TITLE: Women's reasons and perceptions around planning a homebirth with a registered midwife in Western Australia

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ABSTRACT

Background: Qualitative evidence has provided rich descriptions around reasons for planning a homebirth with a midwife. Reasons and the importance, confidence and support around this option have not been examined by parity with a larger cohort.

Aim: examine women's characteristics, reasons and perceptions of the importance, confidence and support around choosing homebirth based upon parity.

Methods: a mixed method approach was undertaken within a prospective cohort study in Western Australia where women planning a homebirth have the option of a publicly funded model or care from privately practising midwives. At recruitment a questionnaire collected demographic data, perceived importance, confidence and support plus reasons for choosing homebirth. A qualitative component included an open ended question that encouraged sharing of opinions providing textual data explored by content analysis.

Findings: Reasons noted by 211 pregnant women for choosing homebirth were: avoidance of unnecessary intervention (58.8%), comfort and familiarity of home (34.1%), freedom of making own choices (25.6%), and having more continuity of care (24.2%). Reasons for planning homebirth were similar by parity, except for comfort of home being more important (44.0% *vs* 28.7%, p=0.025) and continuity of care (13.3% *vs* 30.1%, p=0.006) being less important to primigravid women. Themes revealed common beliefs around childbirth, appreciation for access to homebirth and a desire for greater awareness and less negativity around homebirth.

Conclusion: Regardless of parity, homebirth was believed to be safe and supported by partners. Reasons identified from qualitative research to avoid intervention, the comfort of home, choice and continuity of care were supported.

KEYWORDS*:* homebirth, cohort, parity, birth option, mixed methods

Statement of Significance

Issue Less than 1% of Australian women experience a homebirth. Given the rarity of this birth choice, knowledge from a larger cohort of women around their reasons for selecting this option is necessary to facilitate generalisability to the population.
What is already known Qualitative evidence has provided rich descriptions from small numbers of women around reasons for planning a homebirth including avoidance of unnecessary intervention, and greater choice and control.
What this paper adds Findings contribute to knowledge around why women select homebirth and provide insight into the ranked importance of these reasons plus associations with parity on confidence and support for this choice.

INTRODUCTION

The debate on the safety of planned homebirth continues in Australia. [1,2] Evidence suggests that planned homebirth with a qualified health practitioner is a safe alternative for women determined to be at low risk of pregnancy complications using established screening criteria. [3] Planned homebirth refers to births that are intended to occur at home with the assistance of a qualified practitioner, usually a registered midwife. Pregnancy care for Australian women who plan homebirth is provided by registered midwives working within defined clinical guidelines, with links for referrals and transfers of care at any stage of pregnancy and birth when the pregnancy is no longer considered 'low risk'. [4,5]

Continuity of midwifery carer or case load midwifery is a key characteristic of homebirth services and is associated with lower intervention, greater maternal satisfaction with care, and an enhanced childbirth experience and positive infant health outcomes. [6-9] Women receive their antenatal care, education, intrapartum care and postnatal care from one midwife with a backup or from a small team of midwives. In 2016, the majority of Australian pregnant women (97.5%) experienced a hospital birth, with the remaining women birthing in a birth centre (1.8%), at home (0.3%) or in unplanned settings prior to arrival at hospital (0.4%). [10] In 2016, 0.5% of Western Australian women birthed at home.

With small proportions of Australian women planning for and birthing at home it is predictable that international evidence with large data sets are relied upon. Evidence from the Netherlands confirmed that women planning homebirth experience less interventions. [11] The Birthplace in England study found multiparous women have perinatal outcomes comparable to those in planned hospital births whereas primiparous women have poorer perinatal outcomes. [12] Further analysis from the Birthplace in England cohort study suggested that 'low risk' women planning a non-obstetric unit birth including alongside or freestanding midwifery units [13] or a planned homebirth had a reduced risk of intervention irrespective of ethnicity or area deprivation score. [14] Australian women in New South Wales who planned to birth in a birth centre or at home were significantly more likely to experience a normal labour and birth compared to those in a standard labour ward. [15] Although perinatal outcomes for Australian women planning a publicly funded homebirth over a six year period were encouraging, conclusions were made with caution due to limited sample size. [16]

The reasons why women choose a homebirth have been explored through qualitative research including interviews with small numbers of women from Australia, Sweden, Finland, Canada and the United States. Recurring themes have been found including: safety [17,18]; avoidance of intervention perceived to be unnecessary [17-20]; greater control [18,19,21-23]; choice [18,19,23,24]; comfort with a familiar environment [17-19,23,24]; previous negative hospital birth experience [17,25]; relationship

with a known chosen care provider usually a midwife [19,24, 26,27]; and trust in the birth process. [17,20-24] Additional reasons cited were to avoid pharmacological pain relief [21] inclusion of family and friends [15,20,24,27] and dissatisfaction with medical aspects of hospital care during labour and birth. [21,24]

Qualitative international evidence around reasons for planning a homebirth have provided rich descriptions of themes from small numbers of women as would be expected from these designs. The opportunity to gather data from a larger sample of pregnant women around their reasons based upon parity and their ranked importance, confidence and perceived support was addressed in this study and provides an important step in building knowledge around the topic.

METHODS

The 'Homebirth in Western Australia' study comprised a cohort of prospectively recruited women who planned homebirth antenatally (2012-2014). Using a mixed method approach our aim was to examine women's characteristics, reasons and perceptions of the importance, confidence and perceived support around choosing homebirth based upon parity. Ethical approvals for the study were granted by five Human Research Ethics Committees: the WA Department of Health (2012.24), the Women and Newborn Health Service (2006/EW), the North Metropolitan Area Health Service (2012-119), the South Metropolitan Area Health Service (AR/12/353); and WA Country Health Service (2012/22).

