there was a seamless ability to access emergency care if necessary.

There will always be women who want to have a homebirth, and it is well documented that women want more Birth Centres (Commonwealth of Australia 2009). Currently in Australia and overseas there is much politicising of issues surrounding homebirth that serves as a barrier to progressing this choice for women (de Crespigny, Walker & Savulescu 2012). Despite this, in the USA, the need for constructive dialogue and collaborative processes between disciplines instigated a homebirth summit (Vedam 2011). This involved stakeholders from all disciplines including homebirth consumers, midwives, obstetricians, health policy makers, public health advisers and insurance professionals who came together to write nine consensus statements. These collaboratively created statements were a foundation towards improving care for women and families who choose homebirth, in order to make homebirth the safest it can be. One of the statements detailed the desire for ‘the development of high quality home birth services within an integrated maternity care system’ (Vedam 2011 'Common Ground' page), which sounded similar to the established publicly-funded homebirth services in Australia (see Appendix 13).

The homebirth summit had some success in bringing together stakeholders to discuss issues of homebirth (Vedam 2011). However, as previously discussed, midwives, doctors and women process decisions based on perceptions of risk in quite different ways depending on their philosophy (Davis-Floyd 2001; de Melo-Martin & Intemann 2012; Hoang et al. 2012; MacColl 2009), which was apparent at the homebirth summit. Recently, de Melo-Martin and Intemann (2012) used homebirth as an example of an issue with a divergence of opinions and differences in interpretation of research. The authors argued that unless an engagement and recognition of values was undertaken, the ability to increase the profile of homebirth would not occur; that alongside the necessary

interpretation of evidence regarding safety and risk, there should be an acknowledgement of non-epistemic values amongst researchers. For example, proponents of homebirth can give reasons why the practice is safe, yet opponents do not recognise these reasons as being important or relevant. The authors argue that the ability to understand underlying value judgements when interpreting data would lead to meaningful communication.

Communication and an ability to understand women's desire for a birthplace other than a hospital setting is central to the multidisciplinary collaboration necessary within a publicly-funded homebirth program. Given the extensive multidisciplinary consultation seen in developing a publicly-funded program (Catling-Paull, Foureur & Homer 2012), and the level of opposition to this birthplace from the medical fraternity (RANZCOG 2011a), the need for such communication in Australia appears wholly necessary. Conversely in the UK, the obstetricians' professional organisation, RCOG, has recently suggested that low risk women move away from hospitals as a birth place and consider a homebirth, stating 'too many babies are born in the traditional 'hospital' setting' (RCOG 2011 p. iv). This is the first time a professional medical organisation has promoted homebirth, although RCOG have always been supportive of homebirth and most NHS Trusts have this as a birthplace option.

Understanding the influences women have when they choose to give birth at home is also important to take into consideration when developing a woman-centred program (Proctor 1998; Sword et al. 2012). This study has shown that women were reassured by the publicly-funded homebirth program's links with the hospital, and the flexibility of the midwives to care for women in the Birth Centre and at home. It is likely that most mainstream maternity services in Australia do not have the ability to individualise care as much as small midwifery-led caseload models do. Nevertheless the importance of quality maternity care that takes into account women's different needs, including that of giving birth at home, means that maternity services need to begin widening their capacity to incorporate facilities that work this way. In the past, this has proven to be time-consuming, needing much dedication and negotiation on behalf of the drivers of new publicly-funded homebirth programs (Catling-Paull, Foureur &

Homer 2012), however resources and support are available through a nationwide consortium (Centre for Midwifery Child and Family Health 2013), and new programs are gradually being developed around the country (Miller 2012; Turnbull & Frazier 2012).

More research on publicly-funded homebirth programs in Australia is needed to increase knowledge of these models and explore their strengths and limitations. More available programs would provide more birthplace choice for women, escalate awareness and raise the profile of homebirth within Australia. This would be enhanced and expedited by greater collaboration with obstetricians and hospital management. This study has shown that the influences on women when choosing a publicly-funded homebirth in Australia include the appreciation of such a collaboration, or the 'safety net' when electing to give birth at home, and as such, this study reports the first data on the experiences of women who choose publicly-funded homebirth. Most studies of homebirth concentrate on statistical data of homebirth outcomes, whereas this study brings to life the voices, thoughts and feelings of the women. The safety aspect, as well as issues of control, strength and confidence, support, protection from hospital-related activities and selectivity on who they shared their homebirth plans with, were vital to reinforcing their faith in themselves as normal and low risk, in order to have a safe, fulfilling and satisfying homebirth.

