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Homebirth in WA: why women make this choice.

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Degree: Master of Public Health (by Research)

Date of Submission: 9 April 2014

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ABSTRACT

Background: Homebirths in Western Australia (WA) account for approximately 0.8% of all births. Two consecutive reports from the Perinatal and Infant Mortality Monitoring Committee found increased rates of perinatal mortality in homebirths and recommended a prospective cohort study to assess mortality and morbidity outcomes for women with planned home births in WA. The Homebirth in WA Study, of which this thesis is a component, has been funded by a directed research grant.

Aim: The aim of this study was to explore the specific reasons why women in WA choose homebirth. Research on homebirths is focused on perinatal outcomes and comparisons of satisfaction between hospital and homebirth. Based on these comparisons, assumptions are made as to why women choose to have a homebirth or make this choice. There is a paucity of research directly addressing the reasons why women make this choice.

Methods: This is a quantitative prospective observational study. Pregnant women planning a homebirth in WA were invited to participate in the study. Women recruited into this study (n=135) were asked about their obstetric history and associated satisfaction with their previous birth experience, and were asked to select from any of 27 options as being their reasons for choosing homebirth, with the option to provide additional reasons of their own. They were also asked to select the three most important reasons. Women were asked to rank their perception of how important it is for them to have a homebirth, their perception of the safety, their level of confidence and the support they have received from their spouse and family and friends for their choice. The women were also invited to share further comments.

Results: The majority of women (n=107) received care from the Community Midwifery Program and the remainder (n=28) from privately practicing Midwives. In this study 50 women were nulliparous and 85 multiparous. Women who previously had a homebirth reported a higher level of satisfaction (4.7/5) for the birth experience, compared

to women who had hospital births (2.3/5). Avoiding unnecessary intervention was the dominant reason for choosing home birth in 95.5% of participants, regardless of parity, education or previous birth experience; this was followed by the comfort and familiarity of the home (93%) and the freedom to make their own choices (86%). Avoiding unnecessary intervention ranked the highest of the 3 most important reasons. Women reported a high level of support for their choice from their spouse (4.65/5) and substantially less from family and friends (3.68/5). They ranked the safety of homebirth highly and had a high level of confidence. The women who elected to share further comments referred most frequently (28%) to GP's and obstetricians not presenting homebirth as an option, and also made frequent reference to their negative attitude in relation to the women's choice. Women also commented on the negative attitudes encountered from family and friends, and additional references reflected their attitudes regarding intervention.

Conclusion: Women choosing homebirth in WA do so to avoid unnecessary intervention and have the freedom to make their own choices in the surrounds of the home. They receive limited support for their choice from GP's and obstetricians as well as friends and relatives. This study underscores the reaction of some women to the current rates of obstetric intervention.

DECLARATION

I certify that this thesis does not, to the best of my knowledge and belief:

- (i) incorporate without acknowledgement any material previously submitted for a degree or diploma in any institution of higher education;*
- (ii) contain any material previously published or written by another person except where due reference is made in the text; or*
- (iii) contain any defamatory material. I also grant permission for the Library at Edith Cowan University to make duplicate copies of my thesis as required.*

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In memory of my father, who instilled the value of education in his children and grandchildren and inspired so many with his life-long passion of learning.

Donald Lowe BSc Hons, BA Hons, MEd (1922-2007)

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CHAPTER 1

INTRODUCTION

In contemporary Australia women give birth in hospital as the accepted mainstream model of care. In Western Australia less than 1% of women choose a homebirth, and women who elect to give birth at home are a unique group who face intense criticism and scrutiny for their choice, as do the midwives who practice in this model of care. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) do not support homebirth, citing safety concerns for this stance (RANZCOG, 2011). In contrast, the position statement on homebirth services issued by the Australian College of Midwives (2011) states “The Australian College of Midwives supports the choice of midwife-attended homebirth as a safe option for women with uncomplicated pregnancies” (p.1).

Two consecutive reports by the Western Australian (WA) Perinatal and Infant Mortality Monitoring Committee (PIMC) reported evidence of increased perinatal mortality associated with homebirths (Department of Health Western Australia, 2007; Department of Health Western Australia, 2010). The 2010 report recommended that a prospective cohort study to assess morbidity and mortality for women with planned home birth should be conducted as a priority. In response, the WA Health Department (hereafter referred to as “the Department”) used a competitive tender process to contract research specifically aimed at addressing the PIMC recommendation. The recipients of this grant are currently conducting the ‘Homebirth in WA Study’ to address this issue; and this thesis constitutes one component of the larger study that involves retrospective and prospective elements.

Existing research relating to homebirth is focused essentially on perinatal outcomes of mortality, morbidity and to a lesser extent obstetric intervention, and women’s satisfaction with their care and birth experience. This is also the opinion of Kornelsen (2005, p.1495) who states “...homebirth studies are usually restricted to a focus on morbidity and mortality in the comparisons of

outcomes, whereas home-birthing women's experiences and attitudes remain a largely neglected source of data".

Most of the current published research comprises of comparisons between hospital births and homebirths, with assumptions made as to why women may choose a homebirth. There is currently no published research investigating why women in Western Australia choose homebirth, nor is there a substantive body of research from other countries which directly addresses women's reasons for making this choice. As Janssen, Henderson and Vedam (2009) note, the voices of women who have chosen homebirth have been ignored in the debate and controversy about the safety of homebirth; they also point to the fact that no large scale studies have examined the experiences and reasons for women choosing homebirth.

This research addresses a gap in the body of knowledge, by investigating the reasons why women in Western Australia choose to have a homebirth. In this study 135 women were recruited and data was collected to determine their demographic profile, their past obstetric history, reasons for choosing homebirth, the attitudes of others when women make this choice and the women's confidence in their decision to have a homebirth. Since this research provides a comprehensive profile of the characteristics of women who choose homebirth, and the reasons they offer for their choice, the study will enhance the data obtained from the Midwives Notification system held by the Department, by providing a holistic view of Homebirth in WA. It is anticipated that this research will precipitate a change in the current focus on perinatal morbidity and mortality to be more inclusive and provide new insights into this issue, and the reasons why women choose not to access the mainstream models of care. Research findings may illustrate deficiencies in the current system for low risk women.

The results of this study will formally articulate the participants' perspectives on the issue of homebirth, and will be used by the Department and other healthcare services to better understand the needs, expectations and opinions of women who make this choice. As part of the larger Homebirth in WA Study, this information will inform future planning, service provision and

policy development relating to homebirth locally as well as in the other States and Territories of Australia and the developed world.

Background

Two consecutive reports from the Perinatal and Infant Mortality Monitoring Committee (PIMC) over the past decade found increased rates of perinatal mortality in homebirths. In the 2002-2004 report, the Committee observed the perinatal death rate for term homebirths was approximately three times higher than that for term hospital births. (This figure was based on 3 perinatal deaths at term.) For this report, data were pooled with those from the Committee's 11th Report for the years 2000-01, to allow for a valid statistical analysis, thus representing a term perinatal death rate of 6.7 per 1,000 in planned homebirths compared with 2.1 per 1,000 in planned hospital births in the same period. The 2005-2007 report indicated that the perinatal death rate for term homebirths was 3.9 times higher than for hospital term births; 9.3 per 1,000 planned homebirths compared to 2.93 per 1,000 planned hospital births (Department of Health Western Australia, 2007; Department of Health Western Australia, 2010). Importantly, neither report discussed obstetric risk category associated with the perinatal death cases; however, both did utilise an avoidability scale to score the perinatal deaths.

The following recommendation evolved from the findings of the 2005-2007 report. Recommendation 13c of *The 13th Report of the Perinatal and Infant Mortality Committee of Western Australia for Deaths in the Triennium 2005-2007* stated:

There are insufficient data about morbidity associated with homebirth in WA. A prospective cohort study to assess mortality and morbidity outcomes for women with planned home births in WA should be arranged as a priority. This cohort study should be performed by an independent group of researchers (p.12).

Following this recommendation, the Homebirth in WA Study, funded by the Department, was set up to address the specific recommendation from the WA PIMC which were based on findings of increased perinatal mortality in the years 2002-2004 and 2005-2007.

The 'directed research' commissioned by the department illustrates the importance of homebirth as a research priority. Furthermore, it is recognised that there is a lack of research pertaining to homebirth, which is further compounded by the small number of women who elect to have homebirths, making analysis and interpretation difficult. The 'Homebirth in WA Study', of which this research is a sub-component, is a retrospective-prospective study of WA women who planned home birth using data extracted from the Midwives Notification System from 2002-2013. Primarily, it will examine morbidity associated with planned home birth via comparisons with hospital births and identify the pivotal risk factors associated with morbidity in planned home birth. A component of the prospective arm of the study was to invite women planning a homebirth to complete a questionnaire during pregnancy and another following the birth, to provide further insight to the maternal characteristics and satisfaction with this model of care.

It is the opinion of the investigators that the Home Birth in WA Study will be the largest Australian study collecting data on all aspects of homebirth. This thesis documents research investigating women's reasons for choosing homebirth and forms an important element of this broader landmark study.

The Homebirth model of care in WA

Pregnant women in Western Australia have a few choices when deciding where to deliver their babies. In 2010, of the 30,843 women who gave birth in WA, 96.5% delivered in a hospital, 2.5% at a birth centre and 1% at home. Approximately 40% of hospital births occurred in private hospitals (Joyce & Hutchinson, 2012). Women having homebirths also frequently elect to have water births. This option is available at some Birth Centres and more recently in some hospital settings. Figure 1 highlights the trends of

confinements in WA from 1992-2010 and Figure 2 highlights the homebirth trend during the same period.

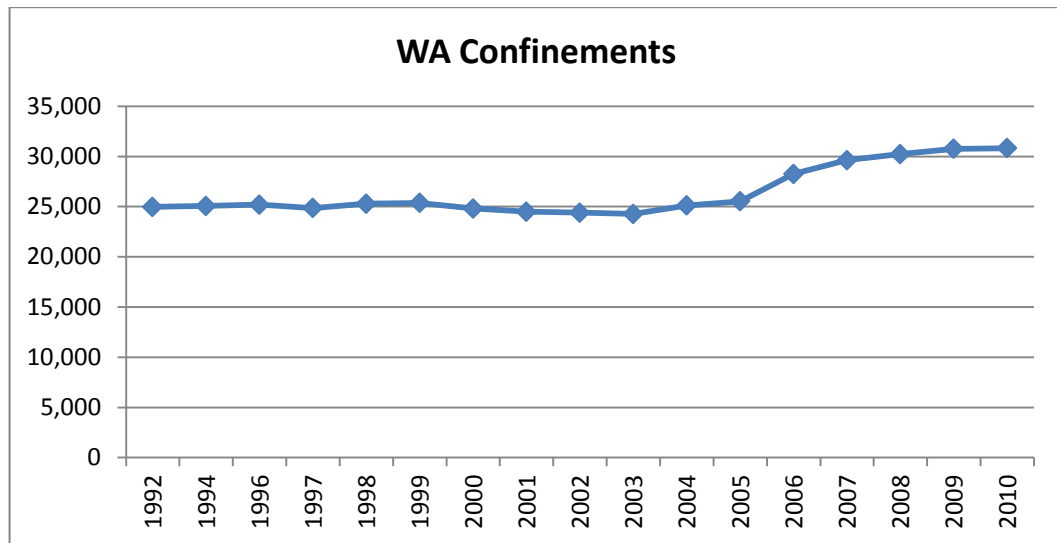


Figure 1. WA Confinements (Data collected from individual AIHW Australia's mothers and babies reports)

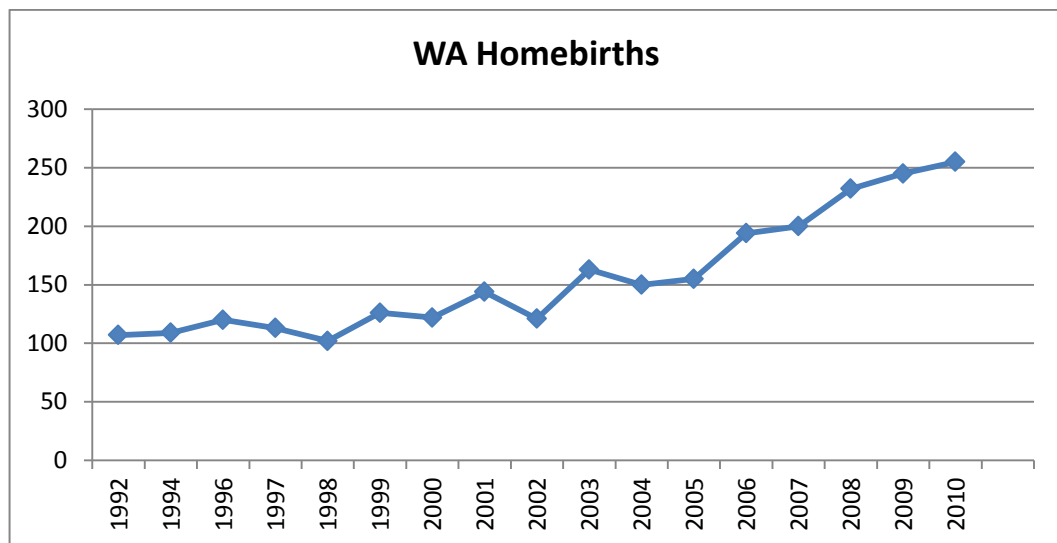


Figure2. WA Homebirths (Data collected from individual AIHW Australia's mothers and babies reports)

Women who elect to have a homebirth in WA currently have the choice of the Community Midwifery Program (CMP) servicing the Perth metropolitan area which has been publically funded since 1996, or they receive care from Privately Practicing Midwives (PPM). More recently, in 2013 the Midwifery

Group Practice (MGP) was introduced to service the Bunbury area within a 30km radius. All practising midwives must be registered with the Australian Health Practitioner Regulation Agency (AHPRA). The care and services provided by CMP and MGP are governed by WA Health Department guidelines - Home Birth Policy and Guidance for Health Professionals, Health Services and Consumers (2012). The CMP and MGP midwives are employed by the WA Health Department, which also provides their professional indemnity insurance. The PPMs are private providers, independent of the public health system and currently working without professional indemnity insurance for intrapartum care (to date they have been unsuccessful in securing private insurance). Women who receive antenatal and postnatal care from PPMs are eligible for Medicare rebates, but are not covered for the cost of intrapartum and delivery care from PPMs. Some PPMs and CMP midwives are also 'Eligible Midwives', a status which confers prescribing rights that are covered by Medicare.

The Home Birth Policy and Guidelines have been formulated in conjunction with the WA Health Department to ensure that only women with low obstetric risk can deliver at home. The category of 'low risk' encompasses women at term with a singleton fetus with a cephalic (head first) presentation, with no pre-existing medical conditions, no obstetric risk factors and no psychosocial risk factors (refer to Appendix 6). Some women who fall outside the parameters of low risk eligibility for CMP and MGP may seek the services of PPMs who may be willing to care for them, but they will not be eligible for Medicare rebates to cover intrapartum care. As well as women opting to deliver through either the CPM, MGP or a PPM, some women elect to 'Free Birth', in which case they deliver without a qualified birth attendant (Jackson, Dahlen & Schmied, 2011). There are no statistics available for this category as there is no official reporting mechanism to record such births.

Despite the enormous effort to restrict homebirths in WA to low risk women, some who fall into the obstetric category of high or moderate risk still seek to have homebirths. This constitutes a major problem for this model of care, especially when obstetric outcomes are evaluated. For example, published statistics in WA, in particular the PIMC reports, fail to differentiate low risk

from high-risk women in homebirth cohorts (Department of Health Western Australia, 2007; Department of Health Western Australia, 2010). In addition, as a result of the very small number of women having homebirths, unfavourable outcomes among high-risk women become over-represented. The difficulty of interpreting the statistics is acknowledged in the 2010 report, which noted that “as the number of deaths from planned homebirths is very small, the reliability of the mortality rates produced is decreased, and caution should be used in interpreting these rates” (p. 80).

Newman (2008) highlights the complexity of the issue of women who choose to free birth, as well as the interpretation of definitions relating to the *intent* of unattended homebirths, which is then represented in homebirth data. Newman also points to the limitations of the stance taken by RANZCOG towards homebirth, in that it fails to:

acknowledge the balance of the research evidence that *planned* homebirth results in no greater mortality or morbidity for mother or infant if the pregnancy is deemed to be *low risk*, if the labour/ birth is *attended* by suitably qualified and experienced health professionals, and if the woman *lives within reasonable distance of back-up obstetric services* (p. 451).

The publically funded homebirth model of care which operates in WA through the CMP was first run as a pilot program in WA in 1996, and subsequently adopted in South Australia, New South Wales and the Northern Territory in 1998. This arrangement does not extend to the remaining states and the Australian Capital Territory, and women wanting homebirths in those jurisdictions have to engage the services of uninsured PPMs. According to Catling-Paull, Foureur and Homer (2011), there are 12 publically funded homebirth programs operating within Australia. They believe that the use of PPMs has declined due to out of pocket expenses incurred by women accessing this service (Catling-Paull et al., 2011).