Western Australian women planning a homebirth under the care of a registered midwife have the option of accessing a publicly funded homebirth (PFHB) model or receive care from Privately Practising Midwives (PPM). PPMs are self-employed, responsible for arranging their own professional indemnity insurance and work as primary midwives for their clients utilising colleagues to provide backup support. Midwives employed in PFHB programs have professional indemnity insurance arranged by their employer and their clients receive midwifery care and hospital maternity care free of charge.

The study recruitment included pregnant women aged 18 years and over, able to give informed consent, were over 16 weeks gestation and planning homebirth with a registered midwife

in publicly or privately funded care. The PFHB and PPM midwives were asked to inform their pregnant clients about the study by distributing a pamphlet. Interested women contacted the research team who verified their intention to have a homebirth. Participation requirements, participants' confidentiality, data de-identification, and the ability to withdraw were discussed as part of informed consent.

Women who consented were asked about their reasons for choosing homebirth and reasons for choosing public or private care. The questionnaire was piloted with the first ten women who confirmed the presentation and wording of all items was clear: no changes were required. The questionnaire was administered at recruitment which included structured questions and free text responses relating to planning a homebirth. Gestational age, maternal age, ethnicity, country of birth, parity, height, weight, and highest education level were collected. Postcodes were used to derive Socio-Economic-Index-For-Areas of Relative Advantage-Disadvantage (SEIFA-RAD) scores and used as an indicator of maternal socioeconomic status. The top two quintiles were categorised together and used in analysis to represent higher socioeconomic status.

The importance, confidence and support around planning a homebirth was determined with eight items measured either on a 5-point Likert scale or with a yes/no response. Two items 'Practical/emotional support after birth available' and 'concerns about giving birth at home' required a yes/no response. Six items employed a 5 point Likert scale ranging from 'slightly' to 'very' for statements such as 'homebirth is important/ safe'; 'confident about birthing at home'; 'partner/family/friends supportive of homebirth' and 'level of support available'.

The selection of 27 pre-specified reasons for women choosing homebirth was based on existing qualitative research on reasons for selecting a homebirth [17,18,23,24,26] and published evidence on facets of satisfaction including: minimal intervention, [28,29] bonding, [29,30] involvement with decisions and choice, [31] continuity of care,[30] home environment, [17,29,30] sense of control, [32-34] empowering experience, [35] better birth experience, [36] and previous negative hospital experience. [17]

The final question in the questionnaire incorporated the qualitative component and encouraged women to share further comments and responses provided rich qualitative data analysed using content analysis which is frequently used with textual data from open-ended survey questions .[37] Content analysis incorporates description at a surface level around an individual's shared experience presented in their own words. [38] A systematic coding and categorising approach was undertaken with the textual information to determine common trends. [37] Analysis was conducted independently by two members of the research team who discussed preliminary findings with the full team until consensus was achieved around emerging themes and subthemes.

Categorical data were summarised as frequency distributions. The 5-point Likert scale responses on the importance, confidence and support for planning a homebirth were collapsed into two levels (the highest level versus the rest) and compared between primigravid vs multigravid women using Chi-square tests. SPSS statistical software was used in data analysis (version 20.0, Armonk, NY: IBM Corp) and p- values<0.05 were considered statistically significant.

RESULTS

Pregnant women were recruited between June 2012 and July 2014 (n=211) with 81.5% (N=172) attending a PFHB program and 18.5% (N=39) under the care of a PPM. The median gestational age at recruitment was 31 pregnancy weeks (IQR: 24-36, range: 15-40): women who planned a homebirth with PPM care were recruited at a later gestational age (median 34 weeks, IQR: 27-38 weeks *vs* median 30 weeks, IQR: 24-35, p=0.035).

Maternal characteristics overall are summarised in Table 1. Seventy five women (35.5%) were primigravid, 136 (64.5%) were born in Australia, 114 (54.0%) had tertiary education including 48 (22.7%) with postgraduate degrees. Apart from the younger maternal age for primigravid women, there were no other differences in characteristics. The multigravid women reported previous hospital births (64.0%), previous planned births at home (50.0%), previous birth centre births (11.0%) and previous intrapartum transfers from planned homebirths (7.4%). Six women under PPM care had a previous caesarean birth.

One hundred forty seven women (69.7%) planned homebirth before conception. The remaining 64 decided on planned homebirth during pregnancy at a median gestational age of 14 weeks (IQR: 8-20, range 4-35). Primigravid women were less likely to decide on planned homebirth before pregnancy (28.6% *vs* 51.6%, p=0.002). Multigravid women with previous planned homebirths were more likely to plan homebirth before pregnancy (88.2% *vs* 11.8%, p=0.004).

Planning homebirth was rated as 'very important' to 51.2% of women, 53.6% were 'very confident' about giving birth at home, and 65.9% believed homebirth was 'very safe' (Table 2). Women's partners (76.3%) were more likely to be very supportive of homebirth than their family and friends (36.0%). Women reported an expectation of practical and emotional support being available post birth (any support was 96.2% and very high support was 59.7%). Very high support was significantly more likely among primigravid women (69.3% vs 54.4%, p=0.016).