APPENDICES

APPENDIX 1: Participant information statement – Women who chose to have a homebirth during pregnancy

SOUTH EASTERN SYDNEY ILLAWARRA NSW HEALTH

UNIVERSITY OF TECHNOLOGY SYDNEY

Approval No 08/STG/129

ST. GEORGE HOSPITAL

PARTICIPANT INFORMATION STATEMENT – Women who chose to have a homebirth during pregnancy

Exploring the influences on choosing a home birth

My name is Christine Catling-Paull and I am a doctoral student at the University of Technology, Sydney. My study is examining the influences on women who choose to have a home birth. You are invited to participate as it was identified that during your pregnancy you were booked to have a home birth. The study hopes to learn about the information you received on home birth that led you to choose to have your baby at home.

If you decide to participate, I would like to interview you (for about an hour) about your choice and influences to have a home birth. To arrange this I will telephone you six weeks after you have had your baby. I will also collect a few details about you (for example your age, how many babies you have had before and what sort of birth you had). The interview will be tape recorded with your permission.

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. If you give your permission by signing the consent form, I will use the information in my doctoral thesis, publish the results in academic journals and discuss at midwifery conferences. In any publication, information will be provided in such a way that you cannot be identified.

If you have any questions I will be happy to answer them. Please feel free to contact me to discuss any other questions in the future about the study. (tel: 0425216890).
As I am a doctoral student, Professor Caroline Homer and Associate Professor Hannah Dahlen are my supervisors. You can also contact them to discuss the study on 9514 4834.

Your decision whether or not to participate will not affect your future relationship with the Hospital. If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time.

You will be given a copy of this form to keep.

If you have any complaints about this study you can direct these to the South Eastern Sydney and Illawarra Area Health Service Human Research Ethics Committee - Central Network, St. George Hospital, Gray St., Kogarah 2217. Telephone: 9113 2481 or 9113 2987.

Participant's Initials _____

APPENDIX 2: Consent form for women participants

PARTICIPANT CONSENT FORM Women who chose to have a homebirth during pregnancy

Exploring the influences on choosing a home birth

You are making a decision whether or not to participate. Your signature indicates that you have decided to participate having read the information provided above.

Signature of subject	Signature of witness
Please PRINT name	Please PRINT name
Date	Nature of Witness
Signature of Investigator	
Please PRINT Name	

REVOCATION OF CONSENT

Exploring influences on women choosing home birth

I WITHDRAW my consent to participate in the research project described above and understand that St. George Hospital has previously agreed that such withdrawal WILL NOT jeopardize any treatment or my relationship with the hospital or my medical attendants.

Signature	Date
Please PRINT Name	

The section for Revocation of Consent should be forwarded to Christine Catling-Paull, Centre for Midwifery, Child and Family Health, Faculty of Nursing, Midwifery and Health, University of Technology, Sydney, PO Box 123, Broadway, NSW, 2007.

APPENDIX 3: Participant information statement – Midwives who work in the Birth Centre

SOUTH EASTERN SYDNEY ILLAWARRA
NSW HEALTH

UNIVERSITY OF TECHNOLOGY SYDNEY

Approval No:.....

ST. GEORGE HOSPITAL

PARTICIPANT INFORMATION STATEMENT – Midwives who work in the Birth Centre

Exploring the influences on choosing a home birth

My name is Christine Catling-Paull and I am a doctoral student at the University of Technology, Sydney. Professors Caroline Homer and Hannah Dahlen are my supervisors. My study is examining the influences on women who choose to have a home birth. You were selected as a possible participant in this study because you care for women who may choose to have a home birth.

The study hopes to gain a better understanding about the information given to women that lead them to choose a home birth. The study is in two parts – the first part involves interviews with women who had chosen to have a home birth, and the second part involves a focus group of the midwives who care for these women.

Participation in the second part of the study will involve being part of a focus group discussing issues around information-giving regarding home birth with the women you care for. The discussion will be tape recorded with your permission.

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. If you give your permission by signing this document, I will use the information in my doctoral thesis, publish the results in academic journals and discuss at midwifery conferences. In any publication, information will be provided in such a way that you cannot be identified.

Your decision whether or not to participate will not affect your future relations with the Hospital or your employment in any way. If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time.

Please ask us any questions. If you have any additional questions later, I, (Christine Catling-Paull tel: 0425216890) will be happy to answer them.

If you have any complaints about the study in the future, these may be directed to the South Eastern Sydney and Illawarra Area Health Service Human Research Ethics Committee - Central Network, St. George Hospital, Gray St., Kogarah 2217. Telephone: 9113 2481 or 9113 2987.

You will be given a copy of this form to keep.

Participant's Initials _____

APPENDIX 4: Consent form for midwives

PARTICIPANT CONSENT FORM - Midwives

Exploring the influences on choosing a home birth

You are making a decision whether or not to participate. Your signature indicates that you have decided to participate having read the information provided above.