Women who opt for a homebirth in WA receive all their antenatal care, antenatal education, intrapartum care and postnatal care from the same midwife. Indeed, continuity of care from the same midwife is one of the hallmark characteristics of homebirth. According to the governing guidelines, the woman has to be seen antenatally by a general practitioner to conduct a risk assessment, and is also required to register at the closest hospital with obstetric services, in the event of the necessity to transfer the care to hospital. The midwife must have a back-up midwife present at the birth. The midwife will continue to see the mother and baby for a minimum of 10 days following the birth. This model of care applies to the CMP, MGP and PPM services.

Brief History of Homebirth in Western Australia

The history of homebirth in WA and for that matter within Australia, has a long legacy of struggle – women fighting for a right to birth at home, midwives fighting for their professional autonomy and for the rights of women, and medical practitioners fighting to control childbirth. The battles have been fought through acts of parliament, professional bodies and persistent lobbying (Stella, Rawlings, Key, Kelly & Thorogood, 2006).

According to Thorogood's account of the history of homebirth in WA (cited in Stella, Rawlings, Key, Kelly & Thorogood, 2006), during the period 1880 to 1910, midwives in Australia experienced the gradual loss of autonomy and had restrictions placed on their practice. The Health Act of 1911 was the first step in legislating midwifery practice, by requiring midwives to meet certain criteria to be registered by the Midwives' Board in order to practice independently.

By the Second World War, most women gave birth in hospital under the supervision of a medical practitioner, even if the woman was delivered by a midwife. This was perceived as common sense and progressive. Towards the end of the Second World War in 1944, midwifery practice was incorporated into the Nurses Act and regulated by the Nurses Board.

Significantly, in a reflection of the dominance of the medical establishment, the Nurses Board was well represented by medical practitioners who were granted the statutory power to control the practice of midwives. Thorogood (cited in Stella et al., 2006), believed midwives in Western Australia have never been able to independently self-govern, as regulatory bodies of the medical and nursing professions have always had legal and subsequently regulatory dominion over them.

As recently as 1991 the Australian Medical Association (AMA) lobbied for the proposed new Nurses Act to contain a clause preventing midwives from practicing without medical supervision. This lobbying was unsuccessful and the AMA finally lost its legal right to control community midwifery practice.

According to Stella et al. (2006), the homebirth movement in WA began in 1955 when a Dutch woman Henny Ligtermoet, having arrived 4 years earlier from the Netherlands, wanted to have a homebirth in keeping with her cultural tradition. She was however faced with many obstacles resulting from the lack of midwives undertaking homebirths and the lack of medical support. She managed to find an independent midwife and a reluctant GP who feared ostracism from his peers.

As a birthing mother, Henny's quest continued and by 1956 she had established a group of similar-minded homebirth advocates under the auspices of the Midwifery Contact Centre (Stella et al., 2006). In addition, she secured "tacit and rudimentary support from the Western Australian Commissioner of Health" (p.4). Interestingly this group only had the services of one midwife and the support of a few GPs who preferred to be called upon only if necessary, and with some asking for their names not to be made public. The first 'noted' homebirth occurred in 1957.

Henny's quest spanned the next 40 years during which she promoted homebirth and became well known in medical, midwifery, parliamentary and women's groups circles. By 1977 she had established the national body, *Homebirth Australia* (HBA – the national peak body representing homebirth in Australia). In 1982 the Homebirth Support Group was established and this marked the end of the Midwifery Contact Centre.

As Stella, et al. (2006) indicated, the independent community midwives continued their lobbying against the medical profession and the State until well into the 1990's. During this time a very small group of independent midwives were operating their own private midwifery practices in the suburbs of Perth, having forged good professional relationships with a small number of GP obstetricians and specialist obstetricians. The midwives received neither a wage nor financial assistance for their equipment from the government. Some midwives found it difficult to ask families for payment and some women bartered for the services of the midwife. The ultimate aim for the midwives was to have a publically funded homebirth program.

There was increasing demand for homebirths in WA as the number of homebirths rose from 60 in 1980 to 150 in 1985. The political battle continued. Stella, et al. (2006) suggests Henny Ligtermoet recognised that midwives and homebirth mothers were not 'political', but had little choice in becoming involved in the 'politics of birth'. The midwives received support from Henny and Dr. Margaret Trudgen (a medical practitioner who was willing to provide medical backup for homebirths) and also began to establish useful political networks.

During the 1990's the campaign by homebirth activists continued and submissions were repeatedly made to the Commonwealth for Medicare provider numbers and rebates for homebirths. Even earlier in 1984, the Medicare Benefits Review Committee identified the need for alternatives to birthing services, and in addition the National Health and Medical Research Council (NHMRC) Women's Health Committee sought national standards and support facilities for homebirths and birthing centres, none of which eventuated. Similarly when several members of the Senate supported the recommendation for a Medicare rebate for midwifery-led homebirth, this too was unsuccessful. The campaign for Medicare provider numbers and rebates was finally successful in 1996 (Thorogood, cited in Stella et al., 2006).

Stella et al., (2006) asserted:

The CMP came about essentially because community-based midwives needed to be paid for their services, and increasing numbers of women were demanding the right to choose how and where they give birth...It was not until the midwives made it more obvious that it was an equity issue for birthing mothers that the government responded to demands for funding. (p.12)

Several unsuccessful attempts were made by a group of midwives to apply for Alternative Birthing Services Program (ABSP) funding. (ABSP was funded by the Commonwealth to provide funding to promote greater choice in birthing for women and to encourage the establishment of services managed primarily by midwives). They eventually realised that the applications were not being processed by the Health Department of WA onwards to the Commonwealth Government for consideration, and ultimately resorted to seeking the support of local politicians to intervene, which was eventually successful (Stella, et al., 2006).

Finally in 1995, after a submission in conjunction with the South Metropolitan Health Service, the Multicultural Women's Health Centre and Woodside Maternity hospital, funding was allocated for a 2 year pilot project. The project encompassed home and 'domino' births (i.e. birthing in a birth centre or hospital with all care provided by a homebirth midwife), antenatal education and pregnancy and birth information services targeted at non-English speaking women. In 1996 funding was approved for the second phase and the Community Midwifery Program commenced; under this scheme, women no longer had to pay for the services of a homebirth (Stella et al., 2006).

Initially in 1996 two full time accredited homebirth midwives were employed, with two part time in training for the accreditation. This program was governed by the standards and protocols for homebirth as stipulated by the WA Health Department as well as the standards of the Australian College of Midwives. At first this service was only available to women residing in the south metropolitan area of Perth, but it gradually expanded to encompass an area 50 kilometres (km) north, 50 km south and 40 km east of the Perth

central business district (CBD). Currently 12 midwives are employed in this service. Privately Practicing Midwives currently unable to secure professional indemnity insurance have been granted an extension to practice until mid-2014 by the WA Health Department, based on a federal decision.

CHAPTER 2

LITERATURE REVIEW

Literature pertaining to homebirth is predominantly based on comparisons between hospital and homebirths. The most prevalent topic in homebirth literature is focused on safety in relation to perinatal mortality and morbidity. The striking feature here is the deeply divided opinion among researchers. Other common topics in the literature pertain to intervention and various facets of satisfaction.

Homebirth in developed countries

A review of international literature illustrates the diversity in the rate of homebirths in various developed countries, as well as the different positions taken by professional medical and midwifery bodies in relation to the safety of homebirth.

The Netherlands features very strongly in literature pertaining to homebirth, and has the highest rate of homebirths among developed countries.

Approximately 30% of Dutch women have homebirths and they are well supported by and integrated into the health care system (de Jonge et al., 2009).

In the United Kingdom approximately 2% of women have a homebirth (Cresswell & Stephens, 2007). In a joint statement by the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives, both professional bodies communicate their support for homebirth for women at low risk of obstetric complications (Cresswell & Stephens, 2007).

In contrast to the situation in the UK, the American College of Obstetricians and Gynaecologists (ACOG) strongly opposes home births, citing a lack of scientific rigor in studies comparing the safety and outcomes of US hospital births to those occurring elsewhere (The American College of Obstetricians and Gynaecologists, 2011). According to Wax, Pinette, Cartin and

Blackstone (2010), approximately 1% of women in the United States deliver at home.

In Canada 1.2% of women have planned homebirths. The Society of Obstetricians and Gynaecologists of Canada (SOGC) acknowledges the importance of choice for women in the birthing process, but notes that they “should understand any identified limitation of care at their planned birth setting” (Executive Committee SOGC, 2003, p. 5).

Closer to home, New Zealand has a publically funded scheme for homebirths. The homebirth rate in New Zealand varies from region to region, but the New Zealand College of Midwives estimates that 7% of women have homebirths (Catling-Paull, Foureur & Homer, 2011).

Significant recent events in maternity care in Western Australia.

Maternity care in WA experienced a difficult period during the late 1990s and early 2000s. The impact of this warrants consideration as it heralded many changes in maternity care and was highly publicised, and therefore cannot be overlooked. For the first time, deficiencies in maternity care and obstetric practice were aired publically and concerns were raised about public confidence. It was a time that many midwives and obstetricians would prefer to forget, as it impacted heavily on professional relationships as well as professional practice and still remains a sensitive issue. The question is whether this influenced women’s choice of where to give birth.

King Edward Memorial Hospital (KEMH), being WA’s sole tertiary maternity hospital, was the subject of an inquiry commissioned by the then Metropolitan Health Service Board in 2000. During early 1999 concerns raised by senior clinicians were directed to the hospital’s Chief Executive. According to the report (Douglas, Robinson & Fahy, 2001), a review was conducted by Child and Glover (dated April 2000), which focused on the clinical care provided by the obstetric and gynaecological services at KEMH. The review was completed in only two weeks, and identified a large number

of serious clinical and administrative problems affecting the quality of patient care and safety. The Child and Glover report made 23 recommendations of which almost half were strongly criticised by the AMA and individual obstetricians; the report also recommended that a further detailed review should be conducted.

The Douglas inquiry was instigated following this recommendation, and it ran over a two year period from 2000 to 2001. In accordance with their Terms of Reference, the inquiry investigated the provision of obstetric and gynaecological services at KEMH during the period 1990 to 2000. During a period of 18 months, 1600 patient clinical files were reviewed and clinical file analysis was conducted on 605 files. The identified problems covered clinical, administrative and management issues; significantly, inadequate supervision of junior medical staff and inadequate management of complex cases. During the inquiry, 106 current and former staff were interviewed, as well as 70 past patients.

In accordance with the recommendations, nine cases were brought to the attention of the Medical Board for further investigation, some of which resulted in the patients taking legal action. The Executive Report of the Douglas Inquiry acknowledged the impact of the inquiry on public confidence by stating:

Sustained public confidence, like sustained high levels of staff morale, is brought about by transparency, openness and accountability in the way that public institutions deal with and serve the public not through a paternalistic approach that seeks to protect the public from knowing the real state of affairs.

Inevitably, there is a good deal of short-term pain involved in revealing to the public the nature and extent of a public institution's problems. There is also a good deal of short-term pain involved in giving the public sufficient information that would allow the public itself to assess the extent and effectiveness of any changes that are made to address

those problems. (p.xxiii)

This statement has a tone of underlying embarrassment of having to 'bear all' to the public. This is a breakaway from the tradition of portraying the medical profession and its practice as faultless, and never allowing any scope for the health consumer to scrutinise the deficiencies and failings in the care they provide, or question the veracity of their decisions and practice. It also raises the question of how safe women may feel giving birth in a hospital setting, given their awareness of serious failings in the system which has resulted in unfavourable outcome for mothers and babies.

Public confidence in the safety of maternity services is an important factor to consider when women choose where to give birth. Armstrong (2010) cites the example in Canada, when during the 2003 SARS epidemic several hospitals closed their maternity wards to contain H1N1 virus, during which at least one hospital quarantined five newborn infants and their mothers for 10 days. Many hospitals during this time took the measure of drastically restricting visitors including family members from hospital visits. This also coincided with midwives reporting an increased interest in home birth among pregnant women, as they came to appreciate the risks of giving birth in hospital settings. Armstrong concluded, "the SARS and H1N1 events remind us that hospitals ought properly to be the preserves of the sick and the individuals who care for them" (p.10).

During this period of turmoil the rate of homebirths in WA increased substantially against the national average and the state trend of homebirths. This raises the question as to whether this increase could be attributed to loss of public confidence in the safety of giving birth within the hospital system in WA. Figure 3 illustrates the homebirth trend in WA and nationally over a 17 year period.

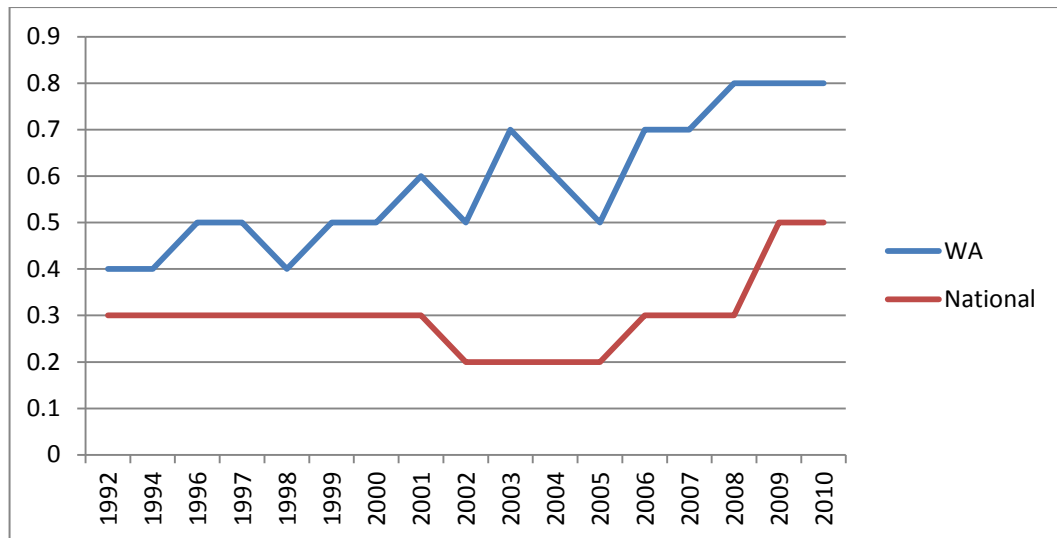


Figure 3. WA and National Homebirths. (Data collected from individual AIHW Australia’s mothers and babies reports)

The Douglas inquiry made 237 recommendations, of which 26 pertained specifically to guidelines and protocols. Symon (2002) in discussing the effects of litigation on obstetric practice also noted the role of clinical guidelines: “Guidelines...within maternity care are driven to a great extent by considerations of risk management which is itself in part driven by the perceived threat of litigation” (p. 169).

Symon (2002) acknowledged that guidelines are essentially devised to ensure that clinical practice is optimal, and at least meets a minimum standard. He also noted that a common feature of poor outcomes has been when staff failed to follow standard accepted practice. However, Symon (2002) cautioned against being “constrained to a straightjacket of clinical conformity” (p. 169), which may obscure common sense, and he contended that guidelines “are double-edged swords: they may be used to blame or excuse” (p. 170). Symon concluded that guidelines needed to be flexible rather than rigid.

It is worth considering whether increased guidelines following the Douglas Inquiry resulted directly or indirectly in an increase in obstetric intervention and whether it fuelled a climate of risk aversion and defensive practice.

Significantly, as KEMH is the sole state tertiary teaching hospital for midwifery and obstetrics, this draws attention to the potential impact on practice of its graduates after being schooled in a risk-averse and interventionist environment. KEMH caters for the majority of high-risk women in WA and provides specialist care facilities for this high-risk category to improve pregnancy outcomes. Clinicians will argue that the high levels of intervention are part of improving pregnancy outcomes in the high risk category. This may be a valid argument for high-risk women, but does not serve the interests of low-risk women, where intervention is not warranted.

During the course of the Douglas Inquiry, medical and midwifery staff were questioned, and in some instances this escalated to giving evidence to the Medical Board and in some cases judicial courts, when patients pursued litigation. It is unlikely that staff involved in being questioned or having to provide evidence could emerge unscathed.

Lane (2001) argued that obstetric decision-making is governed by “an irrational fear of litigation” (p. 1), and described how this fear leads to interventions based on the safest rather than the best options. Lane states:

The safest option (from the obstetric perspective) is to intervene ‘before something goes wrong’ because obstetricians believe (a) that the body is essentially fragile and almost inevitably requires intervention...(b) that women now expect a perfect baby every time (c) that middle-class women, in particular, are more educated and more articulate than ever before and (d) are, therefore much more likely to be litigious. (p.1)

A RANZCOG submission to the Senate Community Affairs Reference Committee in 1999 provided further insights to this issue: “It is hardly surprising that medical practice has now become defensive rather than reactive and that medical indemnity premiums have risen exponentially to meet the costs” (cited in Lane, 2001, p. 3). The RANZCOG submission concluded that “obstetricians also need to survive the hazards of pregnancy

and childbirth” (p. 3) – a statement which highlighted the medical establishment’s perception of childbirth as a high-risk event, both medically and professionally.

MacLennan & Spencer (2002) surveyed 826 Fellows of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists with an Australian postal address and found that in 2000 (one year prior to the survey) the median annual insurance premium for those practising obstetrics was \$35,515. The majority (68%) of obstetricians reported being aware of the possibility of litigation against them at some stage in their careers. Although the full outcomes were not provided, 32% of those surveyed had at some stage been issued with court documents initiating an obstetric claim (p. 426).

