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PUBLICLY-FUNDED HOMEBIRTH IN VICTORIA, AUSTRALIA: EXPLORING THE VIEWS AND EXPERIENCES OF MIDWIVES AND DOCTORS

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ABSTRACT

Objective: To explore midwives' and doctors' views and experiences of publicly-funded homebirthing models.

Design: Cross-sectional survey implemented two years after the introduction of publicly-funded homebirthing models.

Setting: Two public hospitals in Victoria, Australia.

Participants: Midwives and doctors (obstetric medical staff).

Main outcome measures: Midwives' and doctors' views regarding reasons women choose homebirth; and views and experiences of a publicly-funded homebirth program, including intrapartum transfers.

Findings: Of the 44% (74/167) of midwives who responded to the survey, the majority (86%) supported the introduction of a publicly-funded homebirth model, and most considered that there was consumer demand for the model (83%). Most thought the model was safe for women (77%) and babies (78%). These views were stronger amongst midwives who had experience working in the program (compared with those who had not). Of the 25% (12/48) of doctors who responded, views were mixed; just under half supported the introduction of a publicly-funded homebirth model, and one was unsure. Doctors also had mixed views about the safety of the model. One third agreed it was safe for women, one third were neutral and one third disagreed. Half did not believe the homebirth model was safe for babies. The majority of midwives (93%) and doctors (75%) believed that intrapartum transfers from home to hospital were easier when the homebirthing midwife was a member of the hospital staff (as is the case with these models).

Key conclusions and implications for practice: Responding midwives were supportive of the introduction of publicly-funded homebirth, whereas doctors had divergent views and some were concerned about safety. To ensure the success of such programs it is critical that all key stakeholders are engaged at the development and implementation stages as well as in the ongoing governance.

Highlights:

- Midwives' and doctors' views of publicly-funded homebirth have not previously been investigated.
- Midwives (in particular those who had experience working in the program) were very supportive of publicly-funded homebirth for women and most considered there was consumer demand for the model. Most believed the model was safe for women and babies.
- Doctors had mixed views about publicly-funded homebirth. Some were supportive, some considered there to be consumer demand, and some considered it to be a safe model (others did not).

Keywords: homebirth, models of care, maternity care, place of birth

Introduction

Although the majority of Australian women give birth in hospital, a small proportion (0.4%) choose to give birth at home (Australian Institute of Health and Welfare 2014). Like many developed countries, homebirth is a contentious issue in Australia, with debate surrounding its safety when compared with hospital birth (Bryant 2009). Until recently, women in Australia wanting to choose a homebirth could only access this privately, with most having care provided by midwives in private practice (Catling-Paull, Foureur et al. 2012). In

response to consumer demand (Bryant 2009, Dahlen H 2011), various publicly-funded homebirth services have been established in the majority of Australian states and territories (Catling-Paull, Foureur et al. 2012). The publicly-funded programs are usually available to women at low medical or obstetric risk (with strict inclusion criteria), are based within the public hospital system and are usually embedded within a midwifery group practice with obstetric consultation and referral as needed (Catling-Paull et al., 2012).

Differences in professional attitudes towards homebirth have often been along disciplinary lines, with midwives more likely to be supportive of planned homebirth, and medical staff more likely to view homebirth as unsafe (Vedam, Schummers et al. 2012, Vedam, Stoll et al. 2014). A survey of nurse-midwives in the United States concluded that educational and clinical exposure influenced attitudes towards planned homebirth, as did logistical, inter-professional and environmental factors (Vedam, Stoll et al. 2009, Vedam, Aaker et al. 2010). The Canadian Birthplace Study also identified differences in experiences of, and attitudes towards planned homebirth between registered midwives and medical professionals (family physicians and obstetricians) (Vedam, Stoll et al. 2014). Registered midwives who had greater exposure to homebirth were less likely to view homebirth as unsafe. All groups reported uncomfortable inter-professional relationships around planned homebirth. Family physicians and obstetricians reported discomfort in discussing planned homebirth with women.

