Systematic review of women's experiences of planning home birth in consultation with maternity care providers in middle to high-income countries

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Review Article

Systematic review of women's experiences of planning home birth in consultation with maternity care providers in middle to high-income countries

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ABSTRACT

Aim: To synthesise findings from published studies, which reported on women's experiences of planning a home birth in consultation with maternity care providers.
Design: Systematic Review
Data Sources: We searched seven bibliographic databases, (Ovid Medline, Embase, PsycInfo, CINAHL plus, Scopus, ProQuest and Cochrane (Central and Library), from January 2015 to 29th April 2022.
Review Methods: Primary studies were included if they investigated women's experiences of planning a home birth with maternity care providers, in upper-middle and high-income countries and written in English language. Studies were analysed using thematic synthesis. GRADE-CERQual was used to assess the quality, coherence, adequacy and relevance of data. The protocol is registered on PROSPERO registration ID: CRD 42018095042 (updated 28th September 2020) and published.
Results: 1274 articles were retrieved, and 410 duplicates removed. Following screening and quality appraisal, 20 eligible studies (19 qualitative and 1 survey) involving 2,145 women were included.
Key Conclusions: Women's prior traumatic experience of hospital birth and a preference for physiological birth motivated their assertive decision to have a planned home birth despite criticisms and stigmatisation from their social circle and some maternity care providers. Midwives' competence and support enhanced women's confidence and positive experiences of planning a home birth.
Implications for practice: This review highlights the stigma that some women feel and the importance of support from health professionals, particularly midwives when planning a home birth. We recommend accessible evidence-based information for women and their families to support women's decision-making for planned home birth. The findings from this review can be used to inform woman-centred planned home birth services, particularly in the UK, (although evidence is drawn from papers in eight other countries, so findings are relevant elsewhere), which will impact positively on the experiences of women who are planning home birth.

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Introduction

Women and their babies require access to high quality care, although the reality of global maternity care provision lies in or between the two extremes of care that are 'too little, too late (TLTL)' 'too much, or too soon'(TMTS) (Miller *et al.,* 2016). TLTL refers to under-resourced and often sub-standard care which may be available too late to be helpful, while TMTS relates to the over medicalization of maternity care. Respectful maternity care which recognises women's right to autonomy, choice of birthplace and being treated with dignity and respect is advocated by global organizations such as the White Ribbon Alliance for Safer Motherhood (2012) and the World Health Organization (WHO) (2021). In low to lower-middle income countries, the emphasis is often on enabling access to maternity care for women within medical facilities (Arsenault et al., 2018; Kerber *et al.,* 2007), while in

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upper-middle-and high-income countries (Miller *et al.,* 2016), there is increasing prevalence of over-medicalization and unnecessary interventions which takes place in a hospital setting (Scarf *et al.,* 2018; DeJonge *et al.,* 2015; Davis *et al.,* 2011; Brocklehurst *et al.,* 2011).

Background

In upper-middle- and high-income countries, (definition of upper-middle to high-income countries in Supplementary Material 1) access to maternity care is often accessible and available under universal health care provision (Miller *et al.,* 2016). Women need to be given choice of birthplace and care for positive childbirth experiences which enable physiological birth without unnecessary intervention; this includes home birth. There is evidence that for a woman with a straightforward pregnancy, a planned home birth can have similar if not better outcomes, as other birth settings (Reitsma et al., 2020; Hutton *et al.,* 2019; de Jonge *et al.,* 2015; van der Kooy *et al.,* 2011). A recent joint statement by the Royal College of Midwives (RCM) and Royal College of Obstetricians and Gynaecologists (RCOG) (2020) further recognised the benefits of home birth for low-risk women during the COVID-19 pandemic. While the number of planned home births in the UK and further afield remain small (Naylor Smith *et al.,* 2018), there is a growing number of women requesting to plan their birth at home.