According to Lane, medical indemnity insurance costs had risen from \$2,000 in 1988 to \$29,000 in 1995 (p.5). Gannon (2012) referred to a current premium of \$100,000 for obstetricians in WA, due to what he termed the ‘high stakes’, and contended that the distinction between high risk and low risk is false “...because life-threatening situations can and do develop within minutes” (p.41). This article condemns homebirths in WA.

The link between medical indemnity costs and obstetric care was highlighted in an American study by Zwecker, Azoulay and Abenhaim (2011), which reported that when average state malpractice premiums were over \$100,000, they were associated with a higher caesarean section rate, compared to average state premiums less than \$50,000.

Similar dynamics appear to have evolved in Western Australia in the aftermath of the Douglas Inquiry. For example, a qualitative study by West Australian researchers Hood, Fenwick and Butt (2010), based on the experiences of 17 midwives who had directly or indirectly been involved in medico-legal forums related to the Douglas Inquiry, highlighted the impact of this particular inquiry on professional practice. Midwives revealed there was a “culture of fear of litigation”, and that fear was now their “daily companion” (p.278). Some midwives noted:

that expecting women to have a natural birth in a litigation-fear-based environment was 'unrealistic'. As one midwife said, 'philosophically I think there has been a trend to doubt birth...I found that suddenly I would relook at things which I would see as normal and see it as potentially abnormal'. (p. 278)

Hood et al., (2010), suggested that the midwives interviewed made significant changes to their clinical practice based on their fear of litigation, and acknowledged their defensive practice by increased monitoring and intervention, driven by the goal of avoiding litigation. However, by protecting themselves from litigation, midwives felt that it altered the building of relationships and manner of negotiating with the women they provided care for, and placed strain on these relationships. Midwives were distressed by the change in these relationships:

'Not standing with women', as one midwife put it, was the result of midwives feeling unable to partner, advocate and support women's individual requests and choices because of their desire to protect themselves and inability to establish safe boundaries around their practice. (Hood et al., 2010, p. 280)

Increased clinical guidelines following in the wake of the inquiry also emerged as an issue for the midwives. Whilst the clinical guidelines were perceived as a protective mechanism (a safety net) and a source of security, they were also seen as something to hide behind, which came with a cost:

Using guidelines as a protection strategy was considered by these midwives as a potential way to disempower both women and midwives. In the opinion of some of the midwives, the pressure to conform to the guidelines often led to an increase in interventions. Using them as '*absolute rules*' and following '*the policy to the word*' was considered restrictive and not in the interests of providing care tailored

to individual needs and preferences. (Hood et al., 2010, p. 279)

Hood and colleagues' article is revealing, and while it is focused on practices in Western Australia, it echoes national and international literature pertaining to the threat of litigation and impact on obstetric care. The issue of to what extent the fall-out from Douglas Inquiry impacted on WA women's choice of where to give birth is relevant to any discussion on homebirths in WA, and is considered in more detail in the following section, which examines recurrent themes identified in the literature.

Recurrent themes in the literature

Safety of Homebirth

There is little doubt that the heart of the homebirth debate rests with the issue of safety in relation to perinatal morbidity and mortality. However, the wide differences in expert opinion on this subject create a confusing picture for women weighing up the issues of safety in homebirth.

A review of the literature highlights this is also a much contested issue among researchers. A highly regarded and rigorous meta-analysis on the safety of homebirth in developed countries (Olsen, 1997) found no difference in perinatal mortality when comparing hospital to homebirths, and concluded that homebirth was an acceptable alternative for selected women, and led to less intervention. At the other end of the spectrum, a meta-analysis by Wax et al. (2010) also examining the safety of homebirth in developed countries concluded that less medical intervention during planned home birth was associated with a tripling of the neonatal mortality rate. This paper has since been vehemently criticised by other researchers for the methodology and authors' interpretation, but has nevertheless received extensive publicity (Keirse, 2010; Janssen & Klein, 2010). Criticism was levelled at lack of a clear definition of the planned place of birth, the inconsistencies of including

significant studies in the analysis and the authors' definition of the time frame of perinatal death.

A South Australian population-based study (Kennare, Keirse, Tucker, & Chan, 2009) demonstrated a seven-fold increase in intrapartum deaths, and a 27-fold higher risk of intrapartum asphyxia in homebirths when compared to hospital births. The authors clearly indicated that the adverse outcomes also included high-risk women in the homebirth cohort. Similarly, an earlier Australia-wide population based study by Bastian, Keirse and Lancaster (1998), found that homebirths carried a higher perinatal death rate than the national average (5.7 v 3.6 per 1000), and higher intrapartum deaths not due to malformations or immaturity (2.7 v 0.9 per 1000). These authors also found that the largest contributor to the excess mortality was the presence of existing risk factors in some homebirth women.

Conversely, an early West Australian study (Woodcock, Read, Bower, Stanley & Moore, 1994) comparing planned homebirths to matched hospital births between 1981-87, concluded there was less perinatal mortality and morbidity in the homebirth cohort. A more recent review by West Australian researchers concluded: "planned home birth with a qualified home birth practitioner is a safe alternative for women determined to be at low obstetric risk" (Doherty, Hornbuckle, Nathan & Henderson, 2011, p. 16). While making this observation, the researchers also pointed to the evidence indicating that women having homebirths who were determined *not* to be at low obstetric risk, experienced excess neonatal morbidity and mortality associated with homebirth (Doherty et al., 2011).

Internationally, two large studies conducted in the Netherlands (de Jonge et al., 2009; Wiegers, Keirse, van der Zee, & Berghs, 1996) highlighted the safety of homebirth for low risk women, as comparable to hospital births. Similarly, when comparing homebirth to hospital outcomes, a large Canadian study by Janssen, Henderson and Vedam, (2009) reported low and comparable perinatal mortality and morbidity. These findings were supported in a separate Canadian study by Hutton, Reitsma and Kaufman (2009).

American opinion on the matter is divided. Johnson and Daviss (2005)

concluded that neonatal mortality in homebirths was similar to hospital births in low risk women. In contrast, fellow Americans Pang, Heffelfinger, Huang, Benedetti and Weis (2002) reported that homebirths had greater infant and maternal risks when compared to hospital births. These authors concede the limitations of misclassification: “these include the potential for misclassifying unplanned home births as planned home births and for misclassifying various out-comes and covariates” (p. 256).

Research pertaining to perinatal morbidity and mortality has been subject to rigorous debate, intense scrutiny and often harsh criticism as in the case of Wax et al. (2010). It is compounded by differing opinion of peak medical bodies internationally and the inherent difficulty in the interpretation and analysis of statistics pertaining to homebirth. Collectively, it represents a very confusing picture to health consumers.

As noted previously, there are also differing stances taken by national medical bodies; the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) and their American counterparts (ACOG) both reject homebirth outright on the basis of concerns of safety. Adopting a slightly different approach, the British, Canadian and Dutch peak medical bodies cautiously support this model of care for women with low obstetric risk. However, it is important to note that much of the literature, particularly in Australian studies, has failed to distinguish whether the statistics for perinatal morbidity and mortality presented included high-risk women.

Some of the complicating issues of analysis and interpretation are highlighted by Doherty et al., (2011):

The failure to exclude any unplanned home births will overestimate the risk of adverse outcomes ... Prospective studies that compare planned home and hospital births are often based on small samples of pregnancies and are too small to detect any differences in rare adverse outcomes such as perinatal mortality. (p. 2)

Over and above the opinion of health care professionals, parturient women too have divided opinion on the safety of homebirth. In particular, some women argue the case for homebirth based on their belief that hospitals are unsafe due to the inherent potential for unnecessary intervention (Jackson, Dahlen, & Schmied, 2012). These women view safety not from a standpoint of the safety of delivering at home, but rather question the safety of delivering in a hospital. As such, they provide a very different perspective on the mainstream model of hospital-based childbirth to medical professionals.

Obstetric intervention

It is essential to include the issue of increasing rates of medical intervention in any discussion pertaining to homebirth. In 1985 the World Health Organization (WHO) stated: "There is no justification for ... CS rates higher than 10-15%. Until further research gives new evidence, rates >15% may result in more harm than good" (p. 4). According to a 2010 WHO report (Gibbons et al.), both Australia and the United States had a Caesarean Section (CS) rate of 30.3 %, the United Kingdom had a rate of 22%, New Zealand 20.4% and the Netherlands 13.5%. There is no indication in the 2010 report that the 1985 recommendation has been amended in line with the increasing trend for intervention in developed countries. It could be argued that increased intervention stems largely from increasing maternal age, and advances in reproductive and obstetric technology.

According to the Western Australia's Mothers and Babies 2010, 28th Annual Report published by the WA Health Department, the CS rate for the state is 33.6% - more than double the CS rate recommended by the WHO. CS rates at private health services ranged between 27.9% and 55.8%. This report also indicated that 28.5% of labours in WA are induced, while instrumental deliveries accounted for 14.4% of births.

The following graph (Figure 4) illustrates the increased rate of CS in WA between 1983 and 2010.

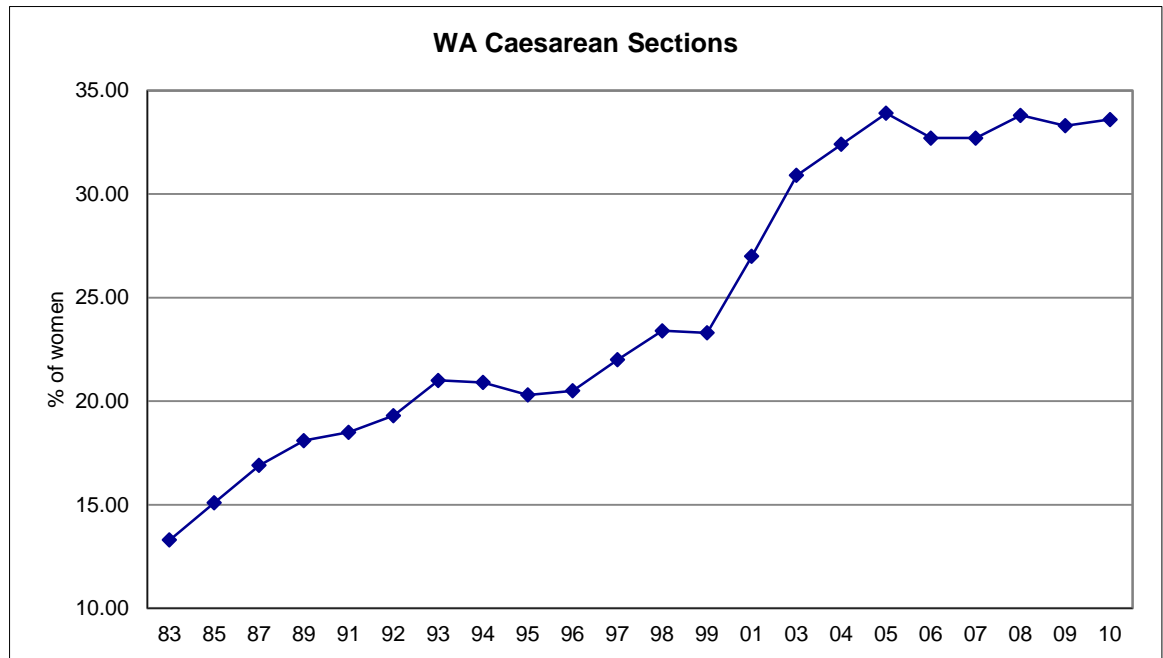


Figure 4. WA Caesarean Sections. (Data collected from individual AIHW Australia's mothers and babies reports)

For many women, the essence of homebirth is the absence of medical intervention, enabling them to labour and deliver spontaneously. It stands to reason that when making the decision to have a homebirth, women will be aware of the potential for intervention if they choose to deliver in a hospital setting given the current climate of increasing obstetric intervention and the level of publicity it receives. An Australian study by Brown and Lumley (1994) demonstrated that women were more negative about the birth experience when they experienced intervention. In addition, some women associate unnecessary intervention with increased risk (Jackson, Dahlen, & Schmied, 2012).

Possamai–Inesedy (2006) argued that pregnant women are unable to escape the consequences of a society preoccupied with risk, in which the perception of health has underpinned a cultural acceptance of medical intervention of childbirth. This author found that among pregnant women in

New South Wales, regardless of where or how they intended to give birth, the discourse of risk was central to the birth event. Generally, the women felt that their fears could be allayed by medical intervention, but the exception was homebirth respondents, who expressed the view that their fears could be allayed by avoiding medical intervention (p. 412). In this context, medical intervention can either alleviate women's anxieties, or conversely be a source of stress for women, depending on how they wish to give birth.

Kornelsen (2005), when investigating pregnant women's attitudes to technology, found that homebirth participants had a balanced view. Whilst avoiding technology was the motivation for having a homebirth, "it was aimed at perceived *unnecessary* intervention, not technology in general." (p.1500). While the homebirth women in this study who had their care transferred to a hospital were disappointed, this was "...somewhat ameliorated by the fact that they believed the use of technology was unequivocally necessary" (p.1502). Thus it seems they were reconciled to medical intervention where they believed it was necessary.

Despite the increased intervention, the rates of perinatal mortality in WA have experienced very little change in the past 27 years. Between 1983 - 2010 the CS rate in WA has continuously risen from 13.3% to 33.6%; a 60.4% increase. On the other hand, the perinatal mortality rate has dropped by 21.7% (from 11.5 – 9.10 per 1,000 births) during that same time period. In 1997 the perinatal mortality rate dropped to 6.3 per thousand, which was a 45% decrease from 1983, but since 1998 the average rate has been relatively steady at 9.5 per 1,000 births. Figure 5 refers to the trend in WA perinatal mortality from 1983 -2010

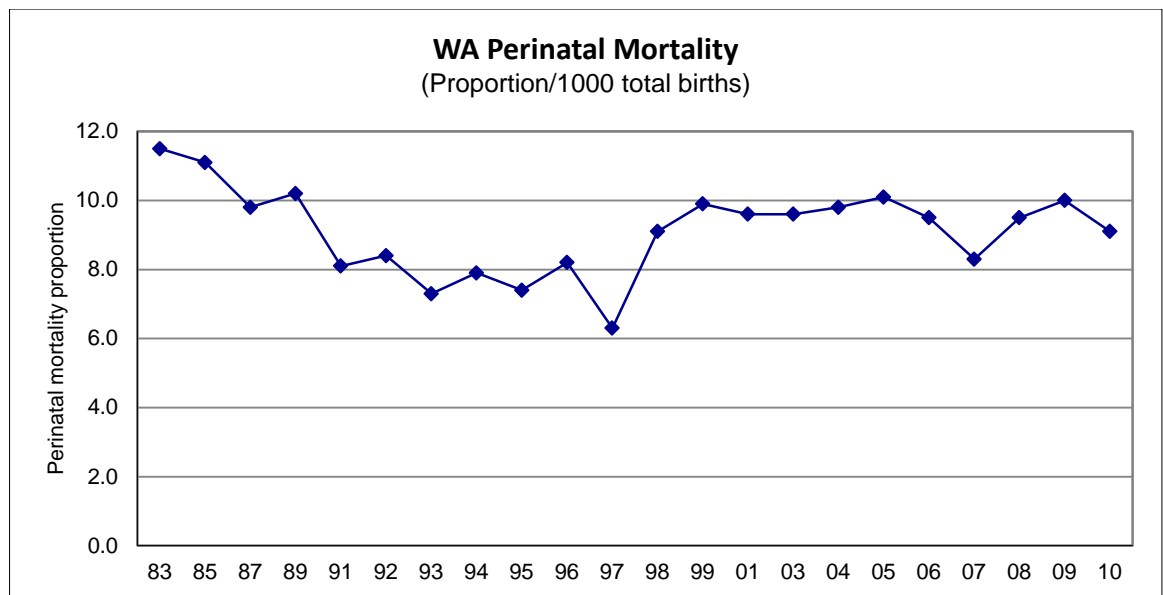


Figure 5. WA Perinatal Mortality. (Data collected from individual AIHW Australia’s mothers and babies reports)

A similar dynamic has been observed in the US. For example, Glantz (2012) discussed CS and induction rates in relation to neonatal mortality in the US:

No clearly ascribable improvement has occurred in neonatal mortality, which gradually declined since 1990 irrespective of whether caesarean section rates rose or fell. Of particular note is that the rate of improvement in neonatal mortality slowed down after 2000, at the time when the rate of rise in number of caesarean sections accelerated. (p.287)

Glantz (2012) also indicated that equally, the increase in the rates of induction of labour has not been accompanied by a proportional decrease in neonatal mortality. He boldly suggested that given the doubling of induction and CS rates without a proportional improvement in perinatal outcome, “one might project that today’s high rates could be halved without compromising the safety of childbirth” (p.290).

Satisfaction – continuity of care, control and a positive birth experience

A substantial body of research has investigated satisfaction levels among women delivering in a hospital and at home. In particular, there seems to be a recurrent theme of satisfaction gained from continuity of care and control among women having a homebirth.