A summary of reasons why women choose to have homebirth is shown in Table 3. The most commonly reported reasons for planning homebirth included: the avoidance of unnecessary intervention (94.8%), the comfort and familiarity of own home (93.8%), the freedom of making own choices (84.8%), more privacy (83.4%), homebirth being 'more natural' (82.5%), more control over the birth process and involvement in decisions (79.6%). Seventy three women (34.6%) reported being fearful of giving birth in a hospital or having a past negative hospital birth experience (24.2%) and seven (3.3%) women selected being fearful of hospital birth as one of the top three reasons for planning homebirth.

When women ranked their reasons for choosing homebirth in order of their importance, the top ranked reasons were: avoidance of unnecessary intervention (58.8%), comfort and familiarity of home (34.1%), freedom of making own choices (25.6%), and having more continuity of care (24.2%). Primigravid women were more likely to plan homebirth wishing for more freedom to make their own choices (92.0 *vs* 80.9%, p=0.031), more control over the birth process (89.3% *vs* 74.3%, p=0.012), greater involvement in decision making (90.7% *vs* 73.5%, p=0.004), greater partner's involvement (76.0% *vs* 52.2%, p=0.001), and for better bonding with the infant (68.0% *vs* 44.1%,

p=0.001). The top ranked reasons for planning homebirth were similar by parity, except for comfort of their own home being more important (44.0% *vs* 28.7%, p=0.025) and continuity of care (13.3% *vs* 30.1%, p=0.007) being less important to the primigravid women.

Ninety one (43.1%) of 211 pregnant women provided multiple comments in response to an open ended question in the questionnaire. Content analysis of their responses revealed three themes: 'beliefs around childbirth', 'opinions around homebirth in WA' and 'awareness, options, choices and attitudes' with five, two and seven corresponding subthemes (Table 4). Definitions and supporting quotes with a participant number (1-211) are provided in Table 4. Women's responses suggested beliefs that childbirth was a natural process more suitable for home rather than hospital where intervention and medicalisation was perceived as the norm. They acknowledged an association between fear and intervention but also recognised that pregnancy and birth don't always progress as planned and in particular circumstances, intervention may be warranted.

In relation to homebirth options in WA, women appreciated access to a publicly funding homebirth service and acknowledged that this option should be for low risk women. Comments suggested that homebirth models provided continuity of care and carer which were valued by women. Limited awareness, support and negativity by medical professionals and the public of this option were noted with women encountering being 'labelled'. The effort involved in making an informed decision was shared and women appreciated the opportunity to participate in research on this topic and have their voice heard.

DISCUSSION

Participant characteristics indicated that the majority of WA women in this study possessed a high education level and were from socioeconomic areas of relative advantage which aligns with a Swedish study that compared characteristics of women who planned a homebirth with those who planned a caesarean birth based upon maternal request. [39] Swedish women who planned a homebirth also mostly represented those with higher education.

Women in this study chose homebirth to avoid 'unnecessary' intervention, to be in the comfort and familiarity of their own home, to have access to continuity of care/carer, and to be more involved in decision making during labour and birth. The top reasons for planning homebirth were similar by parity, except for comfort of their own home being more important and continuity of care being less important to primigravid women. International qualitative evidence around decisions around homebirth align with reasons confirmed by these WA women. Being able to choose the birth attendant and a previous unsatisfactory birth experience were two main reasons ten Finnish women chose a homebirth for a subsequent birth. [24] These multiparous Finnish women also shared how they wanted increased autonomy, valued the home environment, considered birth as a natural process, respected intuition, mistrusted the medical establishment and wanted to have siblings present at the birth. Factors influencing choice shared by 14 British first time mothers included geographical proximity, normality of childbirth, environment, model of care, television programs and recommendations from family and friends. [40]

An Australian study with 17 women explored what influenced them to choose a publicly-funded homebirth. [20] A core category of 'having faith in normal' included six categories: 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. These findings build on previous work that explored confidence to choose a publicly funded homebirth with ten women who described confidence in their bodies, midwives and health system as influencing their decision. [27] Finally, decision making with 34 Canadian women who planned or had birthed at home reflected a central theme capturing the motivation for a homebirth as wanting to optimise choice, comfort and control and fostering family involvement. [18]

The finding that more multigravida women ranked continuity of care higher as a reason is understandable given primigravid women didn't have a previous birth experience as a reference point and were still facing an unknown future labour, birth and postpartum period with their homebirth midwife. The importance of having continuity and a relationship with the care provider

was similarly found for 17 Canadian women choosing an out-of-hospital birth centre as women shared how when they felt known by a midwife whom they perceived as competent, trust grew and contributed to their feeling safe. [41] The benefits of midwifery led continuity models reported in a Cochrane Systematic Review confirmed that women were not only less likely to experience intervention but be more satisfied with care. [6] Swedish women who planned a homebirth had a significantly more positive birth experience and felt less threat to their baby's life during birth, were more satisfied with their participation in decision making, and felt more in control with greater support from their midwife compared to women requesting a planned caesarean birth. [39]

The majority of WA women felt their partner was very supportive of their choice, that they would have practical and emotional support available after the birth and believed that homebirth was safe. Just over half felt homebirth was very important and were confident to birth at home. Although one third shared concerns about birthing at home they felt family and friends were very supportive of their choice. Our findings align with evidence suggesting that women's attitudes toward the medicalisation of childbirth and their socio-demographic and obstetric background affect their birth choices and judgement of their birth experience. [42] For example, an Icelandic study with a cohort of 809 women found those with a positive attitude toward homebirth had more positive attitudes toward birth and more negative attitudes toward intervention. [43]