Midwives are integral to the provision of high-quality maternity care (Kennedy *et al.,*2020; Renfrew *et al.,* 2014; Horton & Astudillo, 2014) for women with a straightforward pregnancy and in collaboration with other members of the multidisciplinary team, particularly obstetricians, care for women with more complex care needs. Maternity care systems and infrastructures that facilitate continuity of care and carer for women throughout pregnancy, birth and postnatally, have been shown to improve maternal outcomes (Rayment-Jones, Murells & Sandall (2015), particularly for women with complex social needs. A survey by the Care Quality Commission (CQC) (2017) highlighted women did not have the opportunity to build a relationship with a midwife, (as they did not see the same midwife during their antenatal or postnatal care) and reported that they experienced less compassionate care (CQC, 2017). Women do not solely base their preferred place of birth on outcomes but also on experiences. The importance of this has been recognised by WHO (2021; 2018). For some women, a planned home birth may provide them with a birth experience that is close to their ideal and helps them to feel more in control of their experience (Zielinski, Ackerson & Low, 2015; Homer *et al.,* 2019).

Previous published reviews have reported on maternal and neonatal outcomes (Catling-Paull *et al.,* 2013; Elder, Alio & Fisher, 2016; Kobayashi et al., 2017; Scarf *et al.,* 2018) drawing comparisons between planned hospital and planned home births (Olsen & Clausen, 2012; 2023; Rossi & Perfumo, 2018). Others have examined post-natal care (Pantoja *et al.,* 2016), models of maternity care (Sandall *et al.,* 2016), how home birth provision fits within a healthcare system (Comeau et al.; 2018) and reasons for transfer to hospital from a planned home birth (Blix *et al.,* 2014; Vedam *et al.,* 2014). A review by Hill (2020) examined women's experiences of planned home birth using the Sample, Phenomenon of Interest, Design, Evaluation, Research (SPIDER) method (Cooke, Smith & Booth, 2012) and included four studies conducted in Australia, Sweden, America, and Finland. However, the review did not focus on the planning phase of the home birth experience in consultation with maternity care providers.

A systematic review of research with a broader scope, including studies from upper-middle to high-income countries is necessary, to provide an in-depth understanding of what matters to women during the planning phase of organising their home birth. This is integral to improving maternity care provision (including information exchange and woman-provider communication) for women planning a home birth. Therefore, this systematic review aimed to synthesise findings from published studies on women's experiences of planning a homebirth in consultation with their maternity care providers.

The review

Review Question

What are women's experiences of planning a home birth in consultation with maternity care providers in upper-middle to high-income countries?

Design

This systematic review was conducted using a developed protocol (PROSPERO registration ID: CRD42018095042) (Centre for Reviews and Dissemination (CRD) 2009) and is reported according to the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) guidelines (Page *et al.,* 2021). The protocol is published (Healy, Bamidele & Gillen, 2021). Operational Definitions are included in Supplementary Material 1.

Search methods

In consultation with an experienced subject librarian, search terms were iteratively developed using text words derived from the review aim, the PICO (Population, Intervention, Comparison and Outcome) framework (Thomas, McNaught & Ananiadou, 2011) and database-indexed terms. Search terms were related to home birth OR childbirth AND plan AND experience. Following testing and refinement, the search strategy was systematically applied (as appropriate) to seven bibliographic databases: Ovid Medline, Embase, PsycInfo, CINAHL plus, Scopus, ProQuest and Cochrane (Central and Library) from January 2015 to 8th July 2021. An update search was conducted on 29th April 2022. The start date for the searches was 1st January 2015 as the NICE clinical guideline (CG190) (National Institute for Health and Care Excellence, 2014) (updated 2017) on Intrapartum Care for Healthy Women and Babies, which advocated home birth as a choice of place of birth for women, was published in December 2014. Therefore, evidence before this would have informed the development of the guideline and may have informed practice and maternity care practice and attitudes towards planned home birth. The search strategies for all databases are presented in Supplementary Material 2.

The refined search terms were tailored to each database indexing requirement using thesaurus terms where appropriate. Boolean operators 'AND' and 'OR' were used to limit or broaden search results, while quotation (") and truncation (*) marks were used to capture possible variations of the search terms on each database. Supplementary searches were also conducted via hand searching of reference lists of included studies, consultation with professional networks and members of the Regulation and Quality Improvement Authority (RQIA) Planning to Birth at Home in Northern Ireland Guideline Development Group and grey literature search on OpenGrey. The searches were conducted by OB but checked by other members of the review team (PG and MH) in line with the Peer Review of Electronic Search Strategies (PRESS) guidelines (McGowan *et al.,* 2016). Search results were managed with the bibliographic software Endnote, Refworks and Covidence.