A combined Dutch and Belgian study in 2009 concluded that women in both countries who planned a homebirth were more satisfied than women who had hospital births (Christiaens & Bracke). A study by Janssen, Carty and Reime (2006) reported similar findings among Canadian women, while an Australian study by Cunningham (1993) demonstrated higher satisfaction among women who had homebirths in relation to the rating of their midwife and the process of bonding to the baby. The homebirth mothers in Cunningham's study perceived the absence of intervention, and having freedom, control and a natural environment as central to the bonding process. These findings were supported in a Canadian study by Fleming, Ruble, Anderson and Flett (1988).

A Finnish study of homebirth women (Jouhki ,2011) reported that a positive birth experience was associated with perceptions of complete autonomy, participation of family members, self-belief to give birth and the absence of pharmacological analgesia. Equally, a negative hospital birth experience was associated with losing autonomy and women feeling excluded from the birth experience.

Regardless of the place of birth, a significant body of evidence has indicated that the issue of control appears to be an important factor related to childbirth satisfaction (Goodman, Mackey, & Tavakoli, 2003; Bryanton, Gaganon, Johnston, & Hatem, 2008; Green, Coupland, & Kitzinger, 1990), while Hodnett (1989) found that homebirths provided women with a greater sense of control than those delivering in a hospital. Kontoyannis and Katsetos (2008) define control in this context as assertive behaviour in which women take charge of their birth experience, such as making decisions relating to the physical environment, people present, and labour and birth positions.

Interestingly, the opposite end of the birth spectrum described by McAra-Couper, Jones and Smythe (2011), indicates that women requesting elective CS may do so to fulfil their need for control in a world which values and expects control and predictability. This exemplifies that the issue of 'control' can have a different perception among women, and illustrates a significant variation in the concept of choice related to CS.

In addition to the relationship between intervention and satisfaction, Brown and Lumley (1994) also found that involvement in decisions about their care was critical to women's satisfaction with the birth experience. Kornelsen (2005) perceived maternal loss of control as a by-product of technology and intervention, which impacted negatively on the woman's birth experience.

Choice

There is very little literature which focuses on the specific issue of *why* women choose to have homebirths. The literature focuses primarily on safety, intervention, satisfaction and control, and these factors are then offered as the reasons contributing to why women may perhaps choose homebirth. In this study these factors were explored specifically.

In an integrative literature review by Hadjigeorgiou, Kouta, Papastavrou, Papadopoulos and Martensson (2011), the authors concluded that women worldwide wish to exercise their right and make informed choices about where to give birth, and perceptions of safety varied such that there was a disparity in the opinion of women as to whether a homebirth or hospital birth was the safest option.

In an American qualitative study, based on the essay question "Why did you choose home birth?", the order of the commonest responses were: firstly safety, followed by the avoidance of unnecessary medical intervention, previous negative hospital experience, more control and finally a comfortable familiar environment. The authors concluded that the women equated

medical intervention with reduced safety (Boucher, Bennett, McFarlin, & Freeze, 2009).

Kontoyannis and Katsetos (2008), investigating what influenced women to choose homebirth, indicated the key factor was to maintain control of the birth experience, in addition to which the home environment provided women with a sense of reassurance and safety which enhanced their self-esteem and confidence.

Choice and the societal construct

The literature also points to the extrinsic component of choice in relation to childbirth, in that it is also determined by the social construct of how childbirth is perceived by society and by the woman. McAra-Couper et al. (2011) argued that the choice in childbirth does not arise solely from the medicalised context “but also - and primarily - from the societal context, for it is society itself that produces the values that constrain and limit the choices women make” (p. 83).

Davis-Floyd (1994) discussed the technocratic body, and argued that society perceives the unique female anatomy and biological processes as being inherently subject to malfunction. She argued that the medical system has succeeded in convincing women of the inherent defects and dangers, and furthermore, that “during pregnancy and childbirth, the usual demands placed on the female body-machine render it constantly at risk of serious malfunction or total breakdown” (p. 1127).

Lavender and Kindgon (cited in McAra-Couper et al., 2011, p. 93) pointed to the dichotomy with some women seeing birth without intervention as old-fashioned; from this perspective, the authors argued that less value is placed on the ability for women to birth naturally, as the use of technology to assist birth is seen as being progressive.

Kleinhenz (cited by McAra-Couper et al., 2011) contended the evolution of choice in relation to childbirth has led to women not only having the freedom to elect to have a caesarean section, “but also to their feeling that they need not explain or apologise for their choice” (p. 83). Theoretically, this premise should also apply to women who elect to have a homebirth, but this does not appear to be the case. South African researchers Chadwick and Foster (2012) elucidate this dichotomy by stating:

While planned home birth is seen as transgressive by feminist scholars, choosing birth via elective (medically unnecessary) caesarean section has not been cast as a subversive move. Instead it is often portrayed as a pathological choice (p. 321).

This perspective points to an inequity in the respect afforded to women for the choices they make in relation to childbirth, and highlights something of a paradox, where a request for a medically unnecessary CS is more readily accepted and even excused, compared to a low risk women electing to have a homebirth.

McAra-Couper et al. (2011) also considered the ethical component of ‘do no harm’ in relation to respecting autonomy for women requesting a CS, and concluded that the ethical considerations of autonomy, beneficence and doing no harm for many health professionals is reconciled when it is viewed in conjunction with the “reasonable wishes of rational agents” and the principles of informed consent (p. 89).

Within the societal construct of childbirth choices, the cost to the taxpayer of the various models of care warrants consideration. In an unpublished WA Health Department report evaluating pregnancy outcomes and cost-effectiveness of models of maternity care in WA, the antenatal care and birth cost for a homebirth with CMP was shown to be the most cost effective model of care (Doherty, Hornbuckle, Hutchinson, Henderson, Montague & Newnham, 2008). The combined antenatal care and birth cost at the time of

this report was approximately \$1,582 for a homebirth. In comparison, the antenatal and birth cost at KEMH was estimated at \$5,002, and reduced to \$3,566 at smaller peripheral hospitals, depending on the level of service provided. The cost for birth centres was estimated at \$2,524. This report also indicated that the average admission cost of birth and postnatal stay at KEMH for an uncomplicated vaginal delivery was estimated to be \$3,765; on the other hand, the admission and birth cost for a CS was estimated at \$7,984. The homebirth cost for delivery and postnatal care was \$950. Figures are unavailable for the cost of antenatal care and birth in the private sector as obstetricians (like other specialists), determine their own fees, and hospitalisation fees vary between private hospitals.

It could be debated whether the taxpayer has the right to question who should incur the cost when women demand elective CS, because they feel they have the right to make this choice in the absence of any medical imperative for intervention.

In conclusion, homebirth research comprises essentially of comparisons between hospital and homebirth outcomes, with a focus on the issue of perinatal mortality and morbidity. Opinions are clearly divided on the topic of safety, and importantly, most of the presented evidence also included high-risk obstetric cases, which may confound the results of any analysis. Commonly, homebirth numbers are very small, thereby complicating statistical analysis and interpretation. The other common facets of homebirth examined in the literature include intervention and satisfaction. Researchers are generally unanimous in these areas. The specific question why women choose homebirth nevertheless remains largely unaddressed in the literature. The issue of choice is strongly shaped by the societal view of childbirth, and where it falls in the spectrum of health and disease. This warrants consideration within the local environment in which women make the choice, and suggests that in understanding women's perspective on homebirth, it is necessary to view the process of childbirth as part of a broader social process.

CHAPTER 3

METHOD

This quantitative prospective observational study investigated reasons why some women in Western Australia choose to have a homebirth.

This study was part of a larger retrospective prospective Homebirth in WA Study, comparing the perinatal mortality and morbidity of planned homebirths from 2002 to 2013 with contemporaneous low-risk hospital births. Part of this study included inviting women planning a homebirth to complete a questionnaire during pregnancy and another following the birth. This study emanates from the antenatal questionnaire.

Subject Selection

A series of meetings were convened with the study investigators, the CMP midwives and Privately Practicing Midwives to promote the Homebirth in WA Study. The CMP midwives and PPMs were supportive of the large study as they recognised the paucity of relevant data from WA. The midwives were asked to bring the Homebirth in WA Study to the attention of all their pregnant clients intending to have a homebirth. Information and contact details about the study were posted on the CMWA website as well as the Women and Infants Research Foundation (WIRF) website.

The midwives were given a supply of pamphlets to distribute to their clients which provided study and contact details. Women contacting the research office were required to verify that they were pregnant and intended to have a homebirth. A full explanation of the study, including confidentiality, de-identified data and right to withdraw, was provided telephonically by the study coordinator.

To be eligible for the study, women had to be over the age of 18, pregnant, planning to have a homebirth and able to read and write English. Women were eligible to be recruited from 16 weeks gestation onward.

Sample Size

Approximately 250 women have homebirths annually in Western Australia. For the purposes of this proposed study, women were recruited from the time ethical approval was granted in January 2013 and continued until August 2013. It was anticipated that approximately 150 participants would be recruited.

It should be noted that eligibility was based on the intention to have a homebirth. According to Joyce and Hutchinson (2012), 18% of women intending a homebirth will ultimately deliver in hospital; with this taken into account, annually approximately 300 women in WA have the intention to have a homebirth.

Data Collection

Questionnaire packages were posted to all women agreeing to participate in the Homebirth in WA Study. The package included an information sheet, a consent form, a contact sheet, a cover letter, the questionnaire and a self-addressed stamped envelope to return the relevant documents.

The antenatal and postnatal questionnaires were developed in conjunction with the investigators of the larger Homebirth in WA Study, and final drafts were approved by the research team. The comprehensibility of the questionnaires was trialled on non-clinical staff at WIRF. The average time to complete the questionnaires was also noted. The questionnaires were required to be included in the KEMH ethics application, which was subsequently approved. The questionnaires were also piloted on the first 10 women participating in the larger study.

The demographic and obstetric history questions used for this study were successfully used in several large studies by WIRF researchers (Newnham et al., 2009; McDonald, Henderson, Faulkner, Evans, & Hagen, 2008) and therefore well validated. The questions pertaining specifically to the reasons for women choosing homebirth were developed to explore recurrent themes in the literature examining various facets of satisfaction:

- lack of intervention (Brown & Lumley, 1994, and Fleming et al., 1998)
- bonding (Cunningham, 1993, and Fleming et al., 1998)
- involvement with decisions and choice (Hadjigeorgiou et al., 2012)
- continuity of care (Cunningham, 1993)
- home environment (Cunningham, 1993; Fleming et al., 1998, and Boucher et al., 2009)
- sense of control (Goodman et al., 2004, Bryanton et al., 2008; Green et al., 2007, and Hodnett, 2007)
- empowering experience (Kontoyannis & Katsetos, 2008)
- better birth experience (Christiaens & Bracke, 2007)
- previous negative hospital experience (Boucher et al., 2009)

The inclusion of details relating to previous birth experience is based on the findings of Catling-Paull, Dahlen and Homer (2011). In addition, a few questions were developed anecdotally from the researcher's extensive professional contact with pregnant women and midwives; these questions included the influence of a mother or sister having had a homebirth and having being present at a homebirth.

The provision of the option for free text to 'share comments' allowed this cohort of women to voice opinions which may enrich the results of the research by including contemporary views, when translated into policy and service provision.

Data Analysis

Quantitative data were analysed using SPSS version 20 (2011). Maternal demographic characteristics; namely, country of birth, level of education, employment status and socio-economic status, was summarised, and the reported reasons for planning a homebirth were examined.

Women were asked to select and rank in order their reasons for choosing homebirth; these results were collated to identify the main factors influencing women's decisions. Specific reasons for choosing homebirth were described for women of differing obstetric histories and demographic features.

Categorical data was summarised using frequency distributions. Continuous data was summarised using means and standard deviations.

The option for free text comments was included to compliment the quantitative component of this study. The comments were manually coded into broad themes, sub-themes and over-arching themes and then summarised.

Data Retention and Ethics

All the data was de-identified. Contact sheets and consent forms are stored separately to the questionnaires. All study material is stored in locked filing cabinets at the offices of the Women and Infants Research Foundation (WIRF). De-identified electronic data is stored on a secure server at WIRF and is only accessible to relevant investigators. Access is secured by username and password.

All hard copy study documents will be stored in locked filing cabinets at WIRF for a period of 7 years, after which they will be destroyed. This is in accordance with NHMRC requirements. The electronic database will be securely deleted after a period of 7 years. All documents and the database will remain the joint property of WIRF and the WA Health Department.

Ethics approval for the Homebirth in WA Study has been obtained from the WA Health Department, the North Metropolitan Area Health Service, the South Metropolitan Area Health Service, WA Country Health Service and King Edward Memorial Hospital for Women. Ethics approval was granted from Edith Cowan University Ethics Committee when the research proposal was approved in December 2012

CHAPTER 4

THE RESULTS

Between December 2012 and August 2013, all women who intended to have a homebirth in Western Australia either through the Community Midwifery Program or with a Privately Practicing Midwife were invited to participate in this study. The final cohort that was recruited and met the selection criteria consisted of 135 volunteers.

The average gestation at recruitment was 30.6 weeks and ranged from 16 to 41 weeks. This sample included 50 (37%) nulliparous women and 85 (63%) multiparous women.

Demographic features:

The average age of the women was 32 years, (standard deviation 4.97) and ranged from 20 to 44 years. The average age for nulliparous women was 30 years and ranged from 20 to 39 years. Figures 6 and 7 provide more detail:

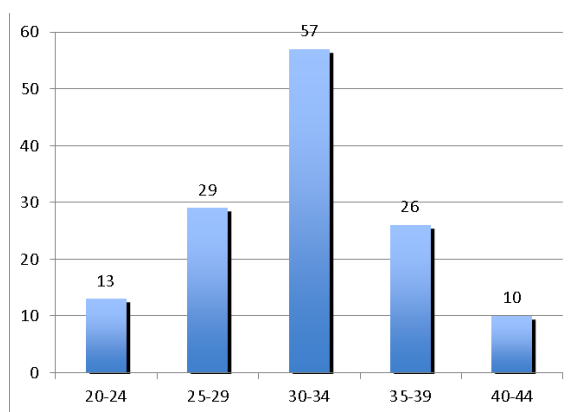


Figure 6. All women – age.

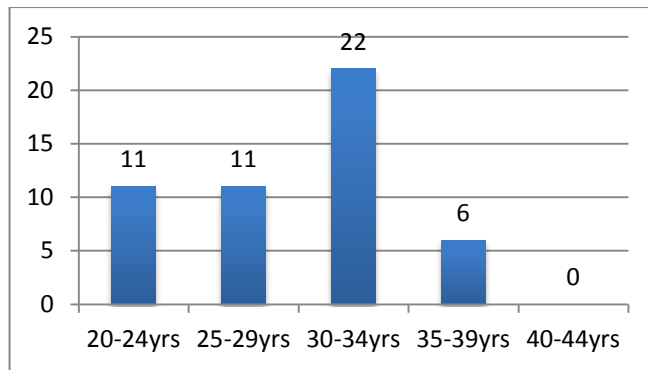


Figure 7. Nulliparous women – age.

The majority of the women in the study were Australian born (64%, n=87), 14% (n=20) were born in the United Kingdom, 8.8% (n=12) were born in New Zealand, the remainder were from Central Europe, Eastern Europe and the United States (n=16). 98% of the women spoke English as their first language.

The socio-economic profile of the women was measured against the Index of Relative Socio-Economic Advantage and Disadvantage (IRSAD) based on the residential postcodes of the women. This index organises socio-economic groups into quintiles, with Quintile 5 indicating the highest level of socio-economic advantage and Quintile 1 indicating the lowest level of socio-economic advantage. Results indicated that 62% of the women were in the higher Socio-Economic Indexes for Areas (SEIFA) category, 31% in the medium category and 5% in the low category. (SEIFA is a product developed by the ABS that ranks areas in Australia according to relative socio-economic advantage and disadvantage. The indexes are based on information from the five-yearly Census.)

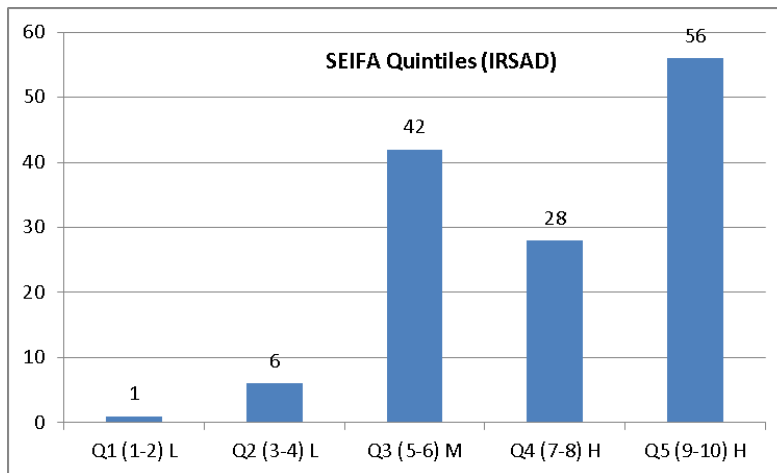


Figure 8. SEIFA Ranking.

As Table 1 and Figure 9 indicate, more than half of the women had a tertiary education (54%, n=73); the next highest level of attained education with was a TAFE qualification (21.5%, n=29) and followed by a year 12 level (13.3%, n=18). The rate of primigravid women with a tertiary education was 52%.

