Exploring midwives perceptions and experiences of home birth

Exploring midwives' perceptions and experiences of home birth

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ORIGINAL

Summary

In the context of the low national home birth rate, a local home birth service was developed. Since its implementation, there has been no formal review of factors that may influence the home birth service's effectiveness. Midwives' perceptions and experience of home birth, which can have an impact on the home birth rate, has been largely unexplored. This service evaluation used a qualitative approach, which highlights that midwives believe issues such as: exposure to home birth, midwifery philosophy, essential home birth training and investment from management would increase midwives' feelings of confidence in home birth, potentially increasing local home birth rates.

Introduction

Home births are associated with significant health benefits for mother and baby, including cost effectiveness to NHS services (Royal College of Obstetricians and Gynaecologists (RCOG) 2007, Hollowell et al 2015, National Institute for Health and Care Excellence (NICE) 2017). The RCOG supports home birth for women with uncomplicated pregnancies (RCOG & Royal College of Midwives (RCM) 2007). The Birthplace Study confirms that, for low-risk women, giving birth is generally very safe (Hollowell et al 2015). The observational data available demonstrates lower intervention rates and higher maternal satisfaction with planned home births compared to hospital births (Edwards 1994, Wiegers & Keires 1996, Borrelli et al 2017, Clancy & Gürgens Gjaerum 2019).

In the UK, the home birth rate is two per cent (Office for National Statistics (ONS) 2018), demonstrating that relatively few women choose to give birth at home, despite the RCM and RCOG's support. The NICE guidance recommends that women classified as low risk of complications should be supported in their choice of where to give birth, including the option to birth at home (NICE 2017). Given the continuing variation in UK home birth rates between local health authorities, from 0.5 per cent to 14.2 per cent (Nove et al 2008, ONS 2015), there is a question of whether the home setting is truly being offered as a place of birth with respect to supporting women's choice.

The literature demonstrates that midwives' attitudes towards home birth are largely positive. However, there is acknowledgement that experience, essential clinical skills and competencies are required to provide safe care (Floyd 1995, Vedam et al 2014). There is no doubt that midwives play an important role in promoting home birth, therefore improving home birth rates and facilitating women's choices in achieving physiological birth with reduced medical complications (Hollowell et al 2015, Hutton et al 2016). While it seems possible that a lack of clinical resources does little to support the facilitation of home birth (Tew 1998), we cannot ignore the possibility that midwives' perceptions of home birth have a direct influence on the choices women make on place of birth.

Since the implementation of the local home birth service, monthly audits demonstrate a home birth rate of between zero to three per cent. Additionally, service-user feedback by the Maternity and Neonatal Voices Partnership (MNVP) highlighted that women experience inconsistent provision of the home birth service. Furthermore, the MNVP engagement report demonstrated that this formed one of the key themes received during their quarterly analysis. Therefore, it was decided that a service evaluation with a qualitative approach would capture valuable feedback from midwives, strengthening the existing data by triangulation of the evidence.

Methodology

Aim and objective

The aim of this service evaluation was to explore midwives' perceptions and experiences of home birth, with the objective of understanding if these could impact on the effectiveness of the home birth service. A service evaluation was deemed most appropriate to collate data with which to generate information that could be used to inform local decision-making and measure the current practice. This is an important element of service evaluation, as it highlights how effective a service is and what changes may be necessary to assist quality improvement (Moule 2017).