Signature of subject	Signature of witness
Please PRINT name	Please PRINT name
Date	Nature of Witness
Signature of Investigator	
Please PRINT Name	

REVOCATION OF CONSENT - Midwives

Exploring influences on women choosing home birth

I **WITHDRAW** my consent to participate in the research project described above and understand that St. George Hospital has previously agreed that such withdrawal WILL NOT jeopardize my relationship with my colleagues or the hospital.

Signature	Date
Please PRINT Name	

The section for Revocation of Consent should be forwarded to Christine Catling-Paull, Centre for Midwifery, Child and Family Health, Faculty of Nursing, Midwifery and Health, University of Technology, Sydney, PO Box 123, Broadway, NSW, 2007.

APPENDIX 5: Participant information statement – Relative of women who chose to have a homebirth during pregnancy

SOUTH EASTERN SYDNEY ILLAWARRA
NSW HEALTH

UNIVERSITY OF TECHNOLOGY SYDNEY

Approval No: 08/STG/129

ST. GEORGE HOSPITAL

PARTICIPANT INFORMATION STATEMENT – Relative of women who chose to have a homebirth during pregnancy

Exploring the influences on choosing a homebirth

My name is Christine Catling-Paull and I am a doctoral student at the University of Technology, Sydney. My study is examining the influences on women who choose to have a homebirth. You are invited to participate as it was identified that you are a relative of a woman who has had a homebirth within the St. George Homebirth program. The study hopes to learn about your knowledge of homebirth, and what role you may have had in your relative's decision to have her baby at home.

If you decide to participate, I would like to interview you (for up to an hour) about your involvement in your relative's decision to have a homebirth. To arrange this I will telephone you to make a date to meet. I will also collect a few details about you (for example your age, educational level, marital status). The interview will be tape recorded with your permission.

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. If you give your permission by signing the consent form, I will use the information in my doctoral thesis, publish the results in academic journals and discuss at midwifery conferences. In any publication, information will be provided in such a way that you cannot be identified.

If you have any questions I will be happy to answer them. Please feel free to contact me to discuss any other questions in the future about the study. (tel: 0425216890).
As I am a doctoral student, Professor Caroline Homer and Associate Professor Hannah Dahlen are my supervisors. You can also contact them to discuss the study on 9514 4834.

Your decision whether or not to participate will not affect your future relationship with the Hospital. If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time.

You will be given a copy of this form to keep.

If you have any complaints about this study you can direct these to the South Eastern Sydney and Illawarra Area Health Service Human Research Ethics Committee - Central Network, St. George Hospital, Gray St., Kogarah 2217. Telephone: 9113 2481 or 9113 2987.

Participant's Initials _____

APPENDIX 6: Consent form for relatives

PARTICIPANT CONSENT FORM Relative of women who chose to have a homebirth during pregnancy

Exploring the influences on choosing a homebirth

You are making a decision whether or not to participate. Your signature indicates that you have decided to participate having read the information provided above.

Signature of subject	Signature of witness
Please PRINT name	Please PRINT name
Date	Nature of Witness
Signature of Investigator	
Please PRINT Name	

REVOCATION OF CONSENT

Exploring influences on women choosing homebirth

I **WITHDRAW** my consent to participate in the research project described above and understand that St. George Hospital has previously agreed that such withdrawal WILL NOT jeopardize any treatment or my relationship with the hospital or my medical attendants.

Signature	Date
Please PRINT Name	

The section for Revocation of Consent should be forwarded to Christine Catling-Paull, Centre for Midwifery, Child and Family Health, Faculty of Nursing, Midwifery and Health, University of Technology, Sydney, PO Box 123, Broadway, NSW, 2007.

APPENDIX 7: Memo notes – examples

Memo notes on wellness

Wellness	HB1 discussed her 'wellness perspective'. Do other women have this? Despite working in a children's hospital, this woman articulated it was 'very separate' to her situation – and her knowledge of being fit and healthy. HB12 appeared to have a solid belief in an alternative/natural lifestyle, and felt having a homebirth fit with this philosophy. Other women have not expressed this as a lifestyle choice – ask this question in future interviews: does having a homebirth fit with their philosophy of lifestyle?

Memo notes on relationship with midwives

Relationship with midwives	HB2: When discussing the midwives who cared for her, her mother (an RN) came into the room and took over answering the question! She had seen the professionalism and abilities of the midwives caring for her daughter and had 'turned' from being afraid of homebirth to being an advocate. I need to ask all women about the relationship with their midwife, and its relevance to their decision to have a homebirth. Its possible that the importance of this grew over time (with trust) corresponding with the number of times women see midwives throughout pregnancy

Memo notes on women's desire for control

Maintaining eligibility to stay on the homebirth program	HB8, when asked to perform her own lower vaginal swab for the Group B Streptococcus (GBS) test, merely waved the swab stick in the air, and hence sent off an invalid swab test. This was to ensure it did not come back as positive. She had researched the risk of neonatal GBS sepsis and decided the risks involved with having her baby in hospital [due to being GBS positive and ineligible to be on the homebirth program] were higher than the likelihood of her baby getting neonatal sepsis. She took control of the decision around this clinical risk issue and disclosed the information with an attitude of triumph that she was able to do this– albeit secretly. HB12 spent a lot of time and effort researching the best possible care for herself in pregnancy. She interviewed a few obstetricians and two independent midwives, [before booking with the publicly-funded homebirth program]. She also had a doula at her birth. She discussed the importance of the home environment during labour and birth – for her it provided 'peace of mind'.