Just over one third of WA women reported being fearful of giving birth in a hospital with one quarter having a past negative hospital birth experience. The impact of a negative, previous birth experience cannot be dismissed and highlights the importance of increasing awareness of what constitutes a negative birth experience and perceptions of a traumatic hospital birth. A retrospective survey with 2192 Dutch women with a self-reported traumatic childbirth experience found that 79.8% were primiparous, and 57.7% experienced either an assisted vaginal birth or a caesarean birth. [44] Three frequently cited responses by the Dutch women were supportive of our findings as reasons women considered planning a homebirth: lack and/or loss of control (54.6%), listen to me (more) (36.9%) and support me (more / better) emotionally / practically (29.8%). [44]

A meta-synthesis of 13 qualitative studies on psychosocial implications of a traumatic birth on maternal wellbeing concluded that the resulting emotions can have long term, negative repercussions on maternal self-identity and relationships. [45] For example, a qualitative study with 25 African American women sharing what influenced their birthing options shared how a 'desire for control', 'avoidance of pharmacological pain relief' and 'dissatisfaction with medical aspects of intrapartum care' were central to their decision. [21] Authors concluded that when women's choice is ignored, medical situations are misrepresented and interventions are perceived as unwarranted, women may develop a mistrust of health professionals. [21]

The freedom to make their own choice was cited by a substantial majority (85%) of WA women confirming the importance of this reason in choosing a homebirth. American women (n=20) who had a previous hospital birth subsequently chose a homebirth as they felt they were given 'real choice'. [19] Within a focus group they shared how they were concerned with the interventions and interruptions associated with a hospital birth and health providers who demonstrated disrespect and dismissal. However, in their own home they were supported by a chosen care provider they felt connected to within a peaceful and calm environment. [19] Another American study used content analysis with responses from 160 women to an open ended question 'why did you choose homebirth' and included reasons such as: safety and better outcomes, avoidance of unnecessary intervention, previous negative hospital experience, control, comfortable familiar environment and trust in the birth process. [17]

Women in this current study expressed a desire for greater awareness and less negativity around this birth option as they encountered being 'labelled' by health professionals and the public. A qualitative study exploring midwives' experience of intrapartum transfer from home to hospital also acknowledged that not only were midwives 'under scrutiny' but they were concerned that women's ongoing care in hospital could be affected due to staff attitudes and use of terms such as that 'homebirth mother'.[46]

Qualitative evidence with 12 Australian women who chose a homebirth following a caesarean birth reflected the negative impact of their previous hospital birth experience through the overarching theme of 'it's never happening again'. [25] Nine Australian women who chose an unregulated birth worker to birth at home shared their experiences and suggested they had either experienced or were exposed to mainstream maternity care which they found traumatising. [47] Preferred birth choices were not accessible within an 'inflexible' system that did not respect choice. Consequently, women sought an option they felt would meet their needs and to avoid a repeat of the trauma experienced through traditional care. [47] The rise of Australian women employing a doula and choosing to freebirth at home unattended by a health professional has been asserted to be a consequence of not meeting the needs of women who want continuity of midwifery care and choice of non-medicalised birth options. [48]

The concept of maternal request against medical advice was explored in a Dutch study indicating two frequent requests that included opting for a homebirth in case of a high risk pregnancy and declining foetal monitoring during labour. [49] However, a request for 'less care' is more likely to be declined than a request for 'more care' and women who decline do require support and counselling from their care provider which is time consuming. [49] Pregnant women in this WA study agreed to the conditions of their PFHB service and the guidelines around PPM care and acknowledged that low risk women were most suitable for homebirth options. However, women may not always agree and have the right to refuse recommended maternity care, therefore Australian researchers have proposed a Personalised Alternative Care and Treatment framework. [50] This framework highlights the woman's role in decision-making, documents information exchanged, respects the woman's birth intentions, permits flexible pathways, and incorporates a mediation role as a failsafe.

Incorporating a quantitative and qualitative component is a strength of this study as their respective results are explicitly related in such a way as to be "mutually illuminating, thereby producing findings that are greater than the sum of parts" (p.7). [51] However, our results reflect the

opinion of a relatively small number of WA women who elected to plan a homebirth and may not be generalisable to all Australian women selecting this birth option. Nonetheless, qualitative findings from international studies demonstrated women's experiences in birthplace choices were similar to the reasons ranked by WA women and were also captured in their descriptive textual responses to the open ended question in the questionnaire.

CONCLUSION

Findings from this prospective cohort study confirmed that reasons generated from international qualitative research for selecting a homebirth option were also supported by a larger cohort of WA women. The desire to avoid unnecessary intervention and having the freedom to make their own choices were equally ranked reasons with primigravid women feeling the comfort and familiarity of the home environment was more important and multigravida women acknowledging the value of continuity of care. Regardless of parity, homebirth is perceived as important, believed to be safe and is supported by partners. Qualitative responses from women who acknowledged homebirth as suitable for low risk women reflected their vision for greater awareness and less negativity from medical practitioners and the public around this birthing option.