Studies were included if they were: (i) primary research which investigated women's experiences and/perceptions of planning a home birth in consultation with maternity care providers and (ii) conducted in upper-middle and high-income countries and (iii) reported in English language and (iv) published between 1st Jan-

uary 2015 and 29th April 2022. Studies were excluded if they were (i) focused on healthcare professionals' or partners' views on home birth planning (ii) grey literature which lacked a clear methodology (for example, editorials and books), (iii) conference abstracts whose full papers could not be accessed (iv) dissertations (v) conducted in lower-middle or low-income countries (due to disparities in the organisation of healthcare systems and structures between low, lower-middle, and upper-middle and high-income countries) and (vi) reported on the entire home birth experience but did not separate data on women's experiences of the planning phase.

Identification and selection of studies

Search results yielded 1274 articles from which 410 duplicates were removed on Endnote and Covidence using a systematic method (Bramer *et al.,* 2016). The title and abstract of the remaining 864 articles were independently screened by two reviewers (OB with PG or MH) on Covidence (Veritas Health Innovation, 2019) and 749 irrelevant articles were excluded. The full text of the remaining 115 studies were independently screened for eligibility (OB with PG or MH) against the review's inclusion and exclusion criteria. 29 eligible research papers were included for quality appraisal. Conflicts were resolved via discussion to reach a mutual agreement. The study identification and selection process are reported on a PRISMA diagram (Supplementary Material 3).

Quality appraisal and data extraction

Two reviewers (OB with PG or MH) independently appraised the quality of the included 29 papers for methodological quality. Conflicts were resolved via discussion to reach a consensus. The studies had different methodological designs including qualitative (n=25), mixed methods (n=2), survey (n=1) and cohort (n=1). We used the Critical Appraisal Skills Programme (CASP) tool (Critical Appraisal Skills Programme CASP, 2020) to appraise the qualitative and cohort studies, the Mixed Methods Appraisal Tool (MMAT) (Hong *et al.,* 2018) for the mixed methods study and the Critical Appraisal of a Survey tool (Critical appraisal of a survey [Internet] 2011). Studies were rated as either high (scoring >= 70%), medium (scoring > 40% < 70%), or low (Scoring < 40%). Quality score was calculated by dividing the number of 'yes' by the total number of domains calculated as a percentage. For example, a qualitative study which scored seven 'yes' out of the ten domains on the CASP tool for qualitative studies, was scored 70% and included in the review. None of the papers were excluded for low quality and were included for data extraction. Data was independently extracted by two reviewers (OB and PG or MH) using MS Excel, and conflicts were resolved via discussion. However, nine of the papers lacked sufficient relevant data and were subsequently excluded from the review. The remaining 20 research papers were included for data analysis (Table 1a & b). Confidence in the review findings was assessed using the GRADE CERQual tool (Lewin *et al.,* 2018) (Table 2). Confidence was assessed for each individual review finding against the four components prescribed by Lewin *et al.,* (2018): methodological limitations, coherence, adequacy of data and relevance of data. The findings were graded as either high, moderate, low or very low. For example, findings which had 'no or very minor concerns' across the four assessment components were graded as high while findings which had minor concerns in at least two of the components were graded as moderate. All three authors discussed and agreed the assessment and grading.

Data analysis

The studies were analysed using thematic synthesis by Thomas & Harden, 2008, which involved three stages: Data from each of the individual studies were coded line by line using words directly from each paper (where appropriate). Similar codes were aggregated into descriptive themes using labels, and patterns. Similarities and differences within the descriptive themes were then explored and interpreted in relation to the review aim to generate new analytical constructs. Data was analysed by OB and deliberated with PG and MH via discussion to mutually agree final themes. Data analysis was managed with the NVivo 12 software (QSR International Pty Ltd. 2020).