An earlier United Kingdom (UK) study of full-time community midwives concluded that quality, rather than extent of experience was most influential in shaping attitudes to planned homebirth (Floyd 1995). Negative attitudes resulted from lack of specific skills (such as intravenous cannulation, perineal suturing and resuscitation), inadequate support, doctors'

attitudes and confusion about emergency cover. In 2009, two publicly-funded homebirth programs (called ‘the homebirth program’ hereafter) were introduced in Melbourne, Australia as part of a Victorian Government-funded pilot. Casey Hospital (part of Monash Health) is located in the south eastern suburbs and has approximately 1300 births per year (Southern Health 2011). Sunshine Hospital (part of Western Health), located in the western suburbs of Melbourne is situated in one of the most culturally diverse municipalities in Australia and has over 3,700 births per year (Western Health 2010). The two sites were chosen as pilot sites by the Victorian Department of Health because they both already operated a caseload (primary midwife-led continuity of care) model, had midwifery staff interested in working in homebirth, and had management support for the program (Department of Health 2011). Both hospitals also had well developed clinical governance structures, policies and procedures to operate their homebirth programs (Department of Health 2011). As part of the pilot, the Victorian Department of Health commissioned an independent external evaluation, comprising six components. These were consultation with key stakeholders; a review of relevant documentation; a survey of women who enrolled in the homebirthing pilot program; a survey of midwives working at each site (including midwives caring for women who planned a homebirth and those caring for women who planned to birth in hospital (‘standard care’)); a survey of obstetric medical staff working at each site/hospital; a review of clinical outcome data; and an economic evaluation of the program (Department of Health, 2011).

This paper reports on two components of the evaluation, and aims to describe and compare midwives’ and doctors’ views regarding reasons women choose homebirth and explore their views and experiences of a newly established publicly-funded homebirth program. To our knowledge the views of midwives and obstetric medical staff in the context of publicly-funded homebirth programs have not been previously studied in Australia.

Methods

This study used a cross-sectional survey design. All full and part-time midwives and obstetric medical staff (including residents, registrars and consultants; called doctors hereafter) at Casey and Sunshine Hospitals (whether or not they were directly involved in the homebirth program) were invited to complete an online questionnaire.

The questionnaire was based on previous Victorian studies investigating midwives' views of maternity care models (Forster, McLachlan et al. 2009, Morrow, McLachlan et al. 2013, Newton, McLachlan et al. 2014) modified as necessary, and then piloted. Wherever possible, the survey questions and response options for doctors matched those for midwives. A project advisory committee comprising key stakeholders was convened by the Department of Health to provide input into the implementation and evaluation of the pilot. This group met with the research team a number of times during the evaluation, and provided feedback on the evaluation strategy, methods and content.

The questionnaire included mainly fixed choice questions exploring midwives' and doctors' views on why women choose planned homebirth; views about, and experience of the homebirth program operating at their hospital; perceived impact of the program; possible improvements to the program; and background/demographics. A small number of open-ended questions provided an opportunity for further comment.

Views and experiences of homebirthing and the publicly-funded homebirthing pilot program were explored under the following themes: perspectives on homebirthing, knowledge of the hospital's homebirthing program, criteria and guidelines, safety, support for the program and working in the program. Under each theme investigated, midwives and doctors were asked their views about a series of statements; they were invited to respond using a 5-point Likert

scale with the following options: 1 = 'strongly disagree', 2 = 'disagree', 3 = 'neither disagree nor agree', 4 = 'agree', 5 = 'strongly agree'.

An e-mail invitation to participate, which included an information statement, a description of the study and a web-link to the questionnaire, was distributed by a hospital manager at the respective sites. Hospital managers were unaware if staff chose to participate in the survey and had no access to responses. The researchers had no access to identifying information concerning participants and received responses with no identifiers. These features reinforced the evaluation's independence and ensured staff privacy and participant protection. Completion of the questionnaire was considered consent to participate.

The hospitals sent reminder emails to invitees at two fortnightly intervals. At the time of the second reminder, the number of responses was lower than expected so following ethical approval, hard copy questionnaires with prepaid addressed envelopes were also distributed by the project coordinator.

Once questionnaires were developed, they were loaded onto Survey-Monkey (SurveyMonkey.com 2011) for completion by respondents. Hard copy survey data were added manually to the electronic survey data, then exported to STATA version 11 for analysis (StataCorp 2011). Questions with fixed choice response options were described using frequencies and percentages. Given the small number of medical practitioners that responded to the survey and the potential for identification of individuals, percentage values only are used in the reporting of data for medical practitioners (including in the tables). The Chi square test was used to compare responses of midwives with homebirthing program experience to those without. Simple thematic analysis was used for the open-ended questions. Data for the two sites are presented together in order to maintain anonymity of the respondents.