Table 1.
Education

	Frequency	Percent	Cumulative Percent
Yr 10	4	3.0	3.0
Yr 12	18	13.3	16.3
Trade	8	5.9	22.2
Prof reg	1	.7	23.0
TAFE	29	21.5	44.4
UGrd	40	29.6	74.1
PGrd	33	24.4	98.5
Other	2	1.5	100.0
Total	135	100.0	

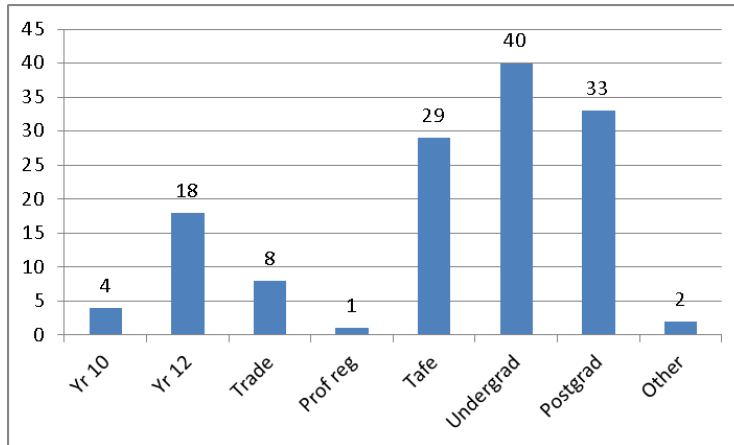


Figure 9. All women – Level of education.

Working status before and during pregnancy:

As indicated in Figure 10, prior to being pregnant 54% (n=73) of the women worked 20-40 hours per week; during pregnancy this decreased to 40% (n=54). Almost 30% of women undertook home duties only before pregnancy, and this increased to 36.2% (n=49) during pregnancy. When comparing nulliparous women to multiparous women, 92% (n=49) of nulliparous worked 20-40 hours prior to pregnancy and this decreased to 78% (n=39) during pregnancy. In the case of all multiparous women, 32% (n=27) worked 20-40 hours per week prior to pregnancy, and this decreased to 18% (n=15) during pregnancy. The percentage decrease of 14% applied to both groups of women.

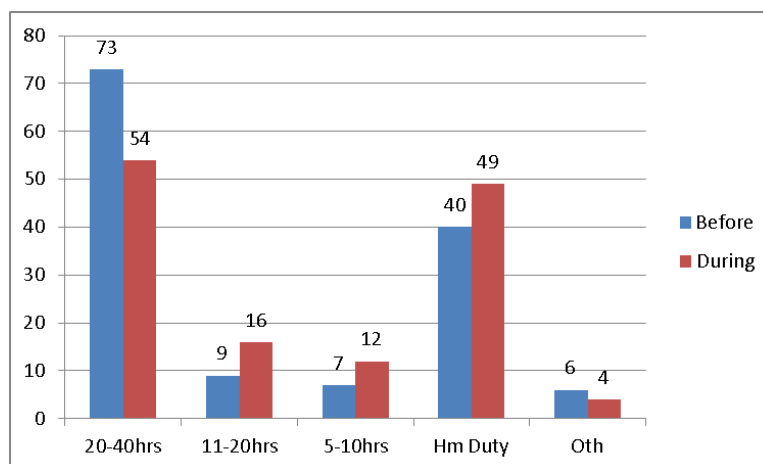


Figure 10. Working status before and during pregnancy.

Homebirth service of choice:

Approximately 79% (n=107) of the women received care from the Community Midwifery Program and 20.7% (n=28) received care from Privately Practicing Midwives. Approximately 70% (n=94) of the women had decided to have a homebirth prior to being pregnant; of the remaining 30%, the decision was made during pregnancy. When the decision was made during pregnancy, it was done on average at approximately 15 weeks gestation. In the case of nulliparous women, 50% wanted a homebirth before being pregnant, and for those making the decision during pregnancy, the decision was made on average at 13.6 weeks gestation.

Previous obstetric history:

There were 50 nulliparous and 85 multiparous women in this study. Just over half of the multiparous women (51.8%, n=44) had previous homebirths. Multiparous women previously had on average 1.6 babies; 56% (n=49) had one baby, 27.1% (n=23) had two, 11.8% (n=10) had three and 3.5% (n=3) had four babies.

Multiparous women were asked to report on the birth of their first baby, and 44.7% indicated they had planned to have a homebirth. Almost 66% of this sub group of women went on to achieve a homebirth. The average satisfaction score of these women was 4.7/5. Of the 13 women who did not achieve a homebirth, 12 births occurred in a hospital and 1 in a birth centre, 3 births resulted in a normal delivery, 8 resulted in an instrumental delivery and one resulted in a caesarean section. The average satisfaction score for these 13 births was 2.3/5.

In the case of the 47 multiparous women who did not intend to have a homebirth for their first baby, 4 births occurred in a birth centre and the remainder in hospital. Of the 43 hospital births, 66% were normal deliveries, 21%) were instrumental deliveries and 4.2% were caesarean sections. The average satisfaction score for all 47 women was 2.8/5. Of the 31 normal

deliveries which occurred in hospital, the average satisfaction score was 2.9/5.

For the 36 women who have had a second baby, 20 planned a homebirth and 18 (90%) of this sub-group achieved a homebirth, with an average satisfaction score of 4.7/5. Of the two women who did not achieve a homebirth, both had normal deliveries in hospital, with an average satisfaction score of 4.5/5. In the case of the 16 women who did not intend to have a homebirth for their second baby, 4 births occurred in a birth centre and 12 in a hospital of which only one resulted in an instrumental delivery, with the rest being normal deliveries. The average satisfaction score for all 16 women was 3.5/5, and for those women who achieved a normal delivery in hospital, the average score was 3.8/5.

In the category of the 13 women having their third baby, 11 planned and achieved a homebirth with an average satisfaction score of 4.8/5. Of the 2 women who did not intend to have a homebirth, one birth occurred in hospital (normal birth, satisfaction score 2.5/5) and the other at a birth centre (a normal birth satisfaction score 4/5).

Three women who participated in the study had 4 babies; of these, 2 planned and achieved a homebirth, and both scored 5/5 for their satisfaction. The third woman had a normal delivery at a birth centre and scored 4/5 for her satisfaction.

Figure 11 refers to the category of women who previously had babies, in relation to whether they had a planned homebirth and whether it was achieved. Figure 12 refers to the satisfaction of previous births.

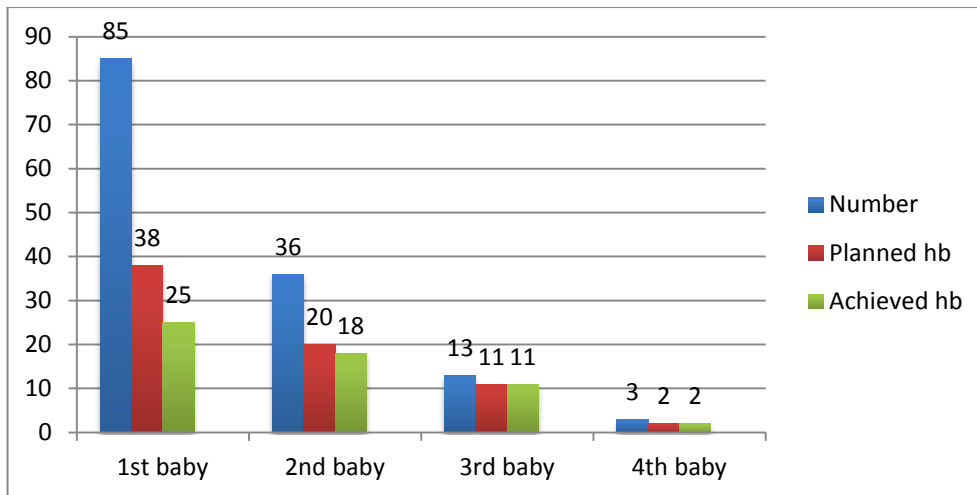


Figure 11. Previous Babies

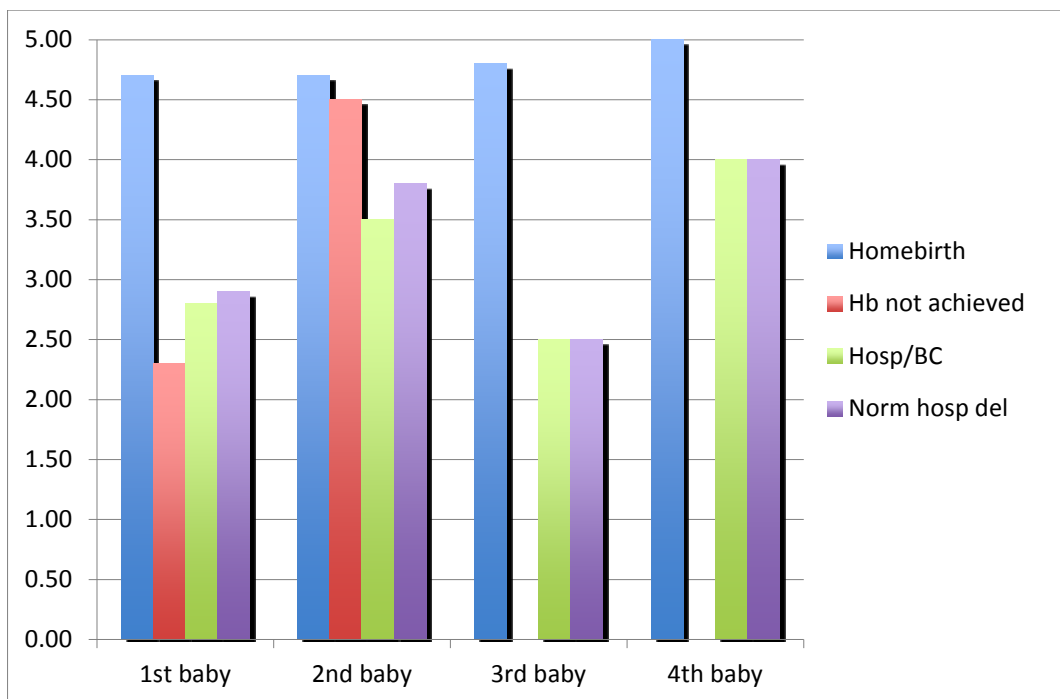


Figure 12. Satisfaction Scores.

Reasons for choosing homebirth:

Women were asked to select from 27 options for choosing to have a homebirth; in addition, they had the option to include up to 3 other reasons of

their own for making this choice. The three most prevalent reasons for choosing homebirth was firstly, wanting to avoid unnecessary intervention which applied to 95% of women, secondly, wanting to deliver in the comfort and familiarity of their own home (93%), and thirdly, wanting the freedom to make their own choices (86%). Other reasons ranked in the top 10, in order, were the desire to have more privacy (83%), wanting to be more involved (81%), being more natural (81%), having more control over the birth process (80%), wanting more continuity of care (79%), having a better birth experience (70%) and having more support (69%). Figure 13 illustrates the ranking of 10 of the most frequently selected reasons.

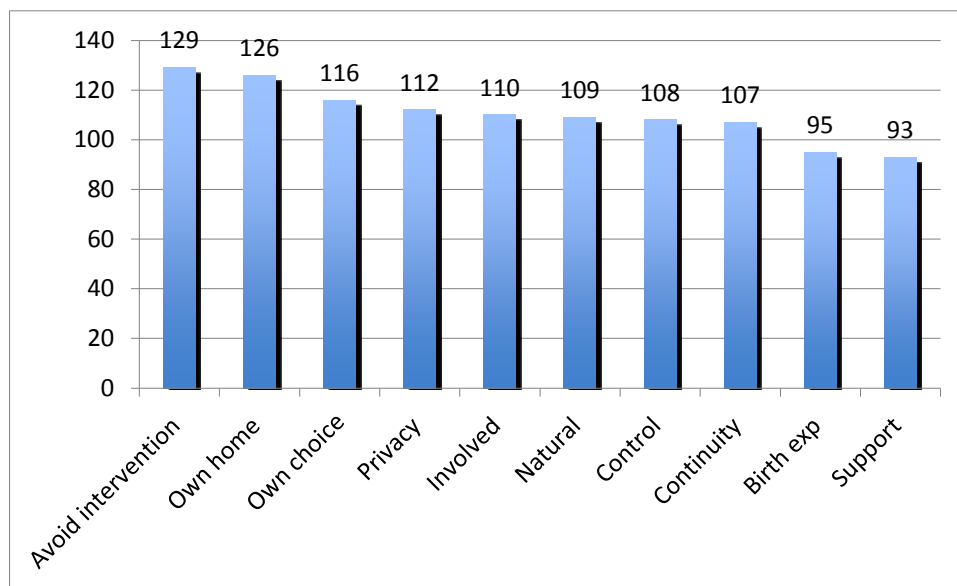


Figure 13. Top 10 reasons for choosing homebirth - all women

Women were given an opportunity to list their own reasons for choosing a homebirth and 35 participants did so. Having the ability to use a birth pool was listed most frequently (26%). A collective theme of avoiding pressure, being more relaxed and alleviating stress emerged as the next most common reason (26%). Singularly, avoiding drugs, not being separated from the partner or baby, and not feeling there is any medical need, emerged equally (8.6%). Other reasons included having previous very quick labours, and a spiritual connection with home.

Participants were asked to rank the three most important reasons they had chosen, and for all three ranking options, avoiding unnecessary intervention remained the most important priority.

For the selection of “most important reason”, avoiding unnecessary intervention was ranked first (26%), followed by wanting more continuity of care (11%) and having the freedom to make their own choice (10%).

For the second most important reason, participants again ranked avoidance of unnecessary intervention highest (25%), followed by freedom of making own choice (11%) and then the comfort and familiarity of the home (10%). The third most important reason, once more rated avoiding unnecessary intervention highest (12.5%), this was followed by the best birth experience (8%) and finally the comfort and familiarity of the home environment (7.4%).

When all three ranks are combined, avoiding unnecessary intervention remains the highest rating factor (21%), followed by the freedom of making own choice (9.6%), closely followed by the comfort and familiarity of home (8.8%) and continuity of care (8.3%).

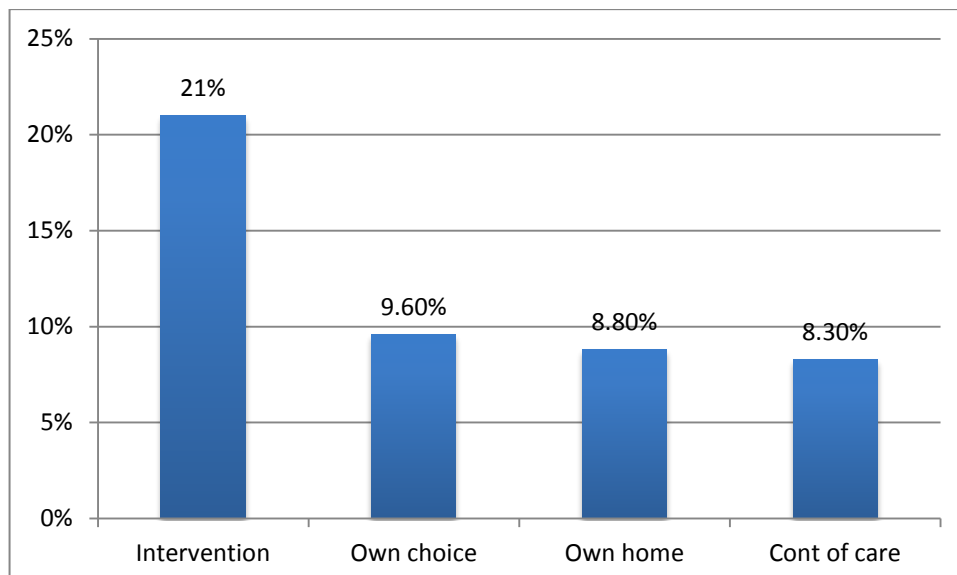


Figure 14. Combined 3 most important reasons – all women

Nulliparous women:

When comparing the responses of nulliparous women (n=50) to multiparous women (n=85) for the reasons for choosing homebirth, the nulliparous women selected avoiding unnecessary intervention most frequently as the reason for choosing homebirth (98%). This was closely followed by the comfort and familiarity of the home (94%), and thirdly, the freedom of own choice (92%). The rest of the top ten reasons were natural process (90%, more involved with decisions ranking equally with more privacy (88%), followed by having more control (86%), having more continuity of care (82%), being more bonded to the baby (74%) and lastly, having the best birth experience (70%). Figure 15 illustrates the responses of nulliparous women.

When asked to select the 3 main reasons for choosing a homebirth, nulliparous women also ranked avoiding medical intervention as the top reason for all 3. When the highest 3 reasons were combined in nulliparous women, avoiding intervention ranked the highest (72%), followed by the freedom of making own choices (38%), the comfort and familiarity of the home (30%); this was followed by having more control, being more natural and having continuity of care, all ranking equally (16%).