REFERENCES

1. Australian College of Midwives. Position Statement on Homebirth Services. 2014. Available from https://12-midwives.cdn.aspedia.net/sites/default/files/uploaded-content/field_f_content_file/position_statement_about_homebirth_services_08112011.pdf
2. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists. Home Birth. 2017. Available from https://www.ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women's%20Health/Statement%20and%20guidelines/Clinical-Obstetrics/Home-Births-(C-Obs-2)-Review-July-17.pdf?ext=.pdf
3. Health Networks Branch, Western Australia. *Models of Maternity Care: Updated Evidence on Outcomes and Safety of Planned Homebirth*. Perth: Department of Health Western Australia; 2011.
4. Australian College of Midwives. *Guidance for midwives regarding homebirth services.* 2011; Available from https://19-midwives.cdn.aspedia.net/sites/default/files/uploaded-content/field_f_content_file/guidance_for_midwives_about_homebirth_services_08112011_0.pdf
5. Australian College of Midwives. *National midwifery guildeines for consultation and referral*. 3rd ed. 2013. Available from https://www.midwives.org.au/resources/national-midwifery-guidelines-consultation-and-referral
6. Sandall J, Soltani H, Gates S, Shennan A, Devane D. Midwife-led continuity models versus other models of care for childbearing women. *Cochrane Database Syst Rev*. 2016; 4:CD004667. doi: 10.1002/14651858.CD004667.pub5.
7. Forster D, McLachlan H, Davey M, Biro M, Farrell T, Gold L. et al. Continuity of care by a primary midwife (caseload midwifery) increases women's satisfaction with antenatal, intrapartum and postpartum care: results from the COSMOS randomised controlled trial. *BMC Pregnancy Childbirth 2016;* **16**, 1.

8. McLachlan H, Forster D, Davey M, Farrell T, Flood M, Shafiei T, et al. The effect of primary midwife-led care on women's experience of childbirth: results from the COSMOS randomised controlled trial. *BJOG* 2016; **123**, 465-474.

9. Zielinski R, Ackerson K, Low L. Planned homebirth: benefits, risks and opportunities. *Int J Womens Health 2015;***7**, 361-377.

10. Australian Institute of Health and Welfare 2018. *Australia's mothers and babies 2016*—in brief. Perinatal statistics series no. 34. Cat. no. PER 97. Canberra: AIHW.

11. van der Kooy J, Birnie E, Denktas S, Steegers E, Bonsel G. Planned home compared with planned hospital births, mode of delivery and perinatal mortality rates, an observational study. *BMC Pregnancy Childbirth* 2017;**17**, 177.

12. Birthplace in England Collaborative Group. Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study. *BMJ 2011;***343**. doi:10.1136/bmj.d7400.

13. Hollowell J, Li Y, Bunch K, Brocklehurst P. A comparison of intrapartum interventions and adverse outcomes by parity in planned freestanding midwifery unit and alongside midwifery unit births: secondary analysis of 'low risk' births in the birthplace in England cohort, *BMC Pregnancy Childbirth* 2017;**17**:95.

14. Hollowell J, Rose R, Townend J, Knight M, Li Y, Linsell L, Redshaw M, et al. The Birthplace in England national prospective cohort study: further analyses to enhance policy and service delivery decision-making for planned place of birth. *Health Services and Delivery Research*, NIHR Journals Library; Southampton, United Kingdom. 2015.

15. Homer C, Thornton C, Scarf V, Ellwood D, Oats J, Foureur M. et al. Birthplace in New South Wales, Australia: an analysis of perinatal outcomes using routinely collected data. *BMC Pregnancy Childbirth* 2014;**14**, 206.

16. Catling-Paull C, Coddington R, Foureur M, Homer C. Publicly funded homebirth in Australia: a review of maternal and neonatal outcomes over 6 years. *MJA* 2013;**11**, 616-620.

17. Boucher D, Bennett C, McFarlin B, Freeze R. Staying home to give birth: Why women in the United States choose homebirth. *J Midwifery Womens Health* 2009;**54**, 119-126.

18. Murray-Davis B, McNiven P, McDonal H, Malott A, Elarar L, Hutton E. Why homebirth? A qualitative study exploring women's decision making about place of birth in two Canadian provinces. *Midwifery* 2012;**28**, 586-581.

19. Bernhard C, Zielinski R, Ackerson K, English J. Homebirth after hospital birth: women's choices and reflections. *J Midwifery Womens Health* 2014;**59**, 160-66.

20. Catling C, Dahlen H, Homer C. The influences of women who choose publicly-funded homebith in Australia. *Midwifery* 2014;**20**, 892-898.

21. Farrish J, von Robertson R. A qualitative examination of factors that influence birthing options for African American women. *Critical Sociology* 2014;**40**,271-83.

22. Lindgren H, Erlandsson K. Women's experiences of empowerment in a planned homebirth: a Swedish population-based study. *Birth* 2010;**37**, 309-317.

23. Sjoblom I, Nordstrom B, Edberg A. A qualitative study of women's experiences of homebirth in Sweden. *Midwifery* 2006;**22**, 348-55.

24. Jouhki M. Choosing homebirth: the women's perspective. *Women Birth* 2012;**25**, e56-e61.

25. Keedle H, Schmied V, Burns E, Dahlen H. Women's reasons for, and experiences of, choosing a homebirth following a caesarean section. *BMC Pregnancy Childbirth* 2015;**15**, 206.

26. Lindgren H, Hildingsson I, Radestad I. A Swedish interview study: parents' assessment of risk in homebirths. *Midwifery* 2006;**22**, 15-22.

27. Catling-Paull C, Dahlen H, Homer C. Multiparouns women's confidence to have a publicly-funded homebirth: a qualitative study. *Women Birth* 2011;**24**, 122-128.

28. Brown S, Lumley J. Satisfaction with care in labor and birth: A survey of 790 Australian women. *Birth* 1994;**21**, 1.