APPENDIX 8: PUBLICATION 1

McMurtrie, J, Catling-Paull, C, Teate, A, Caplice, S, Chapman, M. & Homer, C.S.E. 2009, The St George Homebirth Program: 'an evaluation of the first 100 booked women', *Australian and New Zealand Journal of Obstetrics and Gynaecology*, vol. 49, no. 6, pp. 631-636.

APPENDIX 9: PUBLICATION 2

Catling-Paull, C, Dahlen H & Homer C.S.E. 2011, 'Multiparous women's confidence to have a publicly-funded homebirth: A qualitative study', *Women and Birth,* vol. 24, pp. 122-128.

APPENDIX 10: PUBLICATION 3

Catling-Paull, C, Foureur M.J & Homer, C.S.E. 2012, Publicly-funded homebirth models in Australia', *Women and Birth*, vol. 25, iss. 4, pp. 152-8.

APPENDIX 11: PUBLICATION 4

Catling-Paull, C, Coddington, R, Foureur M.J, & Homer, C.S.E. 'Publicly-funded homebirth in Australia: an evaluation of maternal and neonatal outcomes', submitted to a peer reviewed journal, November 2012.

PUBLICLY-FUNDED HOMEBIRTH IN AUSTRALIA: AN EVALUATION OF MATERNAL AND NEONATAL OUTCOMES

Authors: Christine Catling-Paull, Rebecca Coddington, Maralyn Foureur, Caroline SE Homer

On behalf of the Birthplace in Australia Study and the National Publicly-Funded Homebirth Consortium

ABSTRACT

Background: A number of publicly-funded homebirth programs have been established in Australia since 1996. These programs provide low risk women with the option of giving birth at home with midwives who are employed through the public health system. There has been no national evaluations of the publicly-funded homebirth programs in Australia.

Aims: To report maternal and neonatal outcomes for women planning a publicly-funded homebirth between 2005 and 2010.

Methods: Data from 2005-2010 (or from commencement of the program to 2010) was requested from the 13 publicly-funded homebirth programs currently in place at the time of the study. A descriptive analysis was undertaken.

Results: Nine publicly-funded homebirth programs provided data. Of the 1807 women who intended to give birth at home at the onset of labour, 1506 (83%) did so. A further 315 (17%) transferred to hospital during labour or within one week

postnatally. The Perinatal Mortality Rate was 3.3 per 1000 births, and 1.1 per 1000 births when excluding deaths because of expected fetal anomalies. The vaginal birth rate was 90%.

Conclusion: This study provides the first national evaluation of a significant proportion of women choosing publicly-funded homebirth in Australia. However, sample size does not have sufficient power to determine safety. More research is warranted into the safety of alternative places of birth within Australia.

Key Words: Homebirth, publicly-funded homebirth, perinatal mortality rate, neonatal morbidity, Australia.

INTRODUCTION

Homebirth has been a topic of significant debate in the Australian political and health arenas for many years. The evidence surrounding the safety and benefits of homebirth remains contentious (Newman 2008; Pesce 2009; Pesce 2010) and to date, no randomised controlled trials have been undertaken (Olsen and Clausen 2012). There are differing views about whether this will ever be possible in the future (McLachlan and Forster 2009; Keirse 2010).

Homebirths account for a very small number of births in Australia. In 2010, only 0.3 per cent of all women who gave birth chose homebirth (Laws and Sullivan 2010). This is compared with 2.9 per cent in the same year in England and Wales (UK Office for National Statistics 2010) and 0.6 per cent in the United States in 2006 (MacDorman, Declercq et al. 2011). A study from New Zealand reported that 11 per cent of healthy women choose to have a homebirth (Davis, Baddock et al. 2011). In contrast, the Netherlands, which has a strong history of birth at home for low risk women, has a homebirth rate of around 30% (Euro-Peristat project 2008).

Homebirth has not been a mainstream option for childbirth in Australia for many decades. In 2001, privately practising midwives providing a homebirth service were unable to obtain professional indemnity insurance due to a collapse of the international insurance industry and this significantly reduced the numbers of midwives who offered homebirth. These factors and the lack of government funding have meant that there has been extremely limited access to homebirth for Australian women. There has, however, been a vocal demand from consumers and midwives for such an option (Newman 2008). In the recent *National Review of Maternity Services* in Australia (Commonwealth of Australia 2009), more than 60% of the submissions were about homebirth, with the vast majority from women who wanted access to homebirth (Dahlen, Jackson et al. 2011).