Results

Description of included studies

Twenty papers published between 2015 and 2021 were included in the review. The studies were conducted across nine countries: UK (n=4) (Lee, Ayers & Holden, 2016a; Lee, Ayers & Holden, 2016b; Borrelli, Walsh & Spiby, 2017; Hinton *et al.,* 2018); Australia (n=5) (Keedle *et al.,* 2015; Fox, Sheehan & Homer, 2018a; Fox, Sheehan & Homer, 2018b; Russell et al. 2021; Sassine *et al.,* 2021); United States (n=3) (Fleming *et al.,* 2017; Bonmarito, 2018; Coburn & Doering, 2021); the Netherlands (n=2) (Hollander *et al.,* 2017; Holten, Hollander & de Miranda, 2018); Brazil (n=2) (Ávila Moraes *et al.,* 2016; Volpato *et al.*, 2021); Switzerland (n=1) (Brailey etal., 2015); Canada (n=1) (Difilippo, 2015), Spain (n=1) (Leon-Larios *et al.,* 2019), and Norway (n=1) (Skrondal, Bache-Gabrielsen & Aune, 2020). The quality of the studies was medium to high quality. Data collection across the studies was predominantly via semi-structured interviews (n=18), a focus group (n=1) and a survey with quantitative and qualitative questions (n=1). Confidence in the review findings was generally high (Table 2). A total of 2,145 women, aged 18 - 40 years old who had planned a home birth were included in the studies. The women's ethnicity was not reported in the majority of the studies. Detailed description of participants' demographics is presented in Table 3. Data analysis yielded six descriptive themes which were categorised into two analytical constructs: 'Women's motivations and experiences of planning a home birth' and 'Woman-provider interactions in home birth planning'.

Women's motivations and experiences of planning a home birth

This theme is reported under three descriptive sub-themes: 'motivations for planning a home birth', 'experiencing and dealing with social stigmatisation for planning a home birth', and 'accessing support from social contacts'.

Motivations for planning a home birth

Many of the studies (n=13) reported on women's motivation for planning a home birth (Lee, Ayers & Holden, 2016a; Borrelli, Walsh & Spiby, 2017; Keedle *et al.,* 2015; Russell *et al.,* 2021; Sassine *et al.,* 2021; Fleming *et al.,* 2017; Coburn & Doering, 2021; Hollander *et al.,* 2017; Holten, Hollander, & de Miranda, 2018; Volpato *et al.*, 2021; Brailey *et al.,* 2015; Leon-Larios *et al.,* 2019; Skrondal, Bache-Gabrielsen, & Aune, 2020). A common motivation across these studies was women's priority to have a physiological birth and personal autonomy to decide their birthing preferences. For some women, the plan to have a home birth arose from a previous traumatic hospital birth (Fleming *et al.,* 2017; Coburn & Doering, 2021; Hollander *et al.,* 2017; Volpato *et al.*, 2021; DiFilippo, 2015; Leon-Larios *et al.,*2019). Some women reported a lack of autonomy and

Table 1a
Quality appraisal of included Studies (Qualitative).

Study title, authors and year	1. clear statement of the research aims? Yes Can't tell No	2. Is a qualitative methodology appropriate? Yes Can't tell No	3. Was the research design appropriate to address the aims of the research? Yes Can't tell No	4. Was the recruitment strategy appropriate to the aims of the research Yes Can't tell No	5. Was the data collected in a way that addressed the research issue? Yes Can't tell No	6. Has the relationship between researcher and participants been adequately considered? Yes Can't tell No	7. Have ethical issues been taken into consideration? Yes Can't tell No	8. Was the data analysis sufficiently rigorous Yes Can't tell No	9. Is there a clear statement of findings? Yes Can't tell No	10. How valuable is the research? Yes Can't tell No	Total score % = total number of 'yes' divided by 10 x 100%
Avila Moraes et al. 2016	Yes	Yes	Yes	Can't tell	Can't tell	No	Yes	No	Yes	Yes	60%
Bommarito 2018	Yes	Yes	Yes	Yes	Yes	No	No	Can't tell –	Yes	Can't tell	60%
Borrelli et al., 2017	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	100%
Brailey et al., 2015	Yes	Yes	Can't tell	Yes	Can't tell	Can't tell	Yes.	Yes	Yes	Yes	70%
Coburn and Doering 2021	Yes	Yes	Can't tell	Yes	Yes	Can't tell	Yes	Yes	Yes	Yes	80%
DiFilippo et al. 2015	Yes	Yes	Yes	Can't tell	Can't tell.	Yes	No	Can't tell	Yes	Yes	60%
Fleming, et al. 2017	Yes	Yes	Yes	Yes	Yes	No	Can't tell	Yes	Yes	Yes	80%
Fox, et al. 2018a	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	Can't tell	Yes	Yes	80%
Fox, et al. 2018b	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Yes	90%
Hinton et al. 2018	Yes	Yes	Can't tell	Yes	Yes	Can't tell	Yes	Yes	Yes	Yes	80%
Hollander et al. 2017	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	100%
Holten et al. 2018	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	100%
Keedle et al. 2015	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	100%
Lee, et al. 2016a	Yes	Yes	Can't tell	Yes	Yes	Yes	Yes	Yes	Yes	Yes	90%
Lee et al. 2016b	Yes	Yes	Can't tell	Yes	Yes	Yes	Yes	Yes	Yes	Yes	90%
Leon-Larios et al. 2019	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	100%
Russell et al. 2021	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	100%
Skrondal, et al. 2020	Yes	Yes	Can't tell	Yes	Yes	No	Yes	Yes	Yes	Yes	80%
Volpato et al. 2021	Yes	Yes	Can't tell	Yes	Yes	No	Yes	Can't tell	Yes	Yes	70%