29. Fleming A, Ruble D, Anderson V, Flett G. Place of childbirth influences feelings of satisfaction and control in first-time mothers. *J Pyschomatic Obstet Gynaecol* 1998;**8***,* 1-17.

30. Cunningham J. Experiences of Australlian mothers who gave birth either at home, at a birth centre or in hospital labour wards. *Soc Sci Med* 1993;**36**(4), 475-483.

31. Hadjigeorgiou E, Kouta C,Papastavrou E, Papadopulous I, Martensson L. Women's perceptions of their right to choose the place of childbirth: an integrative review. *Midwifery* 2012;**28***,* 380-390.

32. Goodman P, Mackey M, Tavakoli A. Factors related to childbirth satisfaction. *J Adv Nurs* 2004;**46**, 212-219.

33. Bryanton J, Gagnon A, Johnston C, Hatem M. Predictions of women's perceptions of the childbirth experience. *J Obst Gynecol Neonatal Nurs* 2008;**37***,* 24-34*.*

34. Green J, Baston H. Feeling in control during labour: concepts, correlates and consequences. *Birth* 2003;**30**(4):235-247.

35. Kontoyannis M, Katsetos C. What influences women in Athens to choose homebirth? *Br J* Midwifery 2008;**16**, 44-48.

36. Christiaens W, Bracke P. Place of birth and satisfaction with childbirth in Belgium and the Netherlands. *Midwifery* 2009; **25**, 11-19.

37. Kondracki N, Wellman N, Amundson D. Content analysis: review of methods and their applications in nutrition education. *J Nutr Educ Behav* 2001;**34**, 224-230.

38. Willis D, Sullivan-Bolyai S, Knafl K, Cohen M. Distinguishing features and similarities between descriptive phenomenological and qualitative description research. *West J Nurs Res* 2016;**38**, 1185-1204.

39. Hildingsson I, Radestad I, Lindgren H. Birth preferences that deviate from the norm in Sweden: planned homebirth versus planned cesarean section. *Birth* 2010;**37**, 288-295.

40. Borrelli S, Walsh D, Spiby H. First-time mothers choice of birthplace: influencing factors, expectations of the midwife's role and perceived safety. *J Adv Nurs* 2017;**73**, 1937-1946.

41. Wood R, Mignone J, Heaman M, Robinson K, Roger K. Choosing an out-of-hospital birth centre: exploring women's decision-making experiences. *Midwifery* 2016;**39**, 12-19.

42. Benjamini Y, Molcho M, Gozlan M, Preis H. Women's attitudes towards the medicalisation of childbirth and their associations with planned and actual modes of birth. *Women Birth* 2017;**30**, 424-430.

43. Halfdansdottir B, Olafsdottir O, Hildingsson I, Smarason A, Sveinsdottir H. Maternal attitudes towards homebirth and their effect on birth outcomes in Iceland: a prospective cohort study. *Midwifery* 2016;**34**, 95-104.

44. Hollander M, van Hastenberg E, van Eillen J, van Pampus M, de Miranda E, Stramrood C. Preventing traumatic childbirth experiences: 2192 women's perceptions and views. *Arch Womens Ment Health 2017;***20**:515-23.

45. Fenech G, Thomson G. Tormented by ghosts from their past: a meta-synthesis to explore the psychosocial implications of a traumatic birth on maternal well-being. *Midwifery* 2014;**30**:185-93.

46. Ball C, Hauck Y, Kuliukas L, Lewis L, Doherty D. Under scrutiny: midwives' experience of intrapartum transfer from home to hospital within the context of a planned homebirth in Western Australia. *Sex Reprod Healthc* 2016;**8**, 88-93.

47. Rigg E, Schmied V, Peters K, Dahlen H. Why do women choose an unregulated birth worker to birth at home in Australia: a qualitative study. *BMC Pregnancy Childbirth* 2017;**17**, 99.

48. Dahlen H, Jackson M, Steens J. Homebirth, freebirth and doulas: casualty and consequences of a broken maternity system. *Women Birth* 2011;**24**, 47-50.

49. Hollander M, Holten L, Leusink A, van Dillen J, de Miranda E. Less or more: maternal requests that go against medical advice. *Women Birth* 2018; **31**, 505-12..

50. Jenkinson B, Kruske S, Kildea S. Refusal of recommended maternity care: time to make a pact with women? *Women Birth* 2018; **31**, 433-41.

51. Woolley C. Meeting the mixed methods challenge of integration in a sociological study of structure and agency. J Mix Methods Res 2009, **3**, 7-25.

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Table 1. Participant characteristics by parity

Characteristic	All N=211		Primigravid N=75		Multigravid N=136		
	N	(%)	N	(%)	N	(%)	P
Maternal age (y)							
<25	18	(8.5)	12	(16.0)	6	(4.4)	<0.001
25-35	144	(68.2)	54	(72.0)	90	(66.2)	
≥35	47	(22.3)	8	(10.7)	39	(28.7)	
Australian born	136	(64.5)	44	(58.7)	92	(67.6)	0.192
English spoken at home	208	(98.6)	74	(98.7)	134	(98.5)	0.936
Highest education							
≤Year 12 (Equivalent)	37	(17.5)	10	(13.3)	27	(19.9)	0.512
College Diploma/Trade Certificate	60	(28.4)	23	(30.7)	37	(27.2)	
Undergraduate University Degree	66	(31.3)	22	(29.3)	44	(32.4)	
Postgraduate University Degree	48	(22.7)	20	(26.7)	28	(20.6)	
SEIFA-RAD (highest 2 quintiles)	129	(61.1)	47	(62.7)	82	(60.3)	0.938