The *National Review* ultimately identified that homebirth was a sensitive and controversial issue (Commonwealth of Australia 2009). In particular, the review 'formed the view that the relationship between maternity health care professionals is not such as to support homebirth as a mainstream Commonwealth-funded option, at least in the short term' (Commonwealth of Australia 2009: 20–21). The release of this Report in 2009 heralded the commencement of the most recent homebirth debate.

In an effort to accommodate women who wish to have a homebirth in Australia, publicly-funded homebirth has been introduced over the past decade. These programs cater to women who are at low obstetric risk and wish for a homebirth through the public health system. Professional indemnity insurance for the midwives is provided by the hospital employer. The programs operate within the public hospital system and are often linked with, or arose from, existing birth centres or midwifery group practices (Catling-Paull, Foureur et al. 2012).

Currently there are at least 13 publicly-funded homebirth programs in Australia in every state and territory, except Queensland, Tasmania and the Australian Capital Territory. The programs are situated within public hospitals or health services. A small number of individual program evaluations have been undertaken, for example, the St George Hospital Homebirth Program in New South Wales (NSW) (McMurtrie, Catling-Paull et al. 2009), the Community Midwifery Program in Western Australia (WA) (Thiele and Thorogood 1997), the Casey Hospital Homebirth pilot (VIC) (Hider 2011) and Northern Women's Community Midwifery Program in South Australia (SA) (Nixon, Bryne et al. 2003).

The development of these programs involved extensive multidisciplinary consultation and planning, although differing data collection methods, definitions and guidelines were used (Catling-Paull, Foureur et al. 2011). The programs accommodatewomen who were at low risk of medical or obstetric complications and many used the Australian College of Midwives (ACM) Guidelines for Consultation and Referral to determine women's suitability for homebirth (ACM 2008). A number of publicly-funded homebirth programs based their criteria for homebirth on the South

Australian Government policy for planned birth at home (Government of South Australia 2007). Midwives are usually selected to work within the programs after accreditation processes involving practice review, advanced obstetric emergency training (American Academy of Family Physicians 2010), cannulation and suturing skills (Homer and Caplice 2007; Catling-Paull, Foureur et al. 2011).

Most publicly-funded homebirth programs are run within a midwifery group practice and are linked to a Birth Centre. Within these models, midwives often provide 'caseload' care to a woman which involves continuity of carer, with an allocated back-up midwife. Should women develop risk factors during pregnancy or labour, the primary midwife continues to care for women in collaboration with medical staff, and the woman's birthplace changes to the Birth Centre or Labour Ward. This means there can be an effective transfer and incorporation of other health care professionals usually with no change in the midwife providing care. This midwifery continuity of care is greatly valued by women and has been shown to be associated with positive outcomes (Hatem, Sandall et al. 2008).

In 2010, we developed a National Publicly-funded Homebirth Consortium to network and share resources around the country (Catling-Paull, Homer et al. 2011). Through this linkage, we undertook a national evaluation of the programs which is the topic of this paper. This is the national evaluation of maternal and neonatal outcomes from publicly-funded homebirth programs in Australia.

Ethical approval was provided for the study by the Human Research Ethics Committees of the health services that were involved. Approval was also given from the university.

METHODS

A descriptive study was undertaken. The managers of the programs which were established by December 2011 (n=13) were asked for data for a period of 5 years from January 2005 to December 2010 (or from when the service began, if it had not been operating as long as five years). These were routinely collected maternal and

neonatal data that were stored on databases within the hospitals where the homebirth programs were based. Data were collected on all women who were planning to have a homebirth at the onset of labour.

Data requested included demographic details of the women, mode and place of birth, perineal trauma, third stage management, maternal and neonatal transfer to hospital, birth weight, maternal and neonatal morbidity and mortality, admission to the Special Care Nursery and breastfeeding details. Ten services responded with the provision of five-year data; one with data spanning one year. Any incongruity in numerical data was clarified with individual discussion with the program managers.

RESULTS

In this dataset, between years 2005 and 2010, a total of 1807 women intended, at the onset of labour, to have a homebirth within a publicly-funded homebirth program. The majority of these women were aged 26-35 years of age (67%), and multigravid (68%) (Table 1). More than 83% (n=1506) of women were successful in achieving a homebirth and 945 women (52%) gave birth in water. Overall, 17% of women were transferred during labour to hospital and gave birth either in a Birth Centre (1.4%), Delivery Suite (14.2%) or Operating Theatre (0.2%). Around 1% of babies were born before the arrival of the midwife to the woman's home (Table 2).