Table 1b
Quality appraisal of included Studies (Survey)

	1. Did the study address a clearly focused question / issue? Yes /Can't tell / No	**2.** Is the research method (study design) appropriate for answering the research question? Yes/ Can't tell/ No	**3.** Is the method of selection of the subjects (employees, teams, divisions, organizations) clearly described? Yes/ Can't tell/ No	**4.** Could the way the sample was obtained introduce (selection) bias Yes/ Can't tell/ No	**5.** Was the sample of subjects representative with regard to the population to which the findings will be referred? Yes/ Can't tell/ No	**6.** Was the sample size based on pre-study considerations of statistical power Yes/ Can't tell/ No	**7.** Was a satisfactory response rate achieved? Yes/ Can't tell/ No	**8.** Are the measurements (questionnaires) likely to be valid and reliable? Yes/ Can't tell/ No	**9.** Was the statistical significance assessed? Yes/ Can't tell/ No	**10.** Are confidence intervals given for the main results? Yes/ Can't tell/ No	**11.** Could there be confounding factors that haven't been accounted for Yes/ Can't tell/ No	**12.** Can the results be applied to your organization? Yes/ Can't tell/ No	Score No of yes/12×100
Sassine et al. 2021	Yes	Yes	Yes	Yes	Can't tell	No	Yes	Yes	No	No	Can't tell	Can't tell	42%

woman-centred care in a hospital setting, as they perceived maternity care providers as authoritative in decision-making for the birthing plan and during birth:

"…They said, yes, you have to give birth in the hospital, you can't have a home birth any more. And well, I had just been working on taking charge of my autonomy, so the sentence "you can't have a home birth anymore," that was, that was just very unpleasant for me. I felt that was an unpleasant conversation. And also, for instance, that they said, like, "yes, because you lost so much blood we want to put in an IV and you will get oxytocin right away." . . . It wasn't that I didn't want that, but I didn't want it to happen just because they said so…" (Participant quote), (Holten, Hollander & de Miranda, 2018).

These perceptions were mostly informed by women's previous experiences of hospital consultations. In nine studies (Borrelli, Walsh & Spiby, 2017; Keedle *et al.*, 2015; Coburn & Doering, 2021; Hollander *et al.*, 2017; Holten, Hollander & De Miranda, 2018; Brailey *et al.*, 2015; Leon-Larios *et al.*, 2019; Russell et al. 2021; Skrondal, Bache- Gabrielsen, & Aune, 2020), women emphasised that they prioritised continuity of carer, where they have an established relationship with the same midwife who understands their birthing needs and preferences and can provide woman-centred care throughout pregnancy, childbirth and postnatally. Women stated that this enhanced their sense of security and support in planning a home birth:

"…It was important to me that the same midwife cared for me from beginning to end, that we could build a relationship, that I was not going unprepared into an unknown situation…" (Participant quote), (Brailey *et al.*, 2015).

Many of the women identified their perception of safety/risk as an influencing factor on their decision to plan a home birth (Lee, Ayers and Holden, 2016a; Lee, Ayers and Holden, 2016b; Borrelli, Walsh & Spiby, 2017; Keedle *et al.*, 2015; Fleming *et al.*, 2017; Hollander *et al.*, 2017; Holten, Hollander & de Miranda, 2018; Brailey *et al.*, 2015; Russell et al. 2021; Skrondal, Bache-Gabrielsen & Aune, 2020). They were confident that they had carefully considered the evidence and that a planned home birth was the best option for them:

"You can go on PubMed . . .There are all sorts of social media where you can discuss things with lots of different people. So, I do think that women standing up for themselves more is increasing. What they actually want is to discuss things on a different level. [Women] expect communication to be based on solid scientific information…" (Participant quote), (Holten, Hollander & de Miranda, 2018).

