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From hospital to home: Australian midwives' experiences of transitioning into publicly-funded homebirth programs

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ABSTRACT

Background: Over the past two decades, 14 publicly-funded homebirth models have been established in Australian hospitals. Midwives working in these hospitals now have the opportunity to provide homebirth care, despite many having never been exposed to homebirth before. The transition to providing homebirth care can be daunting for midwives who are accustomed to practising in the hospital environment.
Aim: To explore midwives' experiences of transitioning from providing hospital to homebirth care in Australian public health systems.
Methods: A descriptive, exploratory study was undertaken. Data were collected through in-depth interviews with 13 midwives and midwifery managers who had recent experience transitioning into and working in publicly-funded homebirth programs. Thematic analysis was conducted on interview transcripts.
Findings: Six themes were identified. These were: skilling up for homebirth; feeling apprehensive; seeing birth in a new light; managing a shift in practice; homebirth—the same but different; and the importance of mentoring and support.
Discussion: Midwives providing homebirth work differently to those working in hospital settings. More experienced homebirth midwives may provide high quality care in a relaxed environment (compared to a hospital setting). Midwives acceptance of homebirth is influenced by their previous exposure to homebirth.
Conclusion: The transition from hospital to homebirth care required midwives to work to the full scope of their practice. When well supported by colleagues and managers, midwives transitioning into publicly-funded homebirth programs can have a positive experience that allows for a greater understanding of and appreciation for normal birth.

Summary of relevance:

Problem or issue

Australian midwives who are trained in the hospital system now have the opportunity to provide publicly-funded homebirth.

What is already known

Midwives' experiences of transitioning into new models of care are influenced by attitudes within the maternity system as a whole, as well as locally within their workplace. Adequate training and support is required for midwives to successfully transition into new models of care.

What this paper adds

Providing publicly-funded homebirth offered midwives an opportunity to work to the full scope of their practice. With adequate support from midwifery managers and colleagues, providing publicly-funded homebirth was a positive experience that improved midwives' practice and fostered a new understanding of and appreciation for normal birth.

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1. Introduction

Homebirth is an uncommon event in Australia with the vast majority of births (96.9%) occurring in traditional labour-ward settings.[1] In 2012, only 1177 births occurred at home, representing just 0.4% of all births in Australia.[1] Despite the low number of women accessing a homebirth, there is evidence of strong consumer demand for access to alternative places of birth such as the home.[2,3] In 2008, the Australian government undertook a National Maternity Services Review (MSR) in order to address the 'issues, gaps and priorities which concern Australian women and their families'.[4(p1)] Analysis of public submissions to the MSR's community consultation process by Dahlen,[5] revealed that over 60% of the 900 public submissions were from women advocating and requesting homebirth. In order to meet the demand for safe and affordable homebirth care, a number of publicly-funded homebirth programs have been developed in association with Australian public hospitals over the past 20 years. Currently there are 14 programs operating across New South Wales, Victoria, South Australia, The Northern Territory and Western Australia with further programs under development.[6]

Publicly-funded homebirth programs exist as an extension of the hospital's continuity of midwifery care model, usually known as either a Midwifery Group Practice (MGP) or Community Midwifery Program (CMP). In midwifery continuity of care models, the woman is assigned one primary midwife who provides the majority of her care with the support of other midwives from a small team who are available if the primary midwife is not. The primary midwife cares for the woman throughout the entire antenatal period, is on call to attend the woman's labour and birth, and then continues to provide care in the postnatal period at home following hospital discharge.[7] This model provides the most comprehensive one-to-one midwifery care available within the hospital system.[8]

For the most part, each publicly-funded homebirth program in Australia has been developed in isolation and, as a result, there are a number of differences in the way programs were established and currently operate.[9] Some publicly-funded homebirth programs have a specific team of midwives dedicated to providing homebirth care, while others ensure that the majority of their continuity of care midwives are able to provide homebirth. Midwives working in publicly-funded homebirth programs are usually required by the hospital to become accredited to provide homebirth via attaining a certain set of clinical skills that allow them to work to the full scope of their practice in the community setting.[9] Midwives working in this model remain employees of the hospital and, as such, are covered by the hospital's professional indemnity insurance. These midwives are bound by the same hospital policies and protocols as when attending hospital births and, in the majority of cases, are able to continue providing midwifery care for women who transfer into hospital from a homebirth. This allows them to maintain continuity of care across the full spectrum of a woman's experience.