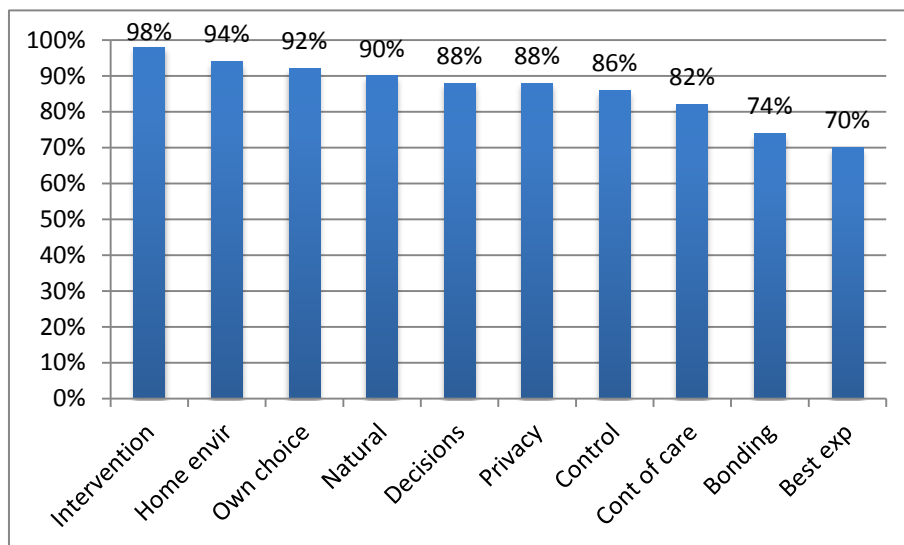


Figure 15. Nulliparous women – top 10 responses

Multiparous women:

Among multiparous women (n=85) avoiding unnecessary intervention was the most prevalent reason for choosing homebirth (95.2%), this was very closely followed by the comfort and familiarity of the home (94.1%), and thirdly freedom of making her own choice (83.5%). The remaining highest 10 reasons were privacy (81.2%), being more involved in decisions (78.8%), continuity of care (78.8%), having more control (77.6%), more natural (76.5%), receiving better support (74.1%) and having the best birth experience (71.1%). Refer to figure 16 below.

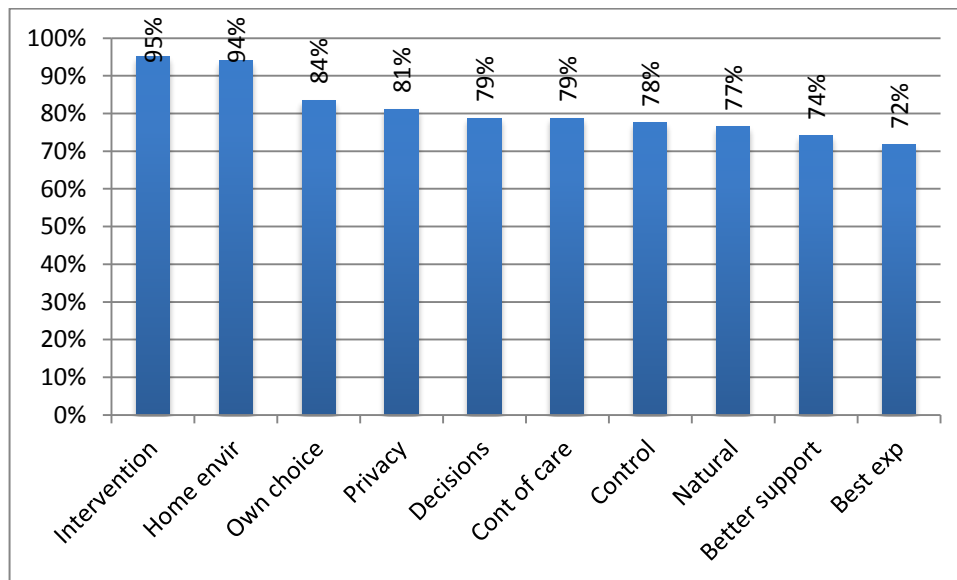


Figure 16. Multiparous women – top 10 responses

As in the case of all the women in the study, multiparous women chose avoiding unnecessary intervention predominantly across all 3 main reasons for choosing homebirth (59%). This was followed by continuity of care (30.5%), the comfort and familiarity of the home (25%) and the freedom to make own choices (23%).

Multiparous women were then separated into those who had previously experienced homebirth and those who had only experienced delivering in a hospital or birth centre. For women who previously had a homebirth (n=44),

the comfort and familiarity of the home equalled avoiding unnecessary intervention as the most prevalent choice (98%); this was followed by continuity of care and more privacy, with an equal prevalence (84%).

Multiparous women who had only experienced delivering in a hospital or birth centre (n= 41) chose avoiding unnecessary intervention most frequently (92.6%), followed by the comfort and familiarity of the home (90.2%), and the freedom of making own choices (85%). Interestingly, this group of women ranked continuity of care as 5th (73%).

Tertiary-educated women:

As Figure 16 highlights, when the responses of women with a tertiary education (n= 73) were examined, the comfort and familiarity of the home emerged as rating slightly higher than avoiding unnecessary intervention as the main reason for choosing homebirth. The third and fourth most frequent responses of continuity of care and more privacy ranked equally.

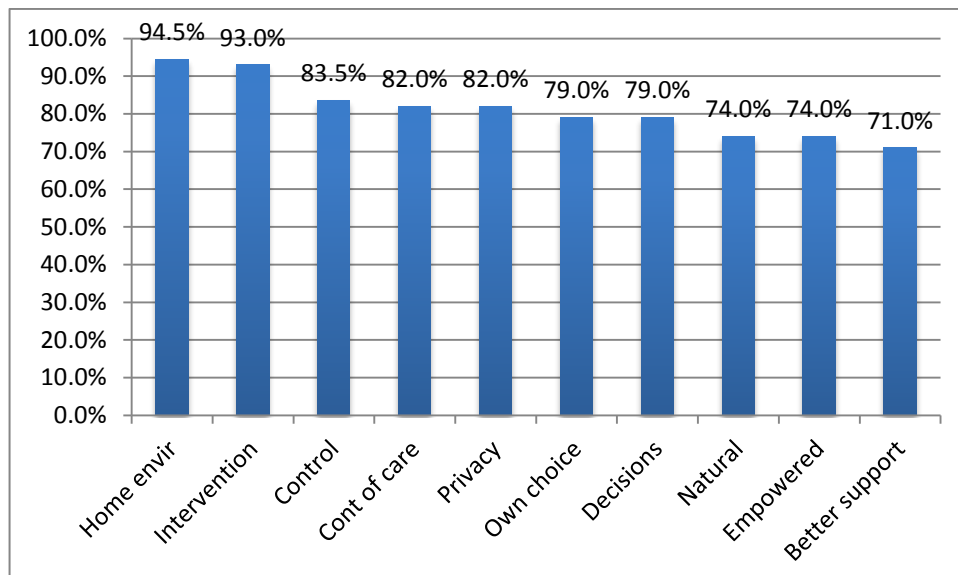


Figure 17. Tertiary educated women - top 10 responses

However, when the 3 most important reasons were examined in women with a tertiary education, avoiding unnecessary intervention ranked the highest for all 3; this was followed across all 3 with continuity of care and thirdly, the comfort and familiarity of the home environment.

Non-Tertiary Educated Women:

In the case of non- tertiary educated women (n= 62), avoiding unnecessary intervention was the highest ranked reason for choosing homebirth (98%). This was followed by the freedom of making their own choice (94%) and thirdly, the comfort and familiarity of the home (92%). For the 3 most important reasons, like tertiary educated women, the non-tertiary educated women also selected avoiding unnecessary intervention highest for all 3. This was followed by the freedom of making their own choice for the first and second reasons. The exception was the third choice category, in which having a better birth experience was ranked equally with having the partner involved.

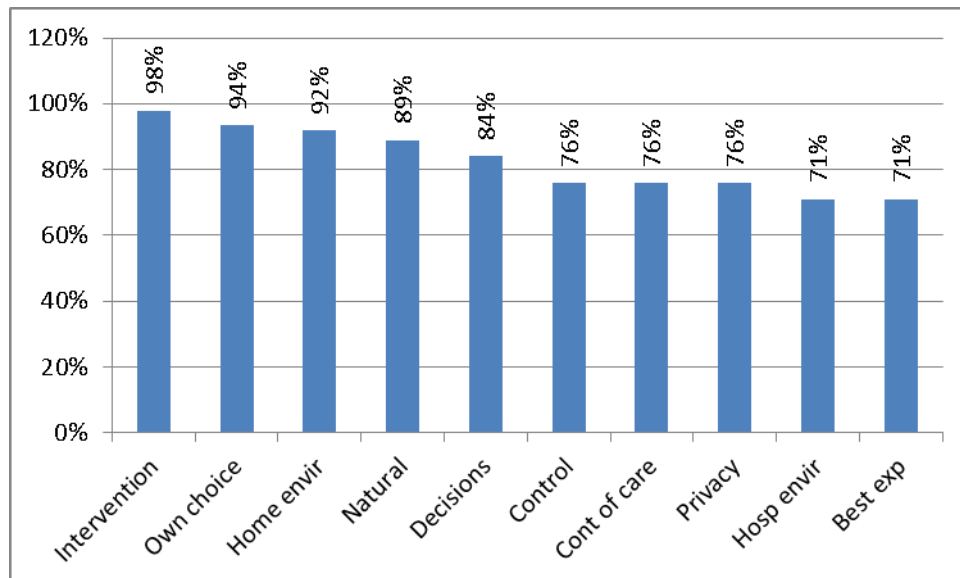


Figure 18. Non-tertiary educated women - top 10 responses

Importance of having a homebirth:

The women in the study were asked how important it was for them to have a homebirth. Their responses were ranked on a score from 1 to 5, with 1 being slightly important and 5 being very important. As in Figure 18, the mean score was 4.25/5 and ranged from 1-5. Almost half of the women (49.6%) scored the importance as 5/5, 29% scored 4/5 and 19.2% scored 3. Only 2.2% (n=3) scored 1 or 2/5. Nulliparous women's average rating score was 4.16/5, while women who had previously experienced a homebirth scored equally to those who had only experienced delivering in a hospital or birth centre (4.3/5).

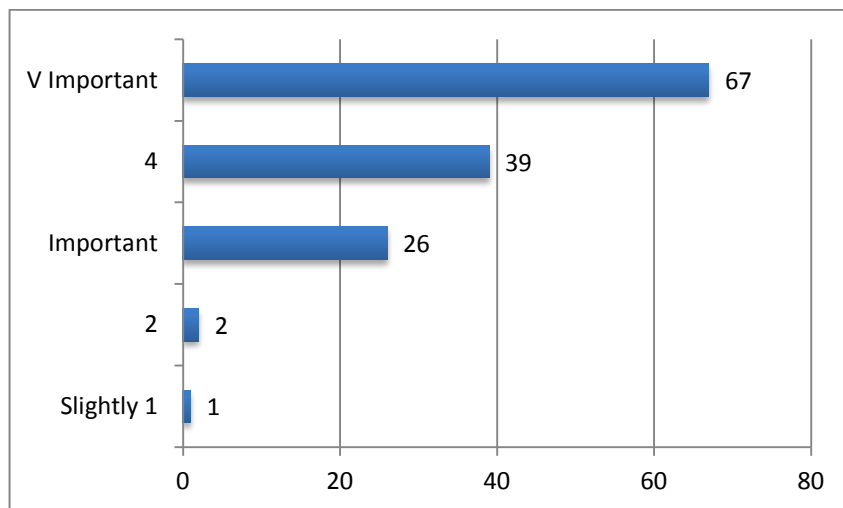


Figure 19. Importance of having a homebirth – all women

Support for choosing homebirth:

Women were asked how supportive their partner or spouse is of their choice to have a homebirth. Their responses were ranked on a score from 1 to 5, with 1 being slightly supportive and 5 being very supportive. The mean score was 4.62/5 with the majority scoring 5/5 (79.2%, n=107), with only 9.6% (n=13) scoring 4/5, and a continuing decrease for the remaining values. When comparing this among nulliparous women and those who had

previously had a homebirth and those who had not, the differences are extremely small and therefore unremarkable.

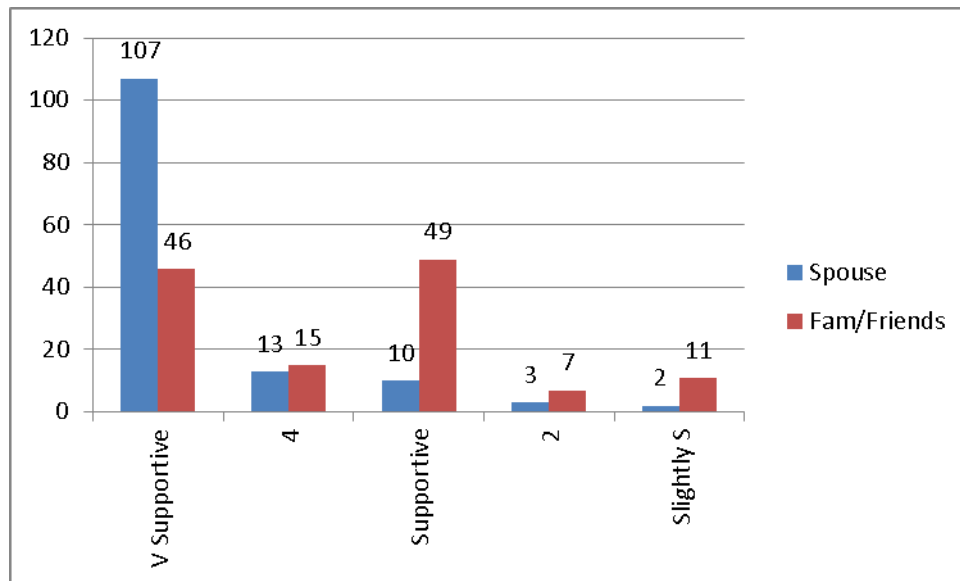


Figure 20. Support from spouse v Family/ friends for homebirth choice.

Women were then asked to report how supportive friends and family were of their choice to have a homebirth. The mean score was 3.68/5, 13% scored 1 or 2. Nulliparous women received the least support (mean =3.56) and women who had previously had a homebirth had the highest mean (4.04). Figure 20 illustrates the support received from the spouse in comparison to family and friends.

Confidence in birthing at home:

Women were asked to rank their confidence to birthing at home and ranked from 1 to 5, with 1 being slightly confident and 5 being very confident. The average ranking score to this response was 4.35/5, with women who had previously experienced a homebirth scoring slightly higher at 4.45/5, with nulliparous, tertiary educated women and previous hospital births only, scoring almost identically.

Safety of birthing at home:

Finally, women were asked to rank their perception of the safety of birthing at home and ranked from 1 to 5, with 1 being slightly safe and 5 being very safe. When asked how safe it was for them to birth at home, the women in this study responded on average at 4.6/5; this was consistent for those with a tertiary education, nulliparous women and those who had only had hospital births. Women who had previously had a homebirth scored slightly higher at 4.75/5.

Other Comments:

Women were offered the opportunity to share any further comments, and 44.4% (n=60) responded. The responses were summarised by key words and then grouped into themes, sub-themes and overarching themes and coded accordingly. The dominating emergent themes related to the perception and attitudes of the medical profession and the public, awareness of the option of homebirth, the women's personal beliefs and experience of homebirth and their perception of the hospital model of care.

References to medical practitioners (GPs and Obstetricians) were particularly dominant (28%), with comments reflecting a combination of a belief that GPs are unaware of the option of homebirth, or do not present homebirth as an option.

"I think GPs should present it as an option rather than automatically assume you want to go into hospital."

"It seems that most GPs are not well educated, informed or supportive of homebirths."

"The GP didn't seem to know a lot about the CMP, which is disappointing."

Other comments relating to GPs and Obstetricians reflect a negative attitude to the woman's decision and a purposeful intent to instil fear. Some women recounted the hostility they received from doctors.

“The rudeness and hurtfulness of comments from professionals has been shocking”.

“I have been lectured by an obstetrician of the ‘dangers’ of birthing at home.”

“Many women don’t even consider HB as an option because it is so demonised by the medical profession”

This theme of the attitude of the medical profession is echoed in women’s comments about the attitude of friends and relatives. In almost 12% of comments, the opinion of others appeared to be frequently fuelled by negative publicity, and resulted in a very negative reaction from relatives and friends to the women’s choice of a homebirth. Some women clearly felt ostracised and unsupported by their family and/or friends (similar to the lack of support they felt about the medical profession).

Other important overarching themes encompassing the medical profession related to the lack of information, lack of education and the need to promote homebirth as an option (26%). The women’s comments in relation to this suggested regret for not being aware of this option previously:

“In my two other pregnancy (sic) no one ever told me told me about this option and the opportunity of an homebirth.”

They also recognised the lack of information available to them, and believed that homebirth needs to be promoted more:

“I believe home birth should be offered to all low risk pregnant women as a viable option by their GPs”

Approximately 26% of women expressed positive feelings about homebirth, either based on their own experience, or what they anticipate they will derive from experiencing homebirth, or their perception on the concept of the homebirth experience. There were also references to the need for more education about homebirth for both the general public as well as health professionals in relation to homebirths.

Some women described their great satisfaction and gratitude for the CMP program (18%), while others commented on the lack of homebirth services in

rural areas and the resultant cost of having to engage a privately practicing midwife.

Women also expressed a belief in their physical and emotional capacity to birth at home, frequently because they perceive it as a natural process. (16%). The issue of intervention was also mentioned in 15% of the comments. These comments related to the concern about the amount of intervention in hospital births, the low threshold for intervening and the wish to avoid intervention.