In two of the studies, women reported how their choice of place of birth had the potential to influence their own physiological birth processes and therefore they planned a home birth (Ávila Moraes *et al.*, 2016; Skrondal, Bache-Gabrielsen & Aune, 2020).

"By no means did I want an epidural, that was a big fear for me. Or anything, really, of painkillers; nothing that would mess up the system, because it is an ingenious system that is designed to function, in my opinion. So, if you start tampering with it, I don't think you will get the best experience" (Participant quote), (Skrondal, Bache-Gabrielsen & Aune, 2020).

Experiencing and dealing with social stigmatisation for planning a home birth

Women in some of the studies experienced critical comments, conflicts, resistance and social stigma from family, friends and maternity care providers for planning a home birth (Bonmarito, 2018;

Table 2
CERQual Overall Summary of Review Findings.

Summary of review findings	Studies contributing to the review finding	CERQual Assessment of Confidence in the Evidence	Explanation ofCERQualassessment
Women prioritized having a birth without unnecessary interventions and autonomy to decide their birthing preferences	Lee, Ayers and Holden, 2016a; Borrelli, Walsh & Spiby, 2017; Keedle et al., 2015; Fleming et al., 2017; Hollander et al., 2017; Holten, Hollander & De Miranda 2018; Brailey et al., 2015; Leon-Larios et al., 2019; Skrondal, Bache-Gabrielsen, Aune, 2020; Russell et al. 2021	High confidence	N/A
Women were motivated by priority for continuity ofcarer, involving the same midwife though the course of their pregnancy, birth and postnatally	Borrelli, Walsh & Spiby, 2017; Keedle et al., 2015; Coburn & Doering, 2021; Hollander et al., 2017; Holten, Hollander & De Miranda 2018; Brailey et al., 2015; Leon-Larios et al., 2019: Skrondal, Bache-Gabrielsen, Aune, 2020	High confidence	N/A
Women experienced critical comments, resistance and social stigma from family, friends and maternity care providers	Keedle et al. 2015; Bonmarito, 2021; Coburn & Doering, 2021; Hollander et al., 2017; Ávila Moraes 2016; Volpato et al., 2021; Leon-Larios et al., 2019; Skrondal, Bache-Gabrielsen, Aune, 2020	Moderate confidence	Minor concerns about methodological limitations and adequacy of data
Women concealed their plan to have a home birth from their family and friends, and avoided discussions related to their birth plans	Keedle et al., 2015; Fox, Sheehan & Homer, 2018b; Bonmarito, 2021; Coburn & Doering, 2021;Holten, Hollander & De Miranda 2018; Leon-Larios et al., 2019; Skrondal, Bache-Gabrielsen, Aune, 2020	Moderate confidence	Minor concerns about components coherence, adequacy of data and relevance
Women empowered themselves by doing personal research on childbirth and proactively sought information from others including like-minded women via their social media networks.	Hinton et al., 2018; Keedle et al., 2015; Sassine et al., 2021; Fleming et al., 2017; Coburn & Doering, 2021; Hollander et al., 2017; Holten, Hollander & De Miranda 2018; Ávila Moraes 2016; Brailey et al., 2015; DeFilippo, 2015; Leon-Larios et al., 2019; Skrondal, Bache-Gabrielsen, Aune, 2020	High confidence	N/A
Some women recalled receiving social support from a variety of sources including other women who had experienced a natural birth, their partners, family and friends who believed in home birth	Hinton et al., 2018; Keedle et al., 2015; Sassine et al., 2021; Bonmarito, 2018; Coburn & Doering, 2021; Hollander et al., 2017; Holten, Hollander & De Miranda, 2018; Ávila Moraes 2016; Volpato et al., 2021; Brailey et al., 2015; DeFilippo, 2015; Leon-Larios et al., 2019; Skrondal, Bache-Gabrielsen, Aune, 2020	Moderate Confidence	Minor concerns about methodological limitations and adequacy of data
Women perceived their partners as supportive of their planned home birth which made the decision-making easier for them and enabled them to withstand criticism from others	Keedle et al., 2015; Brailey et al., 2015; Difilippo, 2015; Leon-Larios et al., 2019;	High confidence	N/A
Women recounted positive experiences of their consultation with maternity care providers to plan a home birth; mostly attributed to midwife's empathy, trust and support to facilitate their planned home birth preference	Lee, Ayers & Holden, 2016a; Lee, Ayers & Holden, 2016b; Borrelli, Walsh & Spiby, 2017; Hinton et al., 2018; Fox, Sheehan & Homer, 2016a; Fox, Sheehan & Homer, 2016b; Fleming et al., 2017; Holten, Hollander & de Miranda, 2018; Brailey et al., 2015; Skrondal, Bache-Gabrielsen & Aune, 2020; Russell 2021	High confidence	N/A
Open communication and information from the midwife provided reassurance regarding the birth process and enhanced trustful woman-midwife relationship	Lee, Ayers & Holden, 2016a; Lee, Ayers & Holden, 2016b; Hinton et al., 2018; Fox, Sheehan & Homer, 2018a; Fox, Sheehan & Homer, 2018b; Fleming et al., 2017; Holten, Hollander & De Miranda, 2018; Ávila Moraes et al., 2016; Leon- Larios et al., 2019; Skrondal, Bache-Gabrielsen & Aune, 2020; Russell 2021	High Confidence	N/A
Women perceived some maternity care providers as lacking consideration for their autonomy to have a planned home birth	Lee, Ayers & Holden 2016b; Keedle et al., 2015; Bonmarito, 2018; Hollander et al., 2017; Holten, Hollander & De Miranda, 2018; Leon- Larios et al., 2019; Skrondal, Bache- Gabrielsen & Aune, 2020; Russell 2021	Moderate confidence	Minor concerns about methodological limitations and adequacy
There were disparities between women's and maternity providers' perception of risk associated with childbirth which informed their prioritized birthplace	Lee, Ayers & Holden 2016b; Hollander et al., 2017; Leon-Larios et al., 2019	High confidence	N/A
Some women expressed a desire for maternity care providers to complement their professional knowledge with compassionate care, friendliness and empathy, highlighting they valued the emotional support even more than medical checks and interventions	Borrelli, Walsh & Spiby, 2017; Hollander et al., 2017; Leon-Larios et al., 2019	High confidence	N/A
Women pointed out the importance of maternity care providers having open unbiased discussions about place of birth options with women	Hinton et al., 2018; Fox, Sheehan & Homer, 2018a	High confidence	N/A
Women identified their perception of safety/risk as an influencing factor on their decision to plan a home birth	Lee, Ayers & Holden, 2016a; Lee, Ayers & Holden, 2016b; Borrelli, Walsh & Spiby, 2017; Keedle et al., 2015; Fleming et al., 2017; Hollander et al., 2017; Holten, Hollander & de Miranda, 2018; Brailey et al., 2015; Skrondal, Bache-Gabrielsen, Aune, 2020; Russell 2021	High Confidence	N/A
Women had faith in their own physiological processes and this was affected by their chosen birth setting	Ávila Moraes 2016; Skrondal, Bache-Gabrielsen, Aune, 2020	High Confidence	N/A