Study location and sample

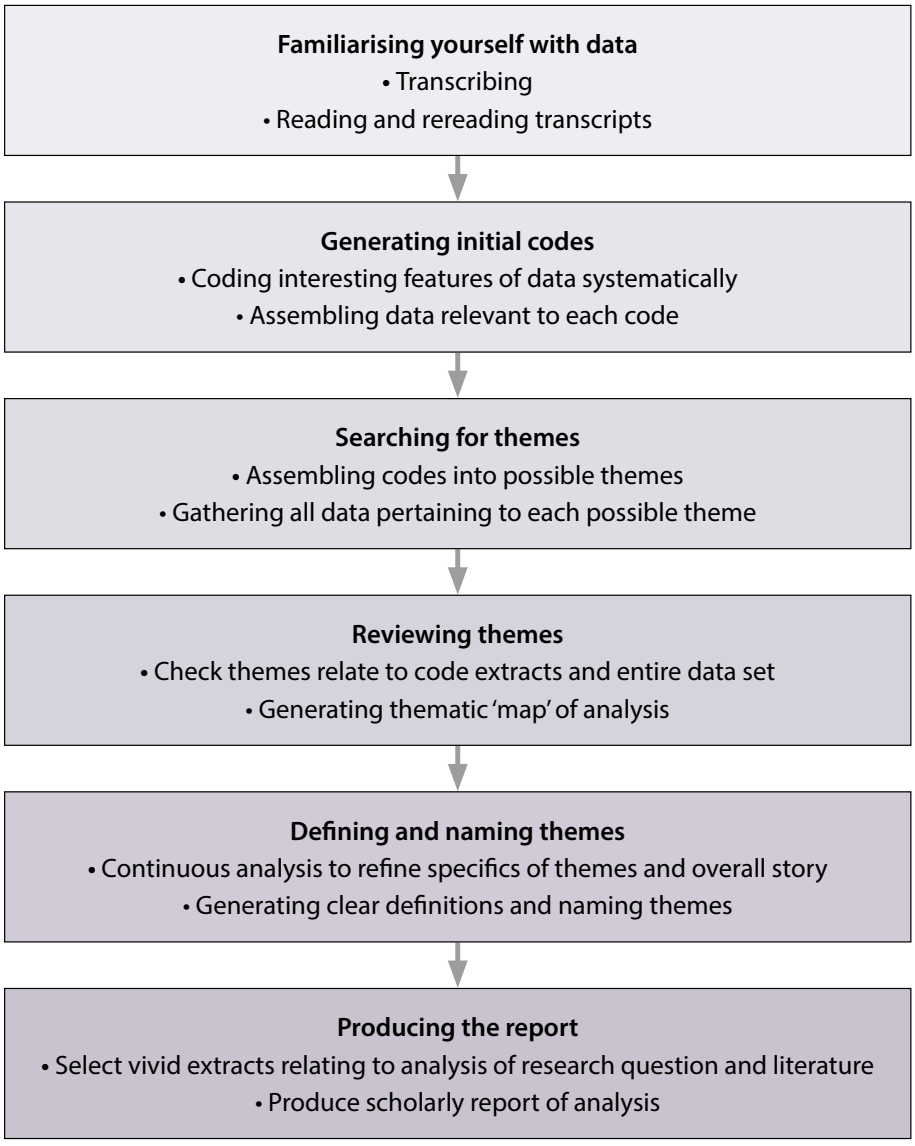
The study was carried out in a maternity unit encompassing an obstetric-led unit, co-located birthing unit, standalone birth centre and a dedicated home birth team. With a birth rate of over 6000 per annum, it is considered one of the largest maternity units in the UK.

A purposive sample of 10 midwives was predetermined and drawn from midwives working in midwifery-led settings to elicit participants' attitudes and experience of home birth.

Data collection

The data were collected by means of semi-structured interviews held via Microsoft Teams and transcribed verbatim. To ensure confidentiality, pseudonyms were assigned to conceal the identity of the participants. An interview guide was used, informed by the aim, objectives and literature review, and data were analysed using Braun & Clarke's thematic analysis framework (Braun & Clarke 2013, Creswell 2014) (see Figure 1).

Figure 1. Braun & Clarke's thematic analysis framework



The midwives were provided with a participant information leaflet and a consent form via email, which included full details of the research study, and how the information would be collated and stored. Within this process, they were assured that their anonymity would be maintained and that they had the right to withdraw from the study at any time, carrying no negative implications. The data collected were stored on the university's encrypted Microsoft OneDrive, in accordance with the university's data protection policy. The interviews were anonymised and given a number known only by the researcher and, once indexed and coded, were destroyed in line with research ethics guidance (Barbour 2014, GDPR 2018).

Ethical approval

Ethical approval was granted by the trust's audit and research department, and by the university's ethics committee.

Findings

Ten midwives were interviewed, sharing their experiences and perceptions of home birth in the local trust. However, data saturation was reached following six interviews as no new insights or themes emerged.

The midwives' characteristics are presented in Table 1.

Table 1. Participants' characteristics

Pseudonym	Gender	Age	Years of experience	Band	Clinical area	Employment status
Zara	Female	58	>16	6	Home birth team	Part time
Fatima	Female	33	>9	6	Birth centre	Full time
Louise	Female	48	>14	7	Birth centre	Part time
Lucy	Female	40	>6	6	Community	Full time
Kathryn	Female	37	>23	6	Home birth team	Full time
Jane	Female	47	>15	6	Birth centre	Full time

Four themes that emerged on data analysis were identified: exposure, philosophy, investment, and strong and supportive leadership.