Results

Participant characteristics

In total, 74 (44%) of the 167 midwives and 12 (25%) of 48 doctors responded to the survey. Table 1 shows the characteristics of respondents. Midwives had between less than one year and greater than 15 years of experience in midwifery, and between one and ten years' experience at their respective hospitals. Approximately one quarter of the midwives had undertaken hospital-based midwifery education programs, one third had completed undergraduate university programs and one quarter had completed a Postgraduate Diploma in Midwifery. Just under half of the midwives rotated through different clinical areas in maternity care. The remainder were caseload midwives who provided homebirth care (19%), caseload midwives who did not provide homebirth care (9%), midwives who worked in only one clinical area (12%) and midwives in consultant and/or management roles (15%). Of the responding doctors, 58% had more than 15 years' experience in obstetrics and 92% had been working at the respective hospital for over one year. Fifty percent were consultant obstetricians, 42% registrars and one was a General Practitioner/Obstetrician (Table 1).

Experience with homebirthing

One third of the midwives and two thirds of doctors had experience with homebirth *prior* to the introduction of the program (Table 1). Prior experience included working in a different hospital that offered homebirth, providing back-up at a homebirth and/or personal experience with self, family or friends. Regarding the homebirthing pilot program, one fifth of responding midwives were working in the homebirthing program. Doctors' experience of caring for women enrolled in or transferred out of the homebirthing pilot program was limited. Most (83%) had not provided antenatal care to any of the women participating in the

program and most had not, or could not remember, caring for women after a transfer from the homebirthing program.

Midwives' and doctors' views about homebirth

Perspectives on 'planned homebirth' as a model of care

Midwives and doctors were asked their views about a series of statements concerning homebirth generally and also about the homebirth program being piloted at their hospital (Table 2). Among midwife respondents there was strong support for homebirthing models of care. Eighty-six per cent thought Australia's public health system should offer 'planned homebirth' as a model of maternity care, although only to women at low obstetric risk. The majority (88%) also thought such a model should operate at the hospital where they worked, and 'agreed' or 'strongly agreed' that there was demand for a homebirthing program (83%). Doctors' responses were far more mixed. Just under half (42%) thought Australia's public health system should offer 'planned homebirth' as a model of maternity care, and one third thought that a homebirthing program should operate at the hospital where they worked. Half of the doctors were unsure whether or not there was demand for the program at their hospital (Table 2).

Safety

The majority of midwives believed the homebirthing program at their hospital was safe; three quarters thought it was safe for women and babies while two thirds felt it was 'safe' for hospital staff (Table 2). Some doctors expressed concerns about the safety of the homebirthing program. One third or less 'agreed' or 'strongly agreed' that the program operating at their hospital was safe for women, safe for babies and 'safe' for hospital staff (Table 2). Between one quarter and one third responded that they neither disagreed nor agreed with these statements, while between one third and one half 'disagreed' with them.

Support for the homebirthing program

Support for each hospital's homebirthing program was explored. Around three quarters of both midwives and doctors responded that the homebirthing program was supported by hospital management, and similar proportions of midwives and doctors agreed that the homebirthing program was supported by midwives. Midwives were less likely than doctors to 'agree' that the homebirthing program was supported by doctors (Table 2).

Level of experience and education for midwives providing care at home

Two-thirds (68%) of the responding midwives and 92% of responding doctors 'agreed' or 'strongly agreed' that midwives working in a homebirthing program need further *education* in addition to that provided in their entry to practice programs (Table 2). Further, 81% of midwives, and all doctors, thought homebirth midwives need specific preparation to understand how to work within the program. The need for homebirthing midwives to acquire extra *skills* was also investigated; three-quarters of the midwives and all of the doctors thought this was necessary. We specifically asked if midwives attending homebirths should have the following additional skills: advanced neonatal resuscitation skills, the ability to insert an intravenous cannula, and perineal suturing skills. Each of these skills was believed to be essential by most of the midwives and all of the doctors. Other scenarios where additional specific skills were mentioned were adult resuscitation, and obstetric emergencies such as postpartum haemorrhage and retained placenta. A number of midwives also commented on the need for additional skills in communication and negotiation.