A total of 1807 babies were born. Almost all (99%) had a birth weight greater than 2500 grams. A small proportion (2.7%; n=48) were admitted to the Special Care Nursery (n=48). There were two stillbirths and four neonatal deaths. Three of these deaths were expected due to previously diagnosed fetal anomalies and in each of these cases the women had decided to continue with their plan to birth at home. The Perinatal Mortality Rate was 3.3 per 1000 births, and 1.1 per 1000 births excluding the expected deaths of babies with fetal anomalies. Nearly all women initiated breastfeeding, with 72% still breastfeeding at six weeks (Table 3).

Most women had an intact perineum (56% n= 999), a further 4.3% (n= 77) sustained a perineal graze and 34.2% (n=610) having a first or second degree perineal tear.

Episiotomy rates (2.6% n=47) and third degree tear rates (1.1% n=20) were both low. Most women opted for a physiological third stage of labour (73% n= 1192), and 1.8% (n=33) had a postpartum haemorrhage (Table 2). There were no maternal deaths.

DISCUSSION

This study contributes to the evidence about homebirth as an option for women at low obstetric risk. The Perinatal Mortality Rate (PNMR), when excluding deaths of babies with fetal anomalies was low at 1.1 per 1000 births. The maternal and neonatal outcomes in this study are comparable with other studies of homebirth for low risk women (Murphy and Fullerton 1998; Johnson, Daviss et al. 2005; de Jonge, van der Goes et al. 2009; Birthplace in England Collaborative Group 2011). For example, the recent Birthplace in England study (2011), analysed a composite of primary outcomes (which included stillbirth and early neonatal death amongst other serious morbidity) in 64,538 low risk women and found no difference in the adjusted odds between obstetric units and other birthplaces, including homebirth. However, higher rates were seen for nulliparous women having a homebirth (adjusted odds ratio 1.75, 95% CI 1.07 to 2.86).

In our evaluation, there was a normal vaginal birth rate of 90%. This concurs with the Birthplace in England study (Birthplace in England Collaborative Group 2011) which showed a higher rate of normal vaginal birth when women gave birth outside of a hospital environment. The intrapartum hospital transfer rates of women in our study are also comparable with others (Murphy and Fullerton 1998; Johnson and Daviss 2005; New Zealand Information Service 2007; Lindgren, Hildingsson et al. 2008). Less than one in five women were transferred to hospital during labour or within one week of giving birth because of factors necessitating medical care.

Of interest was the rate of postpartum haemorrhage in this cohort of women. Most women (74%) had physiological management of the third stage of labour which meant oxytocic agents were not administered prophylactically. One quarter of women active management of the third stage including prophylactic administration

of oxytocin and controlled cord traction. Active management of the third stage is the more common form of management in hospital settings. Despite the lower than usual rates of active management of the third stage in the homebirth cohort, only 1.8% (n=33) had a postpartum haemorrhage. The postpartum haemorrhage rate is similar to the rates found in women being cared for in midwifery models of care (Hatem, Sandall et al. 2008), but lower than NSW population data (Ford, Roberts et al. 2008). Postpartum haemorrhage rates in hospital settings are reported to be 6.3% (Cameron, Roberts et al. 2006) although a proportion of women would be high risk. In a home setting, women who have a postpartum haemorrhage are transferred to hospital for further support, and intravenous fluid therapy and oxytocic medication are initiated by the attending midwives.

The emergency caesarean section rate and assisted vaginal birth rate were low in this study. Low rates of caesarean section have been recorded in women who planned a homebirth in the Birthplace in England Study (2011) (2.8%), and the South Australian study by Kennare (2010), (9.2 planned homebirth vs 27.1% hospital births). More recently, low caesarean section rates have been reported in relation to caseload midwifery care (not necessarily homebirth) in Victoria (McLachlan, Forster et al. 2012). This low rate of caesarean section is also consistent with studies of homebirth in the US (Johnson and Daviss 2005). Given the excessively high rates of caesarean section in developed countries such as Australia, UK and the US, models of care that have consistently low rates of operative deliveries should be enhanced and further developed.

The outcomes in this study may be due to the strict eligibility criteria for women to access a publicly-funded homebirth (Catling-Paull, Foureur et al. 2011). Mostly, women eligible for a publicly-funded homebirth have a singleton pregnancy, are within 37-42 weeks gestation and have no medical/surgical or obstetric risk factors, and have normal pregnancies. The homebirth program midwives work within local policies that are guided by strict state and professional organisation policies (NSW Health Department 2006; South Australian Government 2007; Australian College of

Midwives 2008). The strict suitability criteria for booking women into publicly-funded homebirth programs promotes safety and minimises the need for a hospital transfer. This is reflected in the low rates of hospital transfer and intervention in this study.