Generally, only healthy women deemed at low obstetric risk are eligible for publicly-funded homebirth and midwives working in the model are expected to follow the Australian College of Midwives 'Guidelines for Consultation and Referral'.[10] Eligibility criteria for women to access publicly-funded homebirth programs tend to be strict, though not all services follow the same policies and protocols.[9] For example, some programs require that women have the glucose tolerance test (GTT) screening for gestational diabetes mellitus (GDM). In such programs, declining the GTT would mean the woman is no longer eligible for publicly-funded homebirth, as would a positive result for GDM. In other programs, however, if a woman declines the GTT, so long as the woman is considered to have an adequate understanding of the possible health implications of her decision, she is free to choose publicly-funded homebirth.

Public hospitals offering home as an option for a woman's birthplace is a somewhat radical concept in Australia where the overwhelming majority of women give birth in a hospital setting. In other high-income nations such as England, The Netherlands and New Zealand where homebirth is more common, midwives tend to be exposed to homebirth during their midwifery education.[11,12] In Australia, however, during their midwifery degree, clinical placement for midwifery students takes place almost exclusively in the hospital setting due to difficulties with securing professional indemnity insurance for students. Exposure to homebirth is not built into the University or practical curriculum and a student midwife who is interested in homebirth would have to seek out practical experiences in this setting of her own accord. As such, the vast majority of Australian midwives have never attended a homebirth and their involvement in a publicly-funded homebirth program may be their first exposure to this alternative place of birth.

A small number of individual evaluations have been carried out on several of the publicly-funded homebirth programs.[2,13–16] These studies primarily focused on women's experiences of using the service and evaluated safety outcomes for women and babies who planned to give birth at home within this model. While these evaluations offered some exploration of midwives' experiences within individual programs, to date, no national evaluation has been undertaken on midwives' experiences of working in this relatively new model of care.

The aim of this paper is to examine midwives' experiences of transitioning from providing hospital-based midwifery to homebirth midwifery care. It forms part of a larger PhD study conducted by the first author on midwives' experiences of providing publicly-funded homebirth in Australia. It is hoped that the findings of this research will contribute to the normalisation of homebirth in Australia, along with the continuation of publicly-funded homebirth programs and the expansion of both new and existing models in order to meet increasing consumer demand.

2. Methods

A qualitative study using a descriptive exploratory design was undertaken.[17] Descriptive analysis is recognised as being useful when investigating previously unexamined experiences,[17,18] therefore this design was appropriate for exploring this relatively new way of working for Australian midwives.

The study was advertised through the National Publicly-Funded Homebirth Consortium network via email. The Consortium was established in 2010 by Catling-Paull, Foureur and Homer in order to improve communication between publicly-funded homebirth programs.[9] Its principle aim is to facilitate the sharing of resources between services and has also allowed for a description and comparison of different programs and the collation of data on outcomes for mothers and babies.[9]

Participation in the study was open to all midwives registered to practice who had experience providing publicly-funded homebirth in Australia within the past five years. This time period was chosen so that participants had relatively recent experience of working in the model and also allowed for midwives who had sufficient experience in the model to be able to reflect on their experience of transition. In order to access midwives who may not have been providing clinical care but still played a significant role in the establishment or ongoing management of a publicly-funded homebirth service, the study was also open to midwifery managers. Some midwifery managers also offer care to a small caseload of women as part of their role.

Data were collected through in-depth, semi-structured telephone interviews that were audio recorded and later transcribed. Interviews typically lasted between 45 and 60 min. Field notes were recorded during interviews in order to identify important

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