When midwives were asked to indicate the minimum level of midwifery experience a midwife should have prior to providing labour and birth care in a woman's home, one quarter (24%) considered a minimum of five years and half (48%) thought between one and four years' experience was required. Doctors considered midwives should be very experienced

before caring for women in a homebirthing model. Three quarters thought the minimum midwifery experience required was five years or more, with 58% thinking it should be six years or more.

Views about transfers from home to hospital

A number of questions were asked to explore midwives' and doctors' views regarding women being transferred from home to hospital (Table 3). The vast majority of midwives (93%) and doctors (75%) 'agreed' or 'strongly agreed' that compared with private homebirth models, intrapartum transfers are easier when the transferring midwife is a member of the hospital staff. In response to a statement that 'developing rapport between hospital midwives and women after intrapartum transfer could be difficult', only around a quarter of both doctors and midwives 'agreed' or 'strongly agreed' with the statement. Half of the responding doctors felt 'comfortable' being responsible for the care of women who were transferred out of the homebirthing program, while less than half (42%) thought women were comfortable having them being responsible for their care after transfer (Table 3).

Midwives' and doctors' views on why women choose homebirth

A list of reasons why women might choose a homebirth was included in the survey, and midwives and doctors were asked to rate these. Most thought women choose homebirth because of attributes intrinsic to the home environment, and considered that women 'often' or 'very often/always' choose a homebirth because they feel most comfortable in their own home, want a natural birth, want greater control over their birth and/or want the privacy of their own home (Table 4). The hospital environment/previous experience featured slightly less as an explanation for respondents' impression of women's choice to birth at home. Around one third or less of responding doctors and midwives thought women 'often' or 'very often/always' chose homebirthing because of a fear of hospitals or doctors, although two

thirds of midwives and 42% of doctors thought women were 'often' or 'very often' influenced by a previous negative experience in hospital.

The role of support people was less frequently endorsed as an explanation for women's choice to birth at home, and midwives and doctors differed in their views. Sixty percent of midwives, compared with 17% of doctors, considered that women choose homebirth so that they can have other children present during labour and birth; and most (58%) midwives compared with 17% of doctors considered that enabling a woman's partner to play a stronger advocacy role is 'often' or 'always' a reason women choose homebirth.

Comparing the views of midwives with and without experience of the homebirthing program

We compared the responses of midwives who had experience with the homebirthing program to those without, given this might be a key factor affecting their views. Midwives who had experience with the homebirthing program were more likely to agree that Australia should offer planned homebirth (100% versus 80%; $p=0.007$); that a publicly-funded program should operate at their hospital (100% versus 84%; $p=0.001$); and that there is consumer demand for publicly-funded homebirth programs (100% versus 76%; $p=0.02$). Midwives with experience in the program were also more likely to consider the program safe for women (100% versus 71%; $p=0.01$), and babies (100% versus 71%; $p=0.01$), and less likely to think that homebirth midwives should have extra education (35% versus 78%; $p=0.02$). Similar comparisons of doctors were not possible due to the small number of doctors who participated in the study.

Discussion

Most responding midwives supported the introduction of publicly-funded planned homebirth, but considered that such programs should only be available to women at low obstetric risk.

Most midwives felt that the homebirth program was safe for women, babies and hospital staff. Nearly all believed that intrapartum transfers from home to hospital were easier when the homebirth midwife was a member of hospital staff. However, attitudes amongst doctors towards planned homebirth and the pilot homebirth program were mixed, and some respondents were concerned about the safety of the programs.

Views on why women choose homebirth were similar between doctors and midwives. Both groups believed that women's primary reasons relate to women feeling comfortable giving birth in their own home, seeking greater control over their experience and preferring a natural birth. These were also the key reasons noted by women who participated in the homebirth programs (Department of Health 2011). However, compared to the results of the survey of women, both midwives and doctors overestimated the extent to which women were motivated by negative factors, such as previous negative experiences in hospital or fear of doctors or hospitals (Department of Health 2011).

Different views were offered as to the safety of homebirth, with midwives being much more confident about its safety than doctors. This is similar to the findings of the Canadian Birthplace Study, in which midwives, family physicians and obstetricians all believed their views to be evidence-based, despite these views differing considerably (Vedam, Schummers et al. 2012). The strong differences may reflect professional acculturation in the respective disciplines of midwifery and obstetrics and different interpretations of the evidence regarding the safety of homebirth. Vedam (2014), for example, argues that scientific evidence can often be interpreted and understood through a pre-existing lens that accords with different types of care providers' philosophy of practice and comfort level (Vedam, Stoll et al. 2014).