Theme 1: exposure

Midwives described how exposure to home birth had a positive impact in terms of increasing confidence in practice:

'The best education is on the job. The fear about home birth is because midwives have not experienced it. They haven't had the opportunity as a student midwife.' (Zara)

The midwives expressed that, to build confidence, they needed to have the experience and the necessary insight. They believed that trust is rooted in the empirical knowledge of attending home births, thereby lessening the degree of anxiety that may be held because of limited or no home birth experience:

'You need experience and being exposed to it. If you're not exposed to it, then midwives won't want to go [to a home birth].' (Fatima)

'Having exposure to a normal birth. Exposure to seeing what women can do, that will build midwives' confidence.' (Louise)

Midwives felt that the exposure to home birth and physiological birth should start early in training and form part of educational requirements:

'If students are exposed to home birth, they will see it as a normal part of midwifery and they will see the value in it. They will start to see what normal birth is and it will help them to embed it.' (Zara)

Midwives linked this 'normal birth' paradigm to training requirements and considered the current educational experience of student midwives, acknowledging how limitations in student midwives' practice can contribute to lack of confidence in caring for labouring women at home:

'I think part of our training should facilitate us to have a better understanding. I have spoken to a lot of students recently who have never been to a home birth.' (Lucy)

Aware of how routine technological interventions to manage birth in the hospital setting can shape the way in which birth is perceived, midwives acknowledged how a culture of mistrust in home birth can develop, creating an eventual lack of confidence in the natural birthing process:

'I actually think medical students and obstetricians should see a home birth first to understand what is supposed to happen, otherwise there is a tendency to perceive normal physiological birth as risky.' (Kathryn)

Midwives recognised the value of exposure to home birth to increase not just confidence but also to improve the service by integrating home birth into the hospital rotation:

'You need to expose hospital midwives to low risk and show them how powerful that can be and then have a rotation within the home birth service. Which means midwives can get experience in that team with support.' (Louise)

Theme 2: philosophy

Participants believed that the midwives most likely to offer and feel comfortable providing home birth are those who possess a unique and existential understanding of the female body, in which childbirth plays a significant role in shaping the birth narrative:

'There has to be confidence in the female body and a really good understanding of physiological birth.' (Kathryn)

'You must respect that birth is a natural process and respect for a woman's ability to do it. You need to listen to what the woman is saying is happening.' (Fatima)

A recurring theme of the midwives throughout their interviews was their view of birth as a normal physiological process. There was a constant focus on the female body and the woman as central to the process, both possessing agency and a sense of empowerment:

'The woman is the protagonist. The woman is in charge of it [the birth] because it's taking place within her home. The environment protects that.' (Kathryn)

Midwives spoke of the life-giving and nurturing aspects of birth, and how this belief is learnt from attending home births, while recognising the importance of maintaining a realistic sense of the birthing process:

'You have to trust in the human body. I'm not saying 100% as mother nature doesn't always work as it should.' (Louise)

'I have learnt so much at home births, learnt so much about the human body, about the woman's body and the physiological changes in a woman. And I've grown in terms of resilience and empathy.' (Jane)

The midwives expressed how it was especially important for the midwife to confidently support the birthing process, stressing an atmosphere of peace and calm to facilitate home birth respectfully:

'A good home birth is where a midwife can really exert her powers to effectively advocate for women and support the physiological process of birthing.' (Lucy)

Participants highlighted that negative emotions felt by midwives through lack of confidence can permeate the home birth atmosphere with the effect of enhancing unnecessary actions in decision making, such as transfer into hospital:

'You must have confident midwives who trust in the process of birth, otherwise, they're constantly looking for problems, they constantly act in fear. And, they will have higher transfer rates because that's what they're bringing to the room. It will not be conducive to a calm and relaxed atmosphere.' (Fatima)

Theme 3: investment

A central aspect for the midwives was the delivery of high-quality training in home birth: both 'skills and drills' to enable effective management of emergencies, and the consideration of developing competencies to achieve the necessary skillset: *'You need to have skills in cannulation and suturing, and confidence to manage an emergency'* (Louise).

Skills and training were viewed as essential components to providing safe care in the home environment: *'If you can't suture or cannulate, then that's not providing good care, is it? Midwives need to feel confident in those skills to provide home birth'* (Fatima).

Midwives realised that training requirements needed to be specific to home birth, with an individualised approach rather than one that was generalised to the hospital setting:

'Coming into delivery suite to refresh your skills is the wrong place to refresh these skills. So, kind of identifying what skills midwives need to refresh in home birth and addressing it on an individual basis. So, raising confidence in midwives so that they will feel better placed to support home birth.' (Jane)

Midwives were aware that low-risk home birth care often entailed a different skill set to that required to work in the hospital setting and, therefore, these training needs would look different:

'Having a specific training day for home birth and running it in a house setting, so not a clinical setting. Simulating emergencies such as a cord prolapse on the top floor of a house, to facilitate how to get the woman downstairs and into the ambulance safely.' (Lucy)

Midwives described how home birth proficiency skills could be developed to incorporate a training competency:

'A home birth passport — you get your suturing and cannulation training, having a buddy system, 6 monthly meetings to discuss home birth, embed the storytelling and looking at cases for learning, promote the service for staff to join us and enhance the opportunity for observational learning.' (Kathryn)

The midwives recognised the value of emergency skills and drills but also acknowledged that training needed to be tailored to the individual.