Some comments referred to the hospital model of care (15%) and included feeling like a number, not wanting to utilise hospital resources unnecessarily, believing there is more risk within a hospital and a previous negative experience in hospital:

“Also this will save the government money and free up hospitals for people who actually need them.”

“Why take the risk to expose a brand new baby to a hospital environment?”

The issue of the fear relating to homebirth occurred in 13% of comments. The feeling was predominantly that there is a culture of fear:

“This should be supported more and not so much fear put in women about homebirthing.”

“There is still much fear that exists surrounding childbirth and this fear often increases a mothers need for medical intervention.”

Some comments reflected a belief that fears around childbirth are fostered by the medical profession. Interestingly, none of the women expressed personal fear of homebirth. From their perspective, the culture of fear around homebirth was generated and sustained by the medical profession.

Other women explained that a homebirth is ‘right’ for mother and baby, and some (10%) noted they were pleased this study was being conducted. Isolated comments referred to the need to allow women who had previously had a CS to have a homebirth, feeling that the governing homebirth

guidelines are restrictive, being dissatisfied with the care from CMP (1 case) and believing that choosing where to give birth constitutes a human right.

CHAPTER 5

DISCUSSION

This study highlights the unique features of women in Western Australia who elect to have a homebirth. However, when discussing why this group of women makes this choice, it should be done within the context of current obstetric and midwifery practice in WA, and the social construct of childbirth, as the choice to birth at home does not evolve in a vacuum. West Australian researchers Fisher, Hauck and Fenwick (2006) believed that childbirth takes place within a sociocultural and socio-political context which impacts on the manner in which women approach childbirth. In addition, they stated that the social context not only influences their construct and understanding of childbirth, but also shapes the dynamic of their individual experience. A similar view is held by McAra-Couper et al. (2011), who noted that “choice is always ‘situated’: it is powerfully influenced – and even predetermined – by the context and milieu in which women give birth” (p. 94).

At the heart of the debate is how society perceives childbirth, versus the women’s perception of childbirth - whether it is a medical condition which has to be medically managed or is a natural life event. An important finding emerging from this study is that women choosing to have homebirth do not view childbirth as a medical condition. Furthermore, they are aware of the trends in obstetric practice, prevailing medical opinion, and the perceptions of family and friends, as well as public opinion fuelled by the media. In addition some women are sceptical of the safety of mainstream hospital births.

In 2010, 1345 women in Australia gave birth at home, representing 0.5% of all women who gave birth. The states with the highest proportions (0.8%) were Victoria, Western Australia and the Northern Territory (Australia’s mothers and babies 2010). During that year 255 women in Western Australia had homebirths, out of 307 who intended to have a homebirth.

The majority of women (96.5%) in Western Australia give birth in a hospital, 2.5% in a birth centre and less than 1% have a homebirth (Joyce & Hutchinson, 2012). Currently, women who elect to have a homebirth have the choice of engaging either the services of the Community Midwifery Program (CMP), Midwifery Group Practice (MGP) or employing a Privately Practicing Midwife (PPM). The majority of women having homebirths use the CMP, which is publically funded. In this study, 79.3% (n=107) were receiving care from the CMP and 20.7% (n=28) received care from PPMs.

The demographic results of this study have some distinguishing features which may provide some degree of understanding for the choice of homebirth in this cohort. Of note, on average these women were slightly older with a higher socio-economic status and a tertiary education. These attributes, when combined, may confer a level of empowerment and enables the women to have more control of their lives and the choices they make, as well as the confidence to question the establishment.

The average age of the pregnant women in this study was 32 years, which is slightly older when compared to the national average of 30 and the WA state average of 29.6 (Australia's mothers and babies 2010). Nulliparous women in the study were also slightly older (30 years) when compared to the state average (28 years). Australian born women accounted for 64% of women in the study, 14% of the women were born in the United Kingdom and almost 9% in New Zealand. According to the 2010 Australia's mothers and babies report, 66.7% of women who delivered in WA were Australian born, 6.4% were born in the United Kingdom and 3.7% were born in New Zealand. Both the United Kingdom and particularly New Zealand have higher rates of homebirths than Australia (Cresswell & Stephens, 2007; Catling-Paull, Foureur & Homer 2011); 2% and 7% respectively, and may account for a higher proportion of these women represented in the study.

A noticeable demographic feature of this group of women is the high percentage (54%) with a tertiary education, with 29.6% having an undergraduate degree, and 24.4% completing a postgraduate degree. In comparison, two large WA studies of pregnant women reported rates of 24.4% (Newnham et al., 2009) and 27% (Brooks et al., 2009) as having a tertiary

education. An earlier study by Cunningham (1993) found that women having a homebirth had a higher level of education than the general population, and Jouhki's research with Finnish women revealed a similar pattern (2011).

The impact of the higher level of education in this cohort of women may be evidenced by their comments expressing concerns about the lack of information relating to the option of homebirth, indicating that these women had actively sought and researched information to reach this conclusion. Furthermore it is quite evident from the results that this group of educated women are willing to question the opinions and practices of GPs, obstetricians and midwives.

Another interesting finding is that approximately 70% of the women in this study had decided to have a homebirth prior to being pregnant, the remaining 30% of women decided during pregnancy, and on average had decided by 15 weeks gestation. This would indicate that the option of a homebirth had been carefully considered for a period of time and may also be a reflection of the higher education level in this cohort of women.

Amongst the sample, 63% of women (n=85) had given birth before and 37% (n=50) had not. The majority of women (78.8%) in this study who in previous pregnancies had planned a homebirth, achieved that end; this result is in keeping with other studies in which the achievement of planned homebirths ranged between 69.4% and 78.8% (Kennare et al., 2009; Janssen et al., 2009; Crotty et al., 1990).

For women having their first baby, 44.7% planned to have homebirth (n=38); this was achieved by 65.7% (n=25) of this sub-group. This is slightly higher than the rate reported by Hutton et al. (2009), where 59.5% of primiparous women achieved a homebirth.

On average the women who achieved a homebirth with their first delivery scored their satisfaction at 4.7/5. For those who did not achieve a homebirth, their average satisfaction score was significantly less at 2.3/5 (48% less than those who achieved a homebirth).

In the case of women who did not intend to have a homebirth for their first

delivery (n=47), the average satisfaction score was 2.8/5 for all types of deliveries. The score is fractionally higher (2.9/5) for women who did not intend a homebirth and achieved a normal delivery. For women who had a CS or an instrumental delivery in this category (planned hospital birth) the average satisfaction score was 2.05/5. In summarising the experience of first time mothers, they were more satisfied with their birth experience if they had a homebirth. If as a first time mother they had a normal birth in a planned hospital delivery, they were 36% less satisfied than women who had a homebirth. Both CS and instrumental deliveries were associated with lower satisfaction scores.

A higher percentage (90%) of women planning a homebirth with their second child, achieved a home birth; these figures are similar to Hutton et al. (2009) who reported an achieved rate of 88.6% among multiparous women. Women having their second birth as a homebirth were equally satisfied as mothers having their first birth at home. However, if they achieved a normal delivery in hospital they were only 18% less satisfied than women who had given birth at home. The satisfaction scores increased for births occurring at home for mothers having their 3rd and 4th births at home. (The numbers are too small in this study to comment on the satisfaction for those who did not plan to deliver at home.) In addition, 100% of women having their 3rd or 4th child and who had planned a homebirth, achieved this. In this study the rate of achieved homebirth increased with parity – 90% achieved the planned homebirth with their second birth and 100% with third and fourth births (as opposed to 65.7% first births).

This study clearly indicates that women who have had a homebirth are significantly more satisfied with their birth experience than women who have delivered in a hospital (even if they achieve a normal delivery in hospital). This is in line with the findings of several other studies (Christiaens & Bracke, 2007; Janssen et al., 2006; Cunningham, 1993; Fleming et al., 1998). The Homebirth in WA Study however has only examined the overall satisfaction and not individual elements of satisfaction.

In this study, wanting to avoid unnecessary intervention was the most

frequently selected reason women made for choosing to have a homebirth. This finding was independent of parity, level of education or previous birth experience. This was particularly dominant when women were asked to rank their three most important reasons for choosing homebirth; avoiding unnecessary intervention was ranked 54% more than the second most important reason, which was the freedom to make choices. There was only a difference of approximately 8% between the second and third ranked reason – the comfort and familiarity of the home environment.

The only exception was women who had previously had a homebirth, who rated the comfort and familiarity of the home as being slightly more important than avoiding unnecessary intervention. This may be attributed to the reassurance of having had a homebirth previously; therefore making it unlikely they would require obstetric intervention, in which case other reasons are likely to take precedence.

Avoiding unnecessary intervention is clearly a priority consideration when these women decide where to give birth. With more than half of the women being tertiary educated, it may indicate that the options are researched, questioned and carefully considered. The avoidance of obstetric intervention being most frequently selected from a list of 27 possible options for choosing homebirth was again highlighted when women chose to share additional comments. One woman in the study commented: *“science tells us that using ‘better’ technology creates even greater risks and needs even more intervention.”*

This comment is aligned to previous research by Boucher et al. (2009) and Possamai-Inesedy (2006), which concluded that women equated medical intervention with reduced safety, and contradicts the medical argument that intervention reduces risk and improves outcomes.

The CS rate for WA in 2010 was 33.6%, according to the Western Australia’s Mothers and Babies 2010, 28th Annual Report published by the WA Health Department. This is more than double the CS rate recommended by the WHO. The WA CS rate had risen steeply by 68% since 2000, when the rate was 23% (Figure 4). Similarly, homebirth rates in this state increased

significantly in this period of time by about 62%. The increase is particularly noticeable when compared to the national trend (Figure 3). Given the results of this study, the question has to be asked whether the increase in homebirth rates was in response to the increasing CS rate and climate of increased intervention in the aftermath of the Douglas Inquiry. In addition, it raises the question of public confidence by the end of the inquiry and impact this may have had on women's choice of where to give birth.

Importantly, women in this study distinguished between 'necessary' and 'unnecessary' intervention, in referring to *unnecessary* intervention as well as acknowledging there is a time when intervention is warranted:

"it's never going to be perfect and things can go wrong (e.g. my previous birth didn't go according to plan)"

"I believe it is the mother that delivers the baby not the doctors unless medical intervention is necessary."

Such comments suggest that women in this study had a balanced view on the need for intervention. Similarly, Kornelsen (2005) also found that homebirth participants had a balanced view, by recognising *unnecessary* intervention. This is despite the overarching goal of homebirth being to avoid intervention. Critics of homebirth, who assume that women who choose homebirth are opposed to intervention in its entirety, frequently overlook this balanced view. It could also be argued that constructing women who choose homebirth as being 'radical' women who reject any form of intervention, serves to undermine their legitimacy and credibility – and thus plays into the hands of the 'rational experts' (doctors) who are constructed as being able to make more objective decisions. So it may be that critics of homebirth either consciously or unwittingly promote this polarising view of homebirth advocates because it strengthens their own position.

The comfort and familiarity of the home and the freedom of making choices were also important considerations for the women in this study. There was a consistency among the three most important reasons women chose, when examined in relation to all the women and specific characteristics, namely

parity, level of education and a previous homebirth experience. The importance of continuity of care, although among the top 10 reasons for choosing homebirth, was not associated with any particular characteristics of the women.

Having a homebirth was regarded as being very important to the majority of women, with a mean score of 4.25/5, and almost half scoring the importance as 5/5. The women felt their partners were highly supportive of their choice to have a homebirth, with a mean score of 4.62/5 and a score of 5/5 in almost 80% of cases. However, the women felt their choice was less well supported by friends and relatives, with a mean score of 3.68/5. In addition, primiparous women felt even less supported. The lack of support from friends and relatives is also reflected in the comments shared by the women, which illustrates the impact of the societal construct in which women make the choice to have a homebirth. Comments by the women reflected an acute awareness of this lack of support:

I'm finding right now that people's perception of homebirth is hard to deal with, rather than any other aspect. It would be nice to be able to have a casual non-political or opinionated conversation about my choice of where to birth with my family (extended) and some friends.

I feel sad that some family members are adamantly opposed to my decision to birth at home "why take the risk?!"

...although we are both very excited and feeling v. confident re: birthing at home, we have decided not to tell anyone until afterwards to avoid the negative feedback that we feel we may get. We want to keep everything positive.

In contrast, Jouhki (2011) perceived that support from family and friends influenced woman to choose homebirth, while conversely, negative attitudes, particularly from health care professionals, was an inhibiting factor. Like Australia, homebirth is not supported in Finland, but also has a much lower rate of homebirth at 0.01% (Jouhki, 2011). Finnish women apparently encounter the same obstacles as women in Australia.

Women in this study also voiced their experiences of the lack of support, and in some cases overt criticism from GPs and obstetricians. The comments reflect a hostile environment in which they feel unsupported and criticised. They also commented on the negative publicity which has influenced public perception. Some women commented they had been branded as irresponsible and putting their baby at risk, and made to feel like a 'weirdo' or a 'hippie'. This is similar to the findings of Sjöblom, Idvall, Rådestad and Lindgren (2011) in which Swedish women who planned a homebirth reported they had been confronted with negative attitudes and feelings of hostility, as their decisions were contested by health care providers. This left them feeling alienated. However, rather than persuading them to choose a hospital birth, this Swedish study reported the negativity and lack of respect actually served to erode their confidence in conventional care and was a catalyst for considering other options. A similar dynamic was reflected in a comment from a woman in this current study:

The doctor labelled my midwives as "irresponsible" for "allowing" me to homebirth – even though it was admitted I was a low risk pregnancy! These comments have not only cemented my decision to homebirth, but have made me fearful of birthing in a hospital around medical staff with this attitude – I would not feel safe birthing in a hospital anymore.

One woman commented very strongly by saying:

Many women don't even consider HB as an option because it is so demonised by the medical profession - I myself never would've considered HB as an option, until I had the traumatic first birth that I did. This is a very sad state of affairs if this is how I came to choose it as an option for me.

Despite negative constructions of homebirth by medical professionals, the women's responses indicated a high level of confidence in having a homebirth, irrespective of parity, education or previous birth experiences (average score 4.35/5). Similarly, women scored their perception of the safety of homebirth highly (4.6/5) and this was slightly higher for women who

had a previous homebirth). Some of their comments reflected their belief that there was a 'culture of fear' and perceived that women were fearful of childbirth, and some blamed the medical profession for inciting this fear:

...general population do not know homebirth is an option and GPs put fear into women for thinking of it as a choice.

It is an excellent program and its' a shame there is so much fear and misconception surrounding giving birth and the ability of the mother to give birth along with having the baby at home - it should be encouraged and the norm not strange or 'hippie'.

There is still much fear that exists surrounding childbirth and this fear often increases a mother's need for medical intervention.

Women who plan a homebirth are very much a minority group. This study shows that their choice is carefully considered in what can be an unsupportive and sometimes hostile environment. Childbirth has become increasingly medicalised by society, and may no longer be perceived as a natural process, but instead a medical condition which has to be medically treated. The results of this study indicate very clearly that women who choose a homebirth are aware of the low threshold for intervention; they are clearly opposed to intervention and will resist intervention, especially when the intervention is deemed as unnecessary. Moreover, women choosing to have a homebirth have a clear view of the elements which for them will constitute a good birth experience and will work toward that end resolutely.

Limitations of this study

The limitations of this study in relation to understanding women's satisfaction of previous birth experiences, is that it only reports on the overall birth experience as opposed to the various dimensions/ facets of the birth which is reported in other studies such as continuity of care, freedom of choice and lack of intervention, and may therefore provide a more clearly defined and comprehensive view of satisfaction (this is however examined in detail in the

postnatal questionnaire in the larger WA Homebirth Study, but unfortunately is not within the scope of this thesis). Equally, investigating specific elements relating to safety would have yielded a more defined understanding of the women's perception of safety and is therefore a limitation of this study.

Strengths of this study

This study addresses a gap in the literature, especially within the contemporary West Australian and Australian context. This study will enhance the larger study essentially focused on perinatal outcomes, by providing a broader picture of women who choose to have a homebirth.

CHAPTER 6

CONCLUSION AND RECOMMENDATIONS

Research pertaining to homebirth has focused primarily on safety and perinatal outcomes. Other bodies of research have focused on comparisons of satisfaction between hospital births and homebirth, and by default the findings have been presented as the reasons why women choose homebirths. These assumptions are made in the absence of research which has specifically explored the opinions of women who have made this choice. This study has addressed this gap in the literature, by investigating the specific reasons why this minority group of women in Western Australia choose homebirth.

The current body of research directed at homebirth points to a disparity of expert opinion in relation to the perinatal outcomes and safety of homebirth, primarily as a result of a failure to distinguish high-risk women from low risk women. Satisfaction features strongly as a single facet, but is also integrated with intervention, continuity of care, and control. Intervention presents prominently in the literature as being complex, with an associated underlying matrix of professional risk-aversion, a litigious society, women's expectation of choice, the availability of technology in assisting childbirth, and escalating rates of caesarean sections.

It must also be recognised that childbirth in Australia is subject to strong social norms and values. The choice for a homebirth is made within a societal construct which reflects the attitudes of a medical hegemony, as well as prevailing social values and attitudes, and individual and social perceptions of childbirth as either a medical condition or a natural life event. Together, these factors serve to influence and facilitate or constrain women's choices.