Clinicians' views differed about whether planned homebirth should be offered in the Victorian public health system. Almost all women who participated in the homebirth

programs thought it should be offered, even amongst those who transferred out of the program (Department of Health 2011) and the majority of midwives agreed. However, doctors' views were mixed, reflecting their varied opinions about the safety of homebirth.

Doctors were also more likely to be neutral about whether there was demand for homebirth in their hospital compared to midwives; the majority of the latter group believed there to be demand. It may be that midwives, who care for most women with low-risk pregnancies in Victorian public hospitals, are more likely to have a sense of demand. It is also possible that demand may increase as the programs become more established and better known.

As with other studies (Floyd 1995, Davies, Hey et al. 1996), doctors and midwives agreed that midwives working in homebirth need advanced neonatal resuscitation, cannulation and suturing skills. Support for the idea that additional clinical education of midwives offering homebirth care should take place, extending to skills such as the management of malpresentation and obstetric emergencies such as postpartum haemorrhage, is also in line with other studies (McCormick, Collis et al. 2013).

In this study, few doctors had experienced any direct involvement or contact with women in the homebirthing pilot programs. Given our findings regarding midwives' experience with the program (that is, that more exposure was associated with more support for homebirthing) and the findings by Vedam and colleagues (Vedam, Stoll et al. 2014) in Canada, (that level of exposure to homebirth either during clinical practice or education was associated with higher favourability scores towards homebirth), it is possible that over time the level of comfort doctors feel towards the program may increase.

Strengths and limitations

This is the first study to describe and compare the views and experiences of midwives and doctors involved in an Australian publicly-funded homebirth pilot program. The response fraction for midwives is comparable with other surveys of midwives in Victoria (Morrow, McLachlan et al. 2013, Newton, McLachlan et al. 2014) and the response fraction of 25% for doctors is comparable with other Australian surveys of doctors' views (Varughese, Janda et al. 2014, Wilkinson, de Crespigny et al. 2014). Some of the reasons for poor response rates for doctors appear to be busy work schedules, being frequently approached to respond to surveys, and sometimes gatekeeping by staff (Flanigan, McFarlane et al. 2008).

Nevertheless, the results for both midwives (a relatively high proportion of whom had experience with homebirth) and doctors cannot be assumed to be representative of the attitudes and experiences of all midwives and doctors working at the participating hospitals. Further, we do not have access to any data (including human resource data) to enable a comparison of the characteristics of responders and non-responders. It is also unknown whether responding doctors and midwives with either negative or positive views about homebirth were more or less likely to respond. Neither can we assume the applicability of these results to other maternity units (or to homebirth in a midwifery private practice context) as workloads, work settings, client populations and employment arrangements vary (Wieggers 2007). It would be valuable to replicate this study after the homebirthing pilots have been in place for a longer period of time, and at other sites in Australia offering publicly-funded homebirth.

Conclusion

Midwife respondents were very supportive of publicly-funded homebirth for women with most believing there was consumer demand for the program. Most also believed the program was safe for women and babies. Responding doctors had far more mixed views, with half not supportive of publicly-funded homebirth and over one third not convinced of its safety. To

ensure the success of such programs it is critical that all key stakeholders are engaged at the development and implementation stages as well as in the ongoing governance.

Disclosure of interests

We have no conflicts of interest to declare.

Contribution to authorship

HLM, DF, RS, MAD, MN, FC conceived and designed the study and wrote the initial protocol. HMcK was responsible for day to day management of the study, HLM, DF, MAD, MN, FC provided discipline expertise for the evaluation; HLM, DF, MAD, MN, FC, HMcK developed data collection tools; HMcK had data collection and data management responsibility; HLM, HMcK and RP undertook data analysis, HLM, HMcK and RP drafted the manuscript and all authors contributed to revisions and approved the final manuscript.

Ethics approvals

Approval for the study and the amendment to the methodology was obtained from Southern Health (HREC 11227B), Western Health (HREC/11/WH/60) and La Trobe Human Research Ethics Committees (FHEC 11/150).