Theme 4: strong and supportive leadership

The midwives were aware of the positive impact that management and those in influential roles could have on home birth:

'Having management buy-in is so important, otherwise it's not going to succeed. You need management to celebrate it, especially when the home birth rates go up.' (Zara)

There was a notable recognition that management needed to be responsive to the home birth service requirements, with effective governance to promote a learning culture over one which is fear-based and reactively driven:

'You need a management system that provides effective solutions to difficult situations, you know, not knee-jerk reactions, because that induces fear.' (Ann)

The midwives mentioned that the leadership team needed to affect the culture by embracing home birth and embedding it throughout the service, which would result in a widespread ripple effect:

'You need a supportive leadership team to encourage and support the midwives to implement service improvement for home birth. Once you've got that culture right, that people trust in women's bodies to do what they are evolved to do, then you know, you'll see the home birth rates go up, you'll see an increase in good outcomes and then it carries on…' (Jane)

Discussion

The findings of this service evaluation demonstrate that exposure to home birth enables not only a greater insight into the physiological processes of birth but also offers a profound understanding and deep respect for the female body. Exposure to home birth to increase confidence in midwives was seen as pivotal to improve the home birth rate and challenge the existing barrier of home birth not being regarded as a safe option. These findings are supported by an Australian study, which found that exposure to home birth can create new ways of thinking for midwives, as they demonstrate the transformative effects of understanding birth itself (Coddington et al 2020). A Swedish study found that the work environment can influence midwives in supporting physiological birth and developing their craft (Ahl & Lundgren 2018). This paradigm shifts the appreciation for physiological birth, which can therefore support home birth as a safe option and contribute to reducing the number of interventions that low-risk women labouring in the hospital setting are often subjected to (Hollowell et al 2015).

The findings also demonstrate that clinical skills and proficiency in managing emergency situations were seen as critical to the confidence levels of midwives in providing home birth. Nonetheless, the midwives recognised that such skills were necessary and specific to the home birth setting, and were careful not to pit these against skills recognised within the hospital setting. A UK-based study recognised that these skills needed to be taught explicitly and with specific emphasis on the home environment (Floyd 1995). The correlation of clinical skills and their role in safety in relation to home birth, by means of ensuring safe practice, was considered high. There is a vast body of evidence to support this concept, in which simulated home birth emergencies have contributed to increasing midwives' confidence (Floyd 1995, Sjöblom et al 2014, Dow 2016, Jones & Lewis 2018, Kumar et al 2019).

Midwives also believe management and leadership are central to the effectiveness of the home birth service. Without effective leadership to support service improvement and the continuing development

Table 2. Implications for practice

Implications for practice
Midwives who practice in the home birth service should be offered regular home birth-specific study days to include clinical skills update, emergency skills and drills training, review and discussion of case studies, and celebration of home birth targets and achievements.
Home birth needs to be protected by ensuring there is adequate staffing to cover the service with appropriate escalation to manager on call, should acuity of the unit impede delivery of the home birth service.
Adequate support from management and those that hold key leadership roles should include promotion and celebration of the home birth service.
Internal rotation by less-experienced midwives to the home birth team with adequate support by using a buddy system with a more experienced midwife.
Collaborative working with the university to explore ways of including home birth as an essential component of practice for student midwives.

of home birth, there is a risk that inadequate staffing and a lack of prioritisation of the service would exist in the overall structure of the maternity service.

Limitations

The researcher acknowledges that this service evaluation was undertaken in one setting, which could be perceived as a potential limitation of the study. It is important, however, to stipulate that, in keeping with qualitative inquiry, it was not the researcher's intention to generalise findings. Moreover, it was believed that participating midwives sharing their unique insights into home birth in a rich and meaningful account would deepen the understanding of any unmet needs in which to inform service development within the local setting.

Conclusion

Midwives' experiences and perceptions of home birth were explored and recommendations for practice have been offered. By way of findings, it was realised that exposure and personal philosophy on home birth, alongside investment in specific home birth training, could increase the confidence levels of midwives to provide the home birth service. Furthermore, the home birth rates could be increased with a supportive leadership and management team to truly embed home birth within the heart of the service.

Author

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For more information on this topic see MIC database Search Pack: MS29 Home birth: choice and control.

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