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The influences on women who choose publicly-funded home birth in Australia

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ABSTRACT

Objective: to explore the influences on women who chose a publicly-funded home birth in one Australian state.
Design: a constructivist grounded theory methodology was used.
Setting: a publicly-funded home birth service located within a tertiary referral hospital in the southern suburbs of Sydney, Australia.
Participants: data were collected though semi-structured interviews of 17 women who chose to have a publicly-funded home birth.
Findings: six main categories emerged from the data. 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 core category was having faith in normal. This linked all the 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 home birth.
Conclusion: women reported similar influences to other studies when choosing home birth. However, the women in this study were reassured by the publicly-funded system's 'safety net' and apparent 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.
Implications for practice: women that choose a publicly-funded home birth service describe strong influences that led them to home birth within this model of care. Service managers and health professionals need to acknowledge the importance of place of birth choice for women.

Introduction

Giving birth at home is not a common choice for women in most of the western world. In Australia, the United States of America and Canada only about 1% women choose to give birth at home (Public Health Agency of Canada, 2009; MacDorman et al., 2011; Li et al., 2012). Slightly higher rates occur in the UK (2.4%) (Office for National Statistics, 2013) where home birth is publicly-funded and more readily available with large regional differences (Dodwell and Gibson, 2013). Countries where home birth is more prevalent include New Zealand, where it is estimated that up to 10% women give birth at home (Wastney, 2013), and the Netherlands, where 25% women give birth at home (van der Kooy et al., 2011). This study explored the influences on women who chose a publicly-funded home birth in one Australian state.

Background

Most women in Australia choose midwifery-led or obstetric-led care and give birth in a public (government) hospital (70.1%). Almost one third (29.9%) access obstetric-led private hospitals (Li et al., 2012). Only 0.5% women give birth at home, mostly with privately-practising midwives, and an unknown number of women give birth without health professionals in attendance

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(Jackson et al., 2012). In some parts of Australia, women can have a publicly-funded home birth within a hospital-based home birth service (Catling-Paull et al., 2012).

Since the 1990s, publicly-funded home birth services (essentially free to women) have been developed in Australia as a result of a growing demand from women. These are often embedded within a midwifery group practice in a hospital setting. Most have tight entry criteria, can book only small numbers of women for a home birth due to staffing constraints, and require women to live within a half an hour drive to the affiliated hospital (should a transfer in labour be required) (Catling-Paull et al., 2012). Women booked to have a home birth with these services have to be healthy, with no past or current medical/surgical or obstetric problems that would affect safety (Catling-Paull et al., 2012). Currently there are 15 publicly-funded home birth services in Australia with 10 of these developed since 2006; most within the last four years. These are all relatively unstudied, except for some evaluation reports (Thiele and Thorogood, 1997; Nixon et al., 2003; Homer and Caplice, 2007; Homer and Nicholl, 2008; McMurtrie et al., 2009; Hider, 2011).

Studies examining maternal and neonatal outcomes of publicly-funded home birth services have not been sufficiently powered to draw conclusions about safety, despite one recent small study showing favourable outcomes (Catling-Paull et al., 2013). This retrospective analysis included outcomes from 1807 women and their infants from nine publicly-funded home birth services in Australia. Overall 90% women had a normal birth; 84% at home with 52% in water. The perinatal mortality rate was 1.7 per 1000 births when infants with fetal anomalies were excluded which was consistent with perinatal mortality rates in other low risk populations. This study should not be taken as evidence of safety as the sample size was too small.

An earlier study, McMurtrie et al. (2009) examined the first 100 women who accessed a publicly-funded home birth service in southern Sydney. This small study found low intervention rates and reassuring outcomes for women and infants, but similar to the previous study, was not powered to make conclusions about safety. More recently, there has been an evaluation in Victoria, Australia, (the Casey Hospital Home Birth model) (Hider, 2011). High levels of satisfaction were reported from women and midwives working within the model, although again there were very small numbers of women involved ($n=35$).

Women choose to have a home birth for a number of reasons. These include feeling safe, having control over their birth and surroundings and to avoid intervention (Viisainen, 2001; Boucher et al., 2009; Lindgren et al., 2010); having a belief in their ability to give birth without intervention or technology, having personalised continuity of carer (Abel and Kearns, 1991; Longworth et al., 2001) and not having to be apart from other children (Andrews, 2004). Edwards (2005), in her study of home birth in Scotland, found women expressed a loss of control when faced with medical technology, and felt that trust in caregivers was pivotal to feeling safe.

Despite these studies, the reasons women chose home birth within an Australian public health system is unknown. These publicly-funded services are a relatively new model of care in Australia, and like any new health service, need to be studied in relation to viability, safety and acceptance from the women who use them. Therefore, this study was undertaken to explore the influences on women who chose a publicly-funded home birth.

Methods

A qualitative study using a constructivist grounded theory approach was undertaken. This theory-producing approach was useful to find meaning within a social context and constructivist grounded theory explored specific experiences within society and individuals. Both data collection and analysis occurred concurrently, consistent with grounded theory methodology (Strauss and Corbin, 1998). Explained by Corbin (1998), constructivist grounded theory meant that researchers constructed concepts and theories out of data from research participants in their efforts to explain their experiences. It recognises that researchers are all influenced by their own history and cultural context, and refutes the notion that researchers can have a stance of pure objective reality. Hence, this methodological approach was taken because of its acknowledgement of the association of the researchers and analysis. Throughout the study, the first author of this paper (a midwife with personal and professional experience of home birth) endeavoured to hold the space 'in between' being an insider (part of the group being studied) and outsider (an objective researcher) (Dwyer and Buckle, 2009), and by doing so, not harm the validity and reliability of the research. However, similar to most researchers and all methodologies, it is acknowledged that personal bias may have influenced the findings and conclusions.

Participants

This study was granted ethical approval by the relevant Health Service Health Research Ethics Committee (study number: 08/STG/129), and the University of Technology, Sydney. All data were de-identified at transcription, and storage of data, concurrent with ethical guidelines, was undertaken using the NVIVO software program.

Following approval, recruitment began of 17 women who made the decision during their pregnancies to have a home birth through the publicly-funded home birth service. This was three years after the service had begun in 2005. It is important to note that not all of the participants in this study ultimately achieved a home birth, however, it was their original decision-making that was the topic of interest.

Other participants were chosen through purposive sampling – a recognised method used in grounded theory where an identified need to collect further data has arisen in order to test, elaborate or verify the emerging categories. This included five midwives who worked within the Birth Centre and worked within the home birth service, and two partners of the women.

The midwives who worked in the service were contacted and agreed to discuss the study with women who had chosen to have a home birth. Permission for a researcher to make contact was obtained from women who expressed an interest in the study. Women were informed that a researcher would contact them after the 6-week postnatal period to discuss why they had chosen to give birth at home within the publicly-funded home birth service. We decided only to interview them after the birth so as not to influence their decision making during pregnancy. When the researcher contacted the women she provided a full explanation of the study and written informed consent was obtained prior to data collection.

Data collection and analysis

Data were collected through digitally recorded semi-structured interviews conducted in women's homes. The interviewer received prior training and mentoring in interview techniques. A rapport was quickly established with participants after an explanation of the study, confidentiality, and the research process. These interviews were, on average, an hour in length (range 45–120 minutes). These were transcribed verbatim by the same researcher. Interviews of the midwives and partners of the women were held to give additional explanations regarding the concepts