Women and Birth 26 (2013) 55–59

Contents lists available at SciVerse ScienceDirect

Women and Birth

journal homepage: www.elsevier.com/locate/wombi

The commonalities and differences in health professionals' views on home birth in Tasmania, Australia: A qualitative study

Ha Hoang [a,*], Quynh Le [a], Sue Kilpatrick [b], Madeleine Jona [c], Nidarshi Fernando [c]

[a] Department of Rural Health, University of Tasmania, Locked Bag 1372, Launceston, Tasmania 7250, Australia
[b] Alfred Deakin Research Institute, Deakin University, PO Box 423, Warrnambool 3280, Australia
[c] School of Medicine University of Tasmania, Locked Bag 1377, Launceston, Tasmania 7250, Australia

ARTICLE INFO

Article history:
Received 1 October 2011
Received in revised form 15 March 2012
Accepted 18 March 2012

Keywords:
Home birth
Health professionals
Australia
Opinions
Tasmania
Maternity services

ABSTRACT

Objectives: Home birth has attracted great controversy in the current context. There is a need for the public and health professionals to understand why maternity care providers have such different views on home birth, why they debate, what divides them into two opposite sides and if they have anything in common.
Method: A qualitative study involving twenty maternity health providers in Tasmania was conducted. It used semi-structured interview which included closed and open-ended questions to provide opportunities for exploring emerging insights from the voices of the participants.
Findings: Health practitioners who support home birth do so for three reasons. Firstly, women have the right to choose the place of birth. Secondly, home birth may be more cost effective compared to hospital birth. Thirdly, if home birth is not supported, some women might choose to have a free birth. Those who opposed home birth argue that complications could occur at childbirth and the transfer time is critical for women's and babies' safety. These differences in opinions can be due to the differences in the training and philosophy of the maternity care providers. Despite the differing views on home births, health professionals share a common goal to protect the women and the newborns from unexpected situations during childbirth.
Conclusion: This article provides some significant insights derived from the study of home birth from the maternity health professionals' perspectives and could contribute to the enhancement of mutual understanding and collaboration of health professionals in their services to expectant mothers.
© 2012 Australian College of Midwives. Published by Elsevier Australia (a division of Reed International Books Australia Pty Ltd). All rights reserved.

Introduction

A planned home birth is defined as a birth that is intended to occur at home with the assistance of a health professional from the onset of labour. In the developed world, home birth ranges between 1% and 3% of all births in New Zealand, the United Kingdom and Canada where it is supported with public funding and affordable insurance.[1] In the Netherlands, home births account for more than 25% of all births due to home birth being a traditional part of its culture and its geography.[2] In Australia, where home birth has been recognised as a sensitive and controversial issue,[3] only a small number of women (0.3%) choose to have a planned home birth.

Debates on the safety of planned home birth have been raging for decades and it is likely will continue in research literature. Although most of the investigations have observed that planned home births have lower intervention rates compared with hospital births, other outcomes for mothers and babies have differed in different studies. Some studies consistently show that planned home births in Australia are associated with a higher risk of intrapartum perinatal mortality.[4–6] In contrast to these studies, planned home births have not been associated with an increased risk of adverse perinatal outcomes in studies in Australia,[7] America,[8] England,[9] the Netherlands,[10] New Zealand[11] and Canada.[12]

Given different results in the literature on the safety of home births, there is an ongoing debate about the need for a randomised controlled trial (RCT) which compares home birth versus hospital birth to assess their outcomes and safety.[13] There were only two attempts at setting up such a trial, one in England[14] and another in the Netherlands.[13] The first small feasibility study[14] of such RCT was conducted in England where planned home births accounted

* Corresponding author at: Department of Rural Health, University of Tasmania, Locked Bag 1372, Launceston, Tasmania 7250, Australia. Tel.: +61 03 6324 4031.
E-mail address: Thi.Hoang@utas.edu.au (H. Hoang).

1871-5192/$ – see front matter © 2012 Australian College of Midwives. Published by Elsevier Australia (a division of Reed International Books Australia Pty Ltd). All rights reserved.
http://dx.doi.org/10.1016/j.wombi.2012.03.002

for only 0.3% of births. This trial indicated a recruitment rate of 11 out of 71 women offered entry to the study and suggested that the trial was theoretically possible. However, the second trial,[13] was conducted in the Netherlands where 30% of all deliveries occur at home collapsed as soon as it started. After 6 months of the recruiting, only one woman had given informed consent for randomisation and another 115 women declined the RCT.[13] Given the failure of the trial, the researchers performed a survey to find out why pregnant women refused to be randomly allocated to either home or hospital birth and concluded that "*women want to decide themselves about the place of birth... The fact that women highly value their autonomy in these matters is a factor that cannot easily be manipulated or influenced and has to be respected.*"[13]