SEIFA-RAD-Socioeconomic Index for Areas Relative Advantage-Disadvantage

Table 2. Importance, confidence and support around planning a homebirth by parity

	All N=211		Primigravid N=75		Multigravid N=136		
	N	**(%)**	**N**	**(%)**	**N**	**(%)**	**p**
Homebirth very important	108	(51.2)	35	(46.7)	73	(53.7)	0.330
Very confident about birthing at home	113	(53.6)	40	(53.3)	73	(53.7)	0.962
Homebirth believed to be very safe	139	(65.9)	49	(65.3)	90	(66.2)	0.902
Any concerns about giving birth at home	66	(31.3)	26	(34.7)	40	(29.4)	0.431
Partner very supportive of homebirth[1]	161	(76.3)	58	(77.3)	103	(75.7)	0.794
Family/friends very supportive of homebirth[2]	76	(36.0)	21	(28.0)	55	(40.4)	0.072
Practical/emotional support after birth available	203	(96.2)	71	(94.7)	132	(97.1)	0.459
Very strong support available	126	(59.7)	52	(69.3)	74	(54.4)	0.016

[1] no partner (n=1), [2] no family/friends available (n=3).

Table 3. Reasons for choosing a planned homebirth by parity

Reason	All N=211		Primigravid N=75		Multigravid N=136		
	N	%	N	(%)	N	(%)	p
Top ranked reasons							
To avoid unnecessary intervention	124	(58.8)	46	(61.3)	79	(58.1)	0.646
Comfort and familiarity of home	72	(34.1)	33	(44.0)	39	(28.7)	0.025
Freedom to make own choices	54	(25.6)	24	(32.0)	31	(22.8)	0.145
More continuity of care	51	(24.2)	10	(13.3)	41	(30.1)	0.006
All reasons							
To avoid unnecessary intervention	200	(94.8)	74	(98.7)	126	(92.6)	0.102
Comfort and familiarity of home	198	(93.8)	71	(94.7)	127	(93.4)	0.776
Freedom to make own choices	179	(84.8)	69	(92.0)	110	(80.9)	0.031
More privacy	176	(83.4)	67	(89.3)	109	(80.1)	0.086
Homebirth more natural	174	(82.5)	67	(89.3)	107	(78.7)	0.051
More control over the birth process	168	(79.6)	67	(89.3)	101	(74.3)	0.009
More involvement in decisions	168	(79.6)	68	(90.7)	100	(73.5)	0.003
More continuity of care	163	(77.3)	62	(82.7)	101	(74.3)	0.163
Homebirth gives best birth experience	150	(71.1)	55	(73.3)	95	(69.9)	0.593
Dislike for the hospital environment	149	(70.6)	55	(73.3)	94	(69.1)	0.520
Receiving better support at home	145	(68.7)	50	(66.7)	95	(69.9)	0.633
Empowerment by birthing at home	144	(68.2)	52	(69.3)	92	(67.6)	0.801
Best for baby to birth at home	136	(64.5)	51	(68.0)	85	(62.5)	0.424
Best for mother to birth at home	130	(61.6)	46	(61.3)	84	(61.8)	0.951

Partner can be more involved	128	(60.7)	57	(76.0)	71	(52.2)	0.001
More choice of people as support	126	(59.7)	49	(65.3)	77	(56.6)	0.217
Receiving better care at home	118	(55.9)	40	(53.3)	78	(57.4)	0.573
No transport worries	112	(53.1)	36	(48.0)	76	(55.9)	0.272
Better bonding with baby	111	(52.6)	51	(68.0)	60	(44.1)	0.001
No need to leave other children	73	(34.6)	1	(1.3)	72	(52.9)	<0.001
Fearful of giving birth in a hospital	73	(34.6)	28	(37.3)	45	(33.1)	0.535
Friends have had homebirths	59	(28.0)	24	(32.0)	35	(25.7)	0.332
Poor birth experience in a hospital	51	(24.2)	2	(2.7)	49	(36.0)	<0.001
Partner wants a homebirth	36	(17.1)	15	(20.0)	21	(15.4)	0.399
Sister(s) have had homebirths	27	(12.8)	8	(10.7)	19	(14.0)	0.492
Being present at a homebirth	17	(8.1)	2	(2.7)	15	(11.0)	0.033
Homebirth common in culture	5	(2.4)	4	(5.3)	1	(0.7)	0.055
Other reasons	73	(48.6)	25	(33.3)	48	(35.3)	0.774

Note: Statistically significant differences between primigravida and multigravida are highlighted in grey.