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Table 1: Participant characteristics

Characteristic	Midwives		Doctors
	n	%	%
Years working at hospital	n=60		n=12
< One year	9	15.0	8.3
One to five years	20	33.3	58.3
Six to ten years	13	21.7	33.3
Eleven to fifteen years	5	8.3	0
> Fifteen years	13	21.7	0
Years worked as midwife or in obstetrics	n=60		n=12
<1 year	2	3.3	0
1-5	13	21.7	0
6-10	8	13.3	16.7
11-15	12	20.0	25.0
>15	25	41.7	58.0
Midwifery education	n =74		
Hospital-based education	20	27.0	-

Bachelor of Midwifery	21	28.4	-
Nurs/Mid double degree	2	2.7	-
Postgrad Dip Midwifery	19	25.7	-
Master Midwifery	2	2.7	-
Other (please specify)	7	9.5	-
Homebirth experience	n=69		n=12
Previous homebirth experience prior to pilot	23	33.3	66.7
Current role	n=59		n=12
Caseload midwife (not providing homebirth care)	5	8.5	-
Caseload midwife that provides homebirth care	11	18.6	-
Hospital midwife rotating across areas	27	45.8	-
Hospital midwife in one clinical area	7	11.9	-
Clinical midwifery consultant	2	3.4	-
Management/education/other	7	11.9	-
GP Obstetrician	-	-	8.0
Registrar	-	-	41.7
Consultant	-	-	50.0

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Table 2: Midwives' and doctors' views about homebirth

Statement		Strongly disagree		Disagree		Neither disagree or agree		Agree		Strongly agree	
		n	%	n	%	n	%	n	%	n	%
Australia's public health system should offer 'planned homebirth' as a model of maternity care (midwives n=73/doctors n=12)	Mws Drs	2	2.7	2	2.7	6	8.2	17	23.3	46	63.0
			0		50		8.3		25.0		16.7
Homebirthing should only be available to women at low obstetric risk (midwives n=72/doctors n=11)	Mws Drs	0	0	5	6.9	7	9.7	17	23.6	43	59.7
			0		0		36.4		18.2		45.5
In principle, I believe a homebirthing model should operate at my hospital (midwives n=72/doctors n=11)	Mws Drs	0	0	3	4.2	6	8.3	20	27.8	43	59.7
			0		45.5		18.2		27.3		9.1
There is demand for a homebirthing model at my hospital (midwives n=72/doctors n=11)	Mws Drs	1	1.4	2	2.8	9	12.5	22	30.6	38	52.8
			0		18.2		54.5		27.3		0
The homebirthing model operating at this hospital is safe for women (midwives n=67; doctors n=12)	Mws Drs	1	1.5	4	6.0	10	14.9	25	37.3	27	40.3
			0		33.3		33.3		33.3		0
The homebirthing model operating at this hospital is safe for babies (midwives n=67; doctors n=12)	Mws Drs	1	1.5	4	6.0	10	14.9	25	37.3	27	40.3
			0		50.0		25.0		25.0		0
The homebirthing model operating at this hospital is 'safe' for hospital staff caring for women in this model (midwives n=67; doctors n=12)	Mws Drs	1	1.5	8	11.9	12	17.9	24	35.8	22	32.8
			0		41.7		25.0		33.3		0
Midwives caring for homebirth women need	Mws	2	2.9	13	18.8	7	10.1	27	39.1	20	29.0

extra <i>education</i> in addition to their standard midwifery education (midwives n=69/doctors n=12)	Drs		8.3		0		0		33.3		58.3
Midwives working in a homebirthing model need to understand how to work within the model (midwives n=69/doctors n=12)	Mws	0	0	3	4.4	10	14.5	24	34.8	32	46.4
	Drs		0		0		0		50.0		50.0
The homebirthing model is supported by hospital management (midwives n=68/doctors n=11)	Mws	1	1.5	2	2.9	16	23.5	35	51.5	14	20.6
	Drs		0		0		27.3		54.5		18.2
The homebirthing model is supported by medical staff (midwives n=68/doctors n=11)	Mws	2	2.9	11	16.2	30	44.1	21	30.9	4	5.9
	Drs		0		18.2		27.3		54.5		0
The homebirthing model is supported by hospital-based/standard care midwives (midwives n=68/doctors n=11)	Mws	1	1.5	12	17.6	22	32.4	28	41.2	5	7.4
	Drs		0		27.3		27.3		45.5		0
The homebirthing model is supported by caseload midwives (midwives n=68/doctors n=12)	Mws	0	0	0	0	4	5.9	23	33.8	41	60.3
	Drs		0		0		25.0		25.0		50.0