The strength of this study is that all data were sourced from publicly-funded homebirth services in Australia. Many previous studies in this country have combined homebirth data from women who have had high risk pregnancies (Crotty, Ramsay et al. 1990; Bastian, Keirse et al. 1998; Kennare, Keirse et al. 2010), been attended by non-health professionals at home (Kennare, Keirse et al. 2010), and some have had less data collection methods that have been questioned (Bastian, Keirse et al. 1998). This study provides homogenous data and, as such, can ensure service providers or women deciding upon birthplace that the outcomes reported would be relevant to this option. A limitation is that only nine of the 13 programs provided data. The programs which did not provide data have been estimated to have approximately 60 births in the 5 year period which would mean the total sample would have been 1867. Therefore, we estimate that we have included 97% of births from the likely population.

Another limitation of the study is that we did not collect data on women's reasons for transfer. This would have been useful for determining whether women transferred for medical care or simply for pain relief. We also did not formally collect neonatal data up to 28 days, but used data entered by midwives in the immediate postnatal period. Given the scrutiny on these programs, it is highly likely that any later adverse outcomes would have been reported. A further limitation of this study that applies to any study of women who access homebirth is the 'self-selection' of women who choose to give birth at home. This is likely to be similar in this study, although limited demographic data was obtained. This study is a descriptive analysis of publicly-funded homebirth data. More analytic depth will be provided upon the conclusion of the Birthplace in Australia study which is currently underway. This will provide prospective data that will enable a clearer and larger study into maternal and neonatal outcomes in relation to birthplace.

CONCLUSION

This study provides the first evaluation of a significant proportion of women choosing publicly-funded homebirth. This evaluation demonstrates favourable outcomes for this selected sample of women and babies. However, sample size does not have sufficient power to determine safety. More research is warranted into the safety of alternative places of birth within Australia.

APPENDIX 12: Audit trail examples

Raw Data	Concept	Category
I knew that my body was capable *My body would be fine* *Makes you feel really confident* *Our bodies are designed to do this* *I knew that I could do it* *I know my body* *I know that I have a strong tenacity*	Confidence and personal strength	Feeling independent, strong and confident
I trusted the midwives to know what to do *Their personality… made me trust them and feel safe* *With a support team I felt confident* *With the midwives from St George Hospital, there was no doubt* *I just felt so confident and supported* *I had a big trust in the process of things* *We felt comfortable* *All the support you get*	Confidence in the midwives	
You learn to say 'no' more *Some people worry about what people say… but I am not one of them* *I make the decision pretty quickly and stick to it* *We were so assertive and there's no challenging* *I definitely don't like being told what to do* *I've probably done… things a little differently to people within my family* *If I think a certain path is the right way… I will do that*	Feelings of Independence	

Raw data	Concepts	Category
Just [made me feel] more safe - and I think it helped with the family as well - they knew that the care was going to be there [the back-up of hospital] *Things can get complicated, births and things. Yea I liked the idea of having back-up* *The only thing is that [the midwife] was saying you get priority with the ambulance, there are two trained midwives here so… I wasn't too stressed about it* *I kind of felt reassured that I had this big back-up system behind me and I had a kind of a protocol that was kind of a bit tougher than um if you went independently, like I really had to tick the boxes and jump through the hoops and that* *If its done properly through a hospital with midwives, with back-up, then it's a safe option*	Feeling reassured by the hospital back-up	Having a safety net
The midwife] just said that it's a very safe environment and it was just basically reassuring me saying that it was OK and that if I didn't want to go ahead with it then I could go to the birth centre *Just having that option - I think the main thing is just to be able to feel safe - and reassured throughout the whole period of the pregnancy up until the end, and having choice*	Appreciating flexibility of birthplace	

Raw data	Concepts	Category
I really educated him about it *I had to convince my husband a little bit but he only had to read a few things to go all right* *I showed him a few of the research articles to try and convince him* *So he didn't do a great deal of research - he was just led by me basically* *As we went through that education process, my husband got his confidence about birth* *As soon as I showed hubby the DVDs he was like, yea lets do it, and I was feeding him different things, statistics and things*	Educating partners for support	Engaging support
I took him along to one of the meetings with the midwives and I just reassured him that it would be OK *He kind of relaxed a bit when he realised that they [midwives] were actually really competent and things would be OK*	Engaging midwives for partner support	