Table 4. Themes, subthemes and definitions

Theme and subtheme	Definition	Supporting quotes
Theme: Beliefs around childbirth		
Subtheme**:** Childbirth is a natural process	Beliefs shared around childbirth being a natural process, home environment was regarded as appropriate for women with an uncomplicated pregnancy and childbirth becoming more medicalised which didn't align with beliefs	*I believe birth is a natural process and homebirth should be supported and encouraged more in WA (108)* *Birth is a beautiful, natural thing, and for that reason, it should be done in a beautiful, natural environment. For us that is our home (144)*
Subtheme: Intervention has become the norm	Women didn't accept the assumption that intervention was expected as the norm, were aware of risks of unnecessary intervention and were comfortable questioning clinical practice	*Most of my friends didn't even realise this was an option when they had their kids, they think it is more 'normal' to have medical intervention at a hospital when birthing which is sad (123)* *Science tells us that using 'better' technology and more intervention creates greater risks and needs even more intervention (128)*
Subtheme: The association between fear and intervention	Acknowledged how fear may be contributing to women's vulnerability to accepting intervention but fear could also signify fear of interventions women perceived may not be necessary	*There is still much fear that exists surrounding childbirth and this fear often increases a mother's need for medical intervention (154)* *Thought of medical intervention scares me. I am confident that my birth is very likely to be ok as my last 2 were born vaginally with no difficulties (215)* *Shocked by the Fear Culture that surrounds childbirth, the amount of intervention that occurs is completely unnecessary (216)*
Subtheme: Things can go wrong and intervention may become necessary	Recognised pregnancy and birth don't always go to plan and should circumstances change, intervention may be appropriate. Availability of	*Proper care is essential because it's never going to be perfect and things can go wrong (e.g. my previous birth didn't go to plan - ended up in a hospital due to my high blood pressure) (134)*

	medical services was acknowledged and provided reassurance if intervention was warranted	*Reassured that we live in a time where necessary interventions and pain relief are available should they be needed but I fear all too often these may be used prematurely depending on the disposition of the obstetrician at that time and policies of the hospital (257)*
Subtheme: Hospitals are the domain for the sick and not safe places for normal childbirth	Belief that childbirth is a natural process and hospitals are the domain for the sick: pregnant women are generally not unwell and home rather than hospital is more appropriate for a low risk woman	*Why on earth would I want to go into hospital to increase my chance of infection, interventions, stalling of labour with travel and anxiety of the clinical environment?! (269)* *I am not taking a bed and Dr/nurses time in the hospital. Making that available to people who do need their care… Low risk pregnancies should be encouraged to think about the option to reduce the pressure on the hospitals (255)* *I feel that hospitals are for sick people and birthing and pregnancy does not render me ill or sick (310)*
Theme: Opinions around homebirth in WA		
Subtheme: Appreciate access to a publicly funded homebirth service	Acknowledged how they were appreciative and grateful that this service was available	*I have been through [homebirth program] nearly twice now is amazing, I am completely satisfied with the care and support (108)* *I am incredibly grateful for the service … women are very fortunate to have this birthing option (277)*
Subtheme: Acknowledged homebirth should be for low risk women	Due to preparation making decision to pursue a homebirth, women were aware and supportive that homebirth may not be suitable for all women	*Needs to be promoted more as a safe option for the low risk mothers (123)* *I believe that homebirth should be offered to all low risk pregnant woman as a viable option from their GPs (209)*
Theme: Awareness, options, choice and attitudes		
Subtheme: Continuity of care and carer valued	Access to same midwife or small group of midwives who knew the woman was highly	*Like the idea of continuity of care and being able to let the process unfold naturally rather than being 'churned' through a busy labour ward (108)*

	valued and having continuity was regarded as a benefit of homebirth models	*There are so many positives to birthing at home. Continuity of care and birthing in a relaxed, familiar home environment are very important to my partner and I (139)*
Subtheme: Homebirth not presented as an option	Expressed concern that birthing options are not widely known or openly shared to enable women who have a low risk pregnancy to make an informed choice	*After 7 years of living here I finally found out about the [PFHB] program. In my 2 other pregnancy (sic) no one ever told me about … the opportunity of a homebirth (110)* *I think GPs should present it as an option rather than automatically assume you want to go into hospital (173)* *At first I didn't know homebirth was an option - it was a very pleasant surprise. Need more publicity!! (275)*
Subtheme: Lack of public awareness and negativity toward homebirth	Public are not aware of homebirth as a suitable option for low risk pregnant women and suggested negative attitudes to homebirth were encouraged by detrimental media coverage	*People's perception of homebirth is hard to deal with … It would be nice to be able to have a casual non-political or opinionated conversation about my choice (130)* *Not told many people that we want a homebirth due to the negative perceptions in the media. Hoping to share far and wide after (253)* *My choice to have a homebirth has been met with a surprising amount of stigma and surprise (269)*
Subtheme: GPs and obstetricians not aware or supportive of option	Although WA has a publicly funded homebirth program, women felt medical staff were not aware and / or actively discouraged women who may meet the eligibility criteria to not consider this option	*Many women don't even consider homebirth as an option because it is so demonised by the medical profession - I myself never would've considered homebirth as an option, until I had the traumatic first birth that I did. (143)* *Most GP's are not well educated, informed or supportive of homebirths (172)*

Subtheme: Women believe they are labelled	Encountered 'labelling' by health professionals and the public	M*ake homebirthing a choice which women can make without fear of what others will think and where women will feel supported in their decision, rather than seen as a bit of a 'weirdo' (126)* *Not all homebirth mothers are dirty hippies and the more the public knows that it is a safe way to give birth, the easier it would be for mothers to do what feels best without being judged (304)*
Subtheme: Women value research and the need to educate others	Valued opportunity to participate in research and have their voice heard. Sharing their experience seen as opportunity educate the public and health professionals about what a homebirth can offer and why low risk pregnant women see this option as viable and desirable	*Thank you for conducting this study. It would be wonderful for all women to know how much easier and happier birth can be (136)* *I just think it's great that this study is being done, as there is not much good info out there about homebirth (239)*
Subtheme: Well-informed in decision	Shared the substantial effort undertaken to research and inform their decision to pursue a homebirth	*The decision to opt for a homebirth is one that myself and partner put a lot of thought and research into. We have made an informed decision that we believe is best (128)* *I am educated and can research things myself (162)*