In addition, the debate over the safety of home birth was inflamed by the publication of a meta-analysis by Wax and colleagues. Wax et al.[15] concluded that less medical intervention during planned home birth was associated with a tripling of the neonatal mortality rate. However, the reliability of the findings in the publication has been queried.[2,16] Keirse[2] pointed out that Wax et al.'s meta-analysis referred to planned home births, but most of the births contributing to the final conclusion were derived from a study based on U.S. birth certificates which did not state if they included unplanned home birth or not. Michal et al.[17] criticised that Wax's et al. had many mistakes in design, methodology, and reporting in their study. In particular, according to these authors, the statistical analysis upon which Wax's conclusion was drawn contained improper inclusion and exclusion of studies, many numerical errors, logical impossibilities and mischaracterisation of cited works. Furthermore, the software tool used for over half of the meta-analysis calculations contained major mistakes that "can dramatically underestimate confidence intervals, and this resulted in at least 1 spuriously statistically significant result".[17]

Home birth has clearly divided health professionals into two sides: advocates and opponents. Raisler[18] noted that though home birth draws strong opinions among health professionals, their attitudes are rarely based on research data. This raises the question of why health professionals support or oppose home birth. What factors contribute to the differences in their views? Do they have anything in common? Finding the answers to these questions will provide information that will be beneficial for all professionals involved. It may help reduce the differences in opinions and consequently lead to better collaboration of health professionals resulting in a higher standard of care for women.

Methods

Ethics approval for the study was granted by the Tasmanian Social Sciences Human Research Ethics Network. Between February and May 2011, the authors contacted the managers of hospitals and health centres across Tasmania, Australia to ask for their assistance in participant recruitment.

The managers sent invitation letters to the staff who met the study criteria. The selection criteria for the interviews were that the participants are maternity care providers including midwives, obstetricians and child health nurses and are currently employed by the health system in Australia. Child health nurses are part of the maternity care provider team. The role of a child health nurse is to provide mothers with information, guidance and support on issues including breastfeeding, child health and development, infant and child nutrition, maternity health, and parenting skills. Through referral from the managers, 28 health professionals were invited to participate in the study and twenty accepted. All of the interviews were conducted in a room in a hospital or a health centre by one of the authors. Most of the interviews were carried out during the health professional's lunch break thus lasted about 20–30 min due to their lack of time. The participants were asked about their background their experiences as maternity care providers in Australia and their attitude toward planned home births. They were invited to discuss any issues raised during the interviews that were pertinent to the research questions of this study. The list of core interview questions were prepared as the guide to assist with the interview process and presented in Table 1. Some participant characteristics are presented in Table 2. Saturation was determined by the researchers. No more interviews were needed since after 20 interviews no new themes emerged from the data.

Table 1
Interview guide.

What is your profession?
How long have you been working in your profession?
Where do you work?
What is your opinion about planned home birth?
Why do/do not you support a planned home birth?
Should a planned home birth be a woman's choice of care?
What are the potential benefits of a planned home birth for the health care system?
What are the possible risks in a planned home birth?
Do you think there is any connection between a planned home birth and free birth?
Do you know why maternity health professionals have different opinions on a planned home birth?
Have you ever been a health provider in a planned home birth?
Should the government support women with low risk to have a planned homebirth with assistance of a midwife?

Table 2
Key characteristics of the participants.

Profession	Number of participants (N)
Midwife	9
Work experience	
6–10 years	1
11–20 years	4
21–30 years	1
31–40 years	2
Over 40 years	1
Current work place	
Community health centres	4
Hospitals	5
Obstetrician	5
Work experience	
Less than 5 years	1
6–10 years	2
21–30 year	2
Current work place	
Hospitals	5
Child and family health nurse	6
Work experience	
6–10 years	1
11–20 years	1
21–30 years	1
Over 40 years	3
Current work place	
Community health centres	6

Analysis

All interviews were transcribed verbatim by one of the authors. The data were analysed using grounded theory. Theory development begins with the data contained in the grounded method. Data is coded and categorised as the researcher starts to see patterns emerge. Theory is developed throughout the research process as data interpretation takes place and comparison of that interpretation is made with new data that is collected.[19] All transcribed material was analysed sentence by sentence and coded for the participant's meanings. Initial open coding of the data used differing codes, which were then organised into categories. The

Download English Version:

https://daneshyari.com/en/article/2636076

Download Persian Version:

https://daneshyari.com/article/2636076

Daneshyari.com