NB: For doctors, only percentages are reported

Table 3: Midwives' and doctors' views about homebirth transfers

Statement		Strongly disagree		Disagree		Neither disagree or agree		Agree		Strongly agree	
		n	%	n	%	n	%	n	%	n	%
Developing rapport between <i>women</i> and <i>hospital-based midwives</i> after intrapartum transfer from a planned homebirth to hospital is difficult (midwives n=69; doctors n=12)	Mws Drs	4 0	5.8 0	24	34.8 25.0	20	29.0 50.0	19	27.5 25.0	2 0	2.9 0
Compared with private homebirth models, intrapartum transfers of women from home to hospital are easier because the transferring midwife is a member of the hospital staff (n= 69 midwives; n= 12 doctors)	Mws Drs	0 0	0 0	1	1.5 16.7	4	5.9 8.3	42	61.8 41.7	21	30.9 33.3
I am comfortable being responsible for the care of women being transferred out of the homebirthing program (doctors only; n=12)	Mws Drs	- 0	- 0	-	- 33.3	-	- 16.7	-	- 41.7	-	- 8.3
Women are comfortable having me care for them after being transferred out of the homebirthing program (doctors only; n=12)	Mws Drs	- 8.3	- 8.3	-	- 16.7	-	- 33.3	- 4	- 33.3	-	- 8.3

NB: For doctors, only percentages are reported

Table 4: Midwives' and doctors' views on reasons women choose a homebirth

Statement		Never		Occasionally		Sometimes		Often		Very often/always	
		n	%	n	%	n	%	n	%	n	%
Want a natural birth (midwives n=74; doctors n=12)	Mws Drs	0 0	0 0	0 0	0 25	5 0	6.8 0	23 0	31.1 41.7	46 33.3	62.2 33.3
Previous negative experience in hospital (midwives n=73; doctors n=12)	Mws Drs	0 0	0 8.3	2 0	2.7 8.3	26 0	35.6 41.7	36 0	49.3 41.7	9 0	12.3 0
Fear of doctors (midwives n=74; doctors n=12)	Mws Drs	1 0	1.4 0	23 0	31.1 16.7	29 0	39.2 58.3	19 0	25.7 25.0	2 0	2.7 0
Fear of hospitals (midwives n=74; doctors n=12)	Mws Drs	0 0	0 0	21 0	28.4 16.7	29 0	39.2 50.0	21 0	28.4 33.3	3 0	4.1 0
Want greater control over their birth experience (midwives n=74; doctors n=12)	Mws Drs	0 0	0 0	0 0	0 0	6 0	8.1 16.7	24 0	32.4 58.3	44 0	59.5 25.0
Feel most comfortable in their own home (midwives n=73; doctors n=12)	Mws Drs	0 0	0 0	1 0	1.4 0	2 0	2.7 25.0	20 0	27.4 66.7	50 0	68.5 8.3
Want the privacy offered by home environment (midwives n=73; doctors n=12)	Mws Drs	0 0	0 0	0 0	0 0	9 0	12.3 16.7	23 0	31.5 83.3	41 0	56.2 0
Want more support people than possible with hospital birth (midwives n=73; doctors n=12)	Mws Drs	0 0	0 0	18 0	24.7 8.3	27 0	37.0 41.7	16 0	21.9 41.7	12 0	16.4 8.3
Want their other children present (midwives n=12)	Mws	0	0	9	12.3	21	28.8	33	45.2	10	13.7

n=73; doctors n=12)	Drs		0		41.7		41.7		16.7		0
Want partner to play a stronger advocacy role during labour and birth (midwives n=73; doctors n=12)	Mws	0	0	4	5.5	27	37.0	31	42.5	11	15.1
	Drs		0		25.0		58.3		16.7		0

NB: For doctors, only percentages are reported

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Highlights:

- Midwives' and doctors' views of publicly-funded homebirth have not previously been investigated.
- Midwives (in particular those who had experience working in the program) were very supportive of publicly-funded homebirth for women and most considered there was consumer demand for the model. Most believed the model was safe for women and babies.
- Doctors had mixed views about publicly-funded homebirth. Some were supportive, some considered there to be consumer demand, and some considered it to be a safe model (others did not).