Raw data	Concepts	Category
But there is always that risk, knowing that the drugs are available there [in hospital], you might actually opt for them *Yea I did want to avoid all that I think that the fact that they are there and its available* *I didn't want drugs at all and I knew how much it hurt and I knew that if I was in hospital I'd take them because at the time you would take anything and yea, like I did the first time* *I think I thought it was pretty inevitable to be snowballed in hospital, and to have people suggest things*	Wanting to avoid the temptation of pain medication	Protection from hospital-related activities
The only reason I really thought about it was I hated the fact that husband and I would be separated after such a huge thing to go through and then basically… I just hated the thought of us being separated - that was my main decision *Just staying together as a family that was the main thing, just so nice - kind of like one of the videos we watched afterwards where the mum, the dad and the baby climb into bed together* *Just wanted it to be me [husband] and [baby]… they make [husband] leave… just wanted to be together* *I did a week on postnatal … some of the women were 3, 4, 8 hours away from their babies, so the baby would come up with dad, and women would go to recovery and they wouldn't be united for average 3-4 hours* *I thought how nice it was not to go back to a hospital room … she had about five family members there and they were in and out and in and out, you know, the last thing you want is strangers around you after going through something like that.* *Yea that and the cleaning staff and people with dinner trays and its just I wanted everyone to go away basically*	Wanting her immediate family present only	

Even if I was in hospital I knew that it wasn't an option for me unless I was in hospital for a reason, unless something was wrong, also cos I was scared of having an epidural, and I didn't want that - I know what happens when you have an epidural and then there is just that chain of events and I didn't want that to happen to me *[husband]s sister had given birth in a private hospital 2 yrs before and after 12 hours of labour, which is my labour, ended up having to have a caesarean, mainly because, I mean she was exhausted, but it was midnight on the 1st of January and there wasn't many staff on so the obstetrician was kind of like 'lets do it now' so it kind of was a bit forced on her I think. So that influenced me a bit, knowing that it happened to her* *The concern is the minute you set foot in the hospital there are all these parameters put on you, time frames. .. that then lead to intervention and once you start that rollercoaster, 9 times out of 10 intervention leads to another 'oh lets just use some gel to get things going... oh lets do an episiotomy... oh dear me'* *I went in and she stripped my membranes and a few hours later.. I didn't really want that either but anything to avoid the induction, stuck to a drip and cos I read that active birth by Janet Balaskas, and I wanted to be walking around* *I think they really focused on the whole cascade of intervention thing, and that was a big kind of 'oh my goodness, I don't want all that'*	Wanting to avoid medical intervention	

APPENDIX 13: Common Ground Statements from the Home Birth Summit

Available from: http://www.homebirthsummit.org/outcomes/common-ground-statements

Common Ground: The Statements

(Vedam, 2011)

Statement 1

We uphold the autonomy of all childbearing women.

All childbearing women, in all maternity care settings, should receive respectful, woman-centered care. This care should include opportunities for a shared decision-making process to help each woman make the choices that are right for her. Shared decision making includes mutual sharing of information about benefits and harms of the range of care options, respect for the woman's autonomy to make decisions in accordance with her values and preferences, and freedom from coercion or punishment for her choices.

Statement 2

We believe that collaboration within an integrated maternity care system is essential for optimal mother-baby outcomes. All women and families planning a home or birth center birth have a right to respectful, safe, and seamless consultation, referral, transport and transfer of care when necessary. When ongoing inter-professional dialogue and cooperation occur, everyone benefits.

Statement 3

We are committed to an equitable maternity care system without disparities in access, delivery of care, or outcomes. This system provides culturally appropriate and affordable care in all settings, in a manner that is acceptable to all communities.

We are committed to an equitable educational system without disparities in access to affordable, culturally appropriate, and acceptable maternity care provider education for all communities.

Statement 4

It is our goal that all health professionals who provide maternity care in home and birth center settings have a license that is based on national certification that includes defined competencies and standards for education and practice.

We believe that guidelines should:

•allow for independent practice,

•facilitate communication between providers and across care settings,

•encourage professional responsibility and accountability, and

•include mechanisms for risk assessment.

Statement 5

We believe that increased participation by consumers in multi-stakeholder initiatives is essential to improving maternity care, including the development of high quality home birth services within an integrated maternity care system.

Statement 6

Effective communication and collaboration across all disciplines caring for mothers and babies are essential for optimal outcomes across all settings.

To achieve this, we believe that all health professional students and practitioners who are involved in maternity and newborn care must learn about each other's disciplines, and about maternity and health care in all settings.

Statement 7

We are committed to improving the current medical liability system, which fails to justly serve society, families, and health care providers and contributes to:

•Inadequate resources to support birth injured children and mothers;

•Unsustainable healthcare and litigation costs paid by all;

•A hostile healthcare work environment;

•Inadequate access to home birth and birth center birth within an integrated health care system; and,

•Restricted choices in pregnancy and birth.

Statement 8

We envision a compulsory process for the collection of patient (individual) level data on key process and outcome measures in all birth settings. These data would be linked to other data systems, used to inform quality improvement, and would thus enhance the evidence basis for care.

Statement 9

We recognize and affirm the value of physiologic birth for women, babies, families and society and the value of appropriate interventions based on the best available evidence to achieve optimal outcomes for mothers and babies.

APPENDIX 14: Map of study setting

Google Maps

A = St George Local Health District. St George Hospital Homebirth Program is situated within this District.

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