Demographically, the women in this study are largely a homogenous representation of pregnant women in WA. The higher proportion of women

with a tertiary education - a key feature of the women in this study - suggests that these women carefully consider and research their options, and they also have the confidence to question current obstetric practice.

This study concurs with other research that demonstrates women who had a homebirth were more satisfied with their birthing experience than those who had a hospital birth, even if they had a normal delivery in hospital.

Specific reasons for choosing homebirth identified in this study provide a very strong indication that avoiding unnecessary intervention is the dominant reason for women making this choice, and is a reflection of their awareness of the current levels of unnecessary obstetric intervention. Moreover, as in previous research (Kornelsen, 2005), some women in the study made a clear distinction between necessary and unnecessary intervention. This is contrary to the common assumption by healthcare professionals that these women are opposed to all intervention.

Following intervention, women reported having the freedom to make their own choice, closely followed by the comfort and familiarity of their own home, as being the next most important reasons for their choice of having a homebirth. In essence, the women in this study wished to exercise their right to control their birth experience in the comfort and familiarity of their home.

Safety of homebirth was also highly scored by study participants. Echoing previous research (Jackson et al., 2012), women in this study also viewed safety from a perspective of avoiding unnecessary intervention, with comments indicating some women perceived hospitals as unsafe. It is interesting to note that the women and healthcare professionals viewed the issue of safety differently – with healthcare professionals focused solely on perinatal outcomes. In contrast, the women in this study adopted a broader interpretation of safety which encompasses a wider spectrum of the elements of homebirth.

Women reported a very high level of support for their choice from their partners, but received substantially less support from family and friends. This study demonstrates that this lack of support also extended to GPs and obstetricians, who were described by the women as critical and obstructive

of homebirth. It is evident this lack of support was a major obstacle for some women in this study, and they were very aware of this lack of support from GPs and obstetricians, as well as very critical of this attitude. They also believe there is an element of ignorance among some doctors about the homebirth service, as well as their interpretation of the safety of homebirth.

This study demonstrates that despite the fact that this group of women was well educated and had carefully considered and researched the option of homebirth, their choice was not respected by healthcare professionals and the community. The opinions and attitudes expressed by these women demonstrate their perception that childbirth is a natural process and not a medical condition. However, faced with a lack of support from health professionals, adhering to this belief can be an arduous task.

These women were unaccepting of the prevailing high levels of intervention, and questioned the practice of healthcare professionals. Contrary to prevailing social attitudes, they did not perceive childbirth as a medical condition and believed it was safe to birth at home. Despite demonstrating they were well informed, by acknowledging that there are circumstances which may require intervention, recognising that homebirth should be restricted to women of low obstetric risk, and carefully researching their options, these women were not afforded respect for the choice they make.

Importantly, research investigating homebirth cohorts needs to make a clear distinction between women of low and high obstetric risk, to eliminate the current ambiguity and scope for misinterpretation by both healthcare professionals and consumers. In addition, it is recommended that RANZCOG review its stance toward homebirth and strives for collaboration with the midwifery profession to reach a consensus. The current stance clearly influences the opinions of GPs and obstetricians, and is an obstacle for women trying to make this choice. A more critical use of perinatal morbidity and mortality statistics, as well as the inclusion of women's perspectives on this issue, may result in a more balanced view emerging.

Future research studies should be directed toward investigating specific elements related to the safety of homebirth, to obtain a clearer

understanding of what constitutes safety for these women. There is also a need to further investigate the women's perceptions of intervention, as this is clearly a major factor when considering the option of homebirth. It would be useful for healthcare providers to understand the threshold for intervention which these women may consider reasonable, and therefore diffuse some of the negative attitudes towards homebirth.

This study has indicated a perception that there is a level of ignorance or reluctance among GPs and obstetricians to present the homebirth option or information relating to homebirth services, and needs to be addressed. This suggests the need for a more concerted effort from the WA Health Department to raise the profile of homebirth in WA, to enable women to have access to the full spectrum of choices for childbirth.

Women who access homebirth services truly value the service and have a very high level of satisfaction. Given the long-standing level of dissatisfaction voiced by consumers of the WA healthcare system, the homebirth service should be acknowledged as successful, in that it produces high levels of satisfaction and is cost effective with good outcomes for women of low obstetric risk.

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Appendix 1 – Cover letter



WA Homebirth Study
Women and Infants Research
Foundation
PO. Box 134
SUBIACO 6914

Dear

Thank you for agreeing to participate in the WA Homebirth Study. Your contribution to this study will provide very valuable information, as the topic of homebirth in WA is lacking in much needed research. The results of our research will enable the women of WA to make better informed choices, for health professionals to have accurate information and also be an instrument in formulating policy and guidelines for safe practice.

Please find enclosed an information sheet which explains your participation in this study and is for you to keep. Please sign the consent form, complete the contact sheet and the questionnaire and return all 3 documents in the enclosed stamped envelope as soon as possible. All the information you provide is strictly confidential, your midwife and other health care providers will not have access to the information you provide. Your contact sheet will be separately stored to your questionnaire. Your questionnaire will only have a study number and will not identify you.

When your baby is approximately 4-6 weeks old, the postnatal questionnaire will be posted to you.

Please contact me if you have any queries relating to the study or if you require assistance to complete the questionnaire. My contact details are below.

With very best wishes for the rest of your pregnancy.

Yours sincerely,

Colleen Ball

Research Midwife and Coordinator
WA Homebirth Study
Women and Infants Research Foundation
Ph: 08 9340 1180
Mob: 0414 930 142

Appendix 2 - Information Sheet



Government of **Western Australia**
Department of **Health**
North Metropolitan Area Health Service
Women and Newborn Health Service

INFORMATION SHEET

Homebirth in WA Study

If you are currently planning a homebirth, we would like to invite you to participate in a study conducted by the Women and Infants Research Foundation and the King Edward Memorial Hospital for Women.

This study aims to describe the reasons why women may prefer a homebirth, how often they may choose or require hospital care in pregnancy or in labour after their initial intention to birth at home, and how satisfied are they with the pregnancy and birth care received either at home or in a hospital.

If you agree to be part of the study a research midwife will ask you to complete two questionnaires. The first questionnaire is about you and your pregnancy while you are still pregnant and the second questionnaire is about you and your baby's health between 4 to 6 weeks after your baby is born. We will also ask your permission to collect information from your own and your baby's medical records.

All information provided by you will be treated in strict confidence. We will remove your name and any personal information from the data collected. Study data will be securely stored in accordance with national research guidelines. Any reports generated during this study will not identify you or your baby.

Your participation in the study does not carry any risks to you or your baby. By participating you will contribute to the efforts to improve pregnancy care for pregnant women who choose homebirth in the future.

Your participation in this study is strictly voluntary and your withdrawal will not influence your care in any way. If you agree to participate and change your mind later, you can withdraw your consent at any time by contacting the research midwife listed in this information sheet.

If you would like more information about this study contact the research midwife, Colleen Ball on 9340 1182 or mob 0414 930 142 (e-mail: home.birth@wirf.com.au).

This study is approved by the Human Research Ethics Committee at King Edward Memorial Hospital and by the Human Research Ethics Committee at the WA Department of Health.

If you wish to make any comments or have any concerns or complaints about this study, please contact the Director of Medical Services at KEMH (telephone: 9340 2222) or contact directly the KEMH Ethics Committee monitoring the study on 9340 8221 (e-mail: kemhethics@health.gov.au).

Appendix 3 - Consent Form



Government of **Western Australia**
Department of **Health**
North Metropolitan Area Health Service
Women and Newborn Health Service

FORM OF CONSENT

PLEASE NOTE THAT PARTICIPATION IN RESEARCH STUDIES IS VOLUNTARY AND SUBJECTS CAN WITHDRAW AT ANY TIME WITH NO IMPACT ON CURRENT OR FUTURE CARE.

I have read
Given Names Surname

the information explaining the study entitled '**Homebirth in WA Study**'

.....
I have read and understood the information given to me. Any questions I have asked have been answered to my satisfaction.

I understand I may withdraw from the study at any stage and withdrawal will not interfere with routine care.

I agree that research data gathered from the results of this study may be published, provided that names are not used.

Dated day of 20

Signature

I, have explained the above to the
(Investigator's full name)

signatory who stated that he/she understood the same.

Signature

Appendix 4 - Contact Sheet

WA homebirth Study Contact sheet

Surname.....
First name.....
Street address.....
Suburb..... **Post Code**.....
Email.....
Home phone number.....
Work phone number.....
Mobile phone number.....

Please provide the contact details below of a close relative or friend who does not live with you, that we may contact if we cannot contact you directly.

Surname.....
First name.....
Street address.....
Suburb.....Post code.....
State..... Home phone number.....
Work phone number.....
Mobile phone number.....

FOR OFFICE USE ONLY

Date of birth.....
Due date..... Weeks pregnant.....
Recruited from..... Midwife's name.....
Recruitment date..... Study id.
Consent form
Prelim questionnaire

Appendix 5 - Questionnaire

STUDY QUESTIONNAIRE

Study number : _____

Today's date: _____ / _____ / _____

What is **your** date of birth: _____ / _____ / _____

1. What is your due date _____ / _____ / _____

2. How many weeks pregnant are you? _____ weeks

3. In which country were **you** born? (Please tick the box)

Australia

Other a) which country?.....

b) what year did you come to Australia?.....

4. What language is spoken most often in your home? (Please tick the box)

English

Other (*please specify*).....

5. What is your highest level of completed education?

Year 10 (equivalent)

Year 12 (equivalent)

Trade certificate or apprenticeship

Professional registration (non-degree) eg. Police

College diploma (TAFE/ Technical College)

Undergraduate University degree

Post Graduate University degree

Other (*please specify*).....

6. What has been your employment status? (Please tick the box)

Before pregnancy	During pregnancy
<input type="checkbox"/> Worked 20-40 hours / week	<input type="checkbox"/> Worked 20-40 hours / week
<input type="checkbox"/> Worked 11-20 hours / week	<input type="checkbox"/> Worked 11-20 hours / week
<input type="checkbox"/> Worked 5 - 10 hours / week	<input type="checkbox"/> Worked 5-10 hours / week
<input type="checkbox"/> Home duties	<input type="checkbox"/> Home duties
<input type="checkbox"/> Other	<input type="checkbox"/> Other

7. Are you **currently** receiving care from (tick one)

Public Community Midwifery Program

Privately Practicing Midwife

8. When did you decide you wanted to have a homebirth?

Before I was pregnant

At.....weeks

9. Is this your first baby?

Yes (go to question 27)

No

10. How many babies have you previously had?

Babies.

Please fill in the table below about your pregnancy and birth history:

	Were you planning to birth at home?	Where did you birth?	Type of birth	How satisfied were you with the overall birth experience?	Country where baby was born
1 st baby	Y <input type="checkbox"/> N <input type="checkbox"/>	Home <input type="checkbox"/> Hospital <input type="checkbox"/> Birth Centre <input type="checkbox"/> Other <input type="checkbox"/>	Normal birth <input type="checkbox"/> Vacuum/Forceps <input type="checkbox"/> Elective Caesarean Birth <input type="checkbox"/> Non-elective Score 1-5	

			Caesarean birth <input type="checkbox"/>	(5= highest)	
2 nd baby	Y <input type="checkbox"/> N <input type="checkbox"/>	Home <input type="checkbox"/> Hospital <input type="checkbox"/> Birth Centre <input type="checkbox"/> Other <input type="checkbox"/>	Normal birth <input type="checkbox"/> Vacuum/Forceps <input type="checkbox"/> Elective Caesarean Birth <input type="checkbox"/> Non-elective Caesarean birth <input type="checkbox"/> Score 1-5 (5= highest)	
3 rd baby	Y <input type="checkbox"/> N <input type="checkbox"/>	Home <input type="checkbox"/> Hospital <input type="checkbox"/> Birth Centre <input type="checkbox"/> Other <input type="checkbox"/>	Normal birth <input type="checkbox"/> Vacuum/Forceps <input type="checkbox"/> Elective Caesarean Birth <input type="checkbox"/> Non-elective Caesarean birth <input type="checkbox"/> Score 1-5 (5= highest)	
4 th baby	Y <input type="checkbox"/> N <input type="checkbox"/>	Home <input type="checkbox"/> Hospital <input type="checkbox"/> Birth Centre <input type="checkbox"/> Other <input type="checkbox"/>	Normal birth <input type="checkbox"/> Vacuum/Forceps <input type="checkbox"/> Elective Caesarean Birth <input type="checkbox"/> Non-elective Caesarean birth <input type="checkbox"/> Score 1-5 (5= highest)	

11. What influenced your decision to choose a homebirth in this pregnancy?
(Tick **all which apply to you**)

1. I want the freedom to make my own choices
2. I want to be more involved in decisions
3. I want the comfort and familiarity of delivering in my own home
4. I have a had a previous unsatisfactory experience giving birth in a hospital
5. I want to avoid unnecessary intervention
6. I don't like the hospital environment
7. Having a home birth will give me the best birth experience
8. I want to have more control over the birth process
9. My partner wants me to have a homebirth
10. My partner can be more involved
11. More natural

- 12. It is common in my culture to birth at home
- 13. My mother / sisters have had homebirths
- 14. My friends have had homebirths
- 15. I have been present at a homebirth
- 16. I will be empowered by birthing at home
- 17. It is best for me to birth at home
- 18. It is best for my baby to birth at home
- 19. I will be better bonded to my baby if I birth at home
- 20. I will receive more continuity of care
- 21. I will receive better care
- 22. I will receive better support
- 23. I will have more privacy
- 24. I am fearful of giving birth in a hospital
- 25. I have more choice of who I have present as support people
- 26. No need to leave other children at home
- 27. No transport worries
- 28. Other.....
- 29. Other.....
- 30. Other.....

12. What are the **3 most important reasons** for choosing to have a homebirth out of those selected by you in question 11?

(Please write down **number** in box.)

First most important reason

Second most important reason

Third most important reason

13. How important is it for you to have a homebirth?

(Tick the number which applies)

Slightly important

Important

Very important

1

2

3

4

5

14. If you have a partner, how supportive is your partner of your choice to have a homebirth?

(Tick the number which applies)

Slightly supportive

Supportive

Very supportive

1

2

3

4

5

Or

I don't have a partner

15. What level of support do you have from family and friends for your choice to have a homebirth?

(Tick the number which applies)

Slightly supportive

Supportive

Very supportive

1

2

3

4

5

Or

No family or friends available for support

16. How **confident** do you feel about birthing at home?

(Tick the number which applies)

Slightly confident

Confident

Very confident

1

2

3

4

5

17. How safe do you believe it is for you to birth at home?

(Tick the number which applies)

Slightly safe

Safe

Very safe

1

2

3

4

5

18. Are there any further comments you would like to share with us?

.....

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Thank you for completing this questionnaire.

Appendix 6- CMP Homebirth Inclusion Criteria

Policy for Publicly Funded Homebirths including Guidance for Consumers, Health Professionals and Health Services

Inclusion criteria and prerequisites for a home birth

Women accessing publically funded planned home birth programs must be considered to be at low risk of pregnancy and birth complications and meet the following criteria:

- is over the age of 18
- has the capacity to give informed consent.
- live within a geographical boundary no further than 30 minutes from a maternity service
- has received regular antenatal care, with a health professional beginning in the first trimester, in line with recognised guidelines
- has booked into the home birth program by 35 weeks of pregnancy
- have a singleton pregnancy
- at the time of labour has a cephalic presentation of gestational age between 37 and 42 weeks
- is free from pre-existing medical or pregnancy complications (as stated in the exclusion criteria in Section 3.2)
- has a suitable home environment including but not limited to:
 - clean running water and electricity
 - has easy vehicular access (that includes access by vehicles in the event transfer during labour is warranted)
 - general home cleanliness with ability to provide hygienic sanitation

Exclusion criteria for planning a home birth

Women will be ineligible for a planned home birth if on initial assessment any of the following exclusion criteria apply.

Previous obstetric history:

- caesarean section
- postpartum haemorrhage in excess of 1000 mL
- shoulder dystocia
- retained placenta requiring manual removal
- perinatal death at term of a normally formed infant.

Medical history:

- pre-pregnancy BMI > 35
- any significant medical condition
- uncorrected female genital mutilation

Social determinants of health:

- domestic violence
- alcohol and/or drug dependency of woman and/or family member

Other factors for consideration:

Where the following conditions apply to either the woman or the baby they should be referred for consultation with an Obstetrician/Neonatologist/allied health professional to determine the appropriate clinical pathway:

- will not accept blood and blood products if required
 - previous baby with Group B Streptococcus (GBS) neonatal sepsis
 - newborn or child at risk of harm
-

Appendix 7 - Glossary

GLOSSARY

Antenatal – during pregnancy

Cephalic presentation – baby presenting head first

Induced labour – labour is brought about usually by administering a synthetic hormone (oxytocin)

Instrumental delivery – the baby is delivered vaginally with the assistance of forceps or vacuum

Intrapartum – during labour

Intrapartum asphyxia –lack of oxygen to the baby via the placenta occurring during labour

Multiparous – a woman who has given birth more than once

Nulliparous – a woman who has never given birth

Parturient – pertaining to the act of childbirth

Perinatal – the period from 20 weeks gestation to 28 days after birth

Postnatal – after the birth for up to 6 weeks

Primiparous – first birth