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Table 3
Characteristics of included studies

Authors/year	Study Setting (Country)	Study Aim	Methodology	Sample Characteristics	Key conclusions	Recommendation for practice	Quality Appraisal Score (CASP)
Ávila Moraes, et al. 2016	Goiânia, Brazil	To analyse the representation of the pain of childbirth for women attending Planned Home birth	Grounded theory using semi-structured interviews. Interview setting not reported	Fourteen women who planned home birth with the assistance of a professional team, married (85.7%), completed higher education (64.3%), had home delivery of first pregnancy (50%), and had a minimum of eight to thirteen prenatal consultations (64.3%). Ethnic breakdown not specified	Despite social stigma associated with home birth, educated and married women in Brazil continue to desire this birthplace option because they perceived the experience of labour pain as a sign of strength and increase in confidence	While care is standardised, it can be personalised to the needs of each woman	60%
Bommarito et al. 2018	Upper Midwest Region, USA	a.) What is it like for women to plan a home birth in a society in which this choice is stigmatised? b.) for women who experience stigma, in relation to home birth, how do they cope with that stigma?	Ethnography using interviews, participant observation during prenatal appointments at women's homes or midwives' offices, pre-natal field notes and blog material	Eleven women aged between 26 -37 years; of White (n=10) and Black(n=1) ethnic origin; mostly married (n=10), all educated to at least degree level (n-8) or master's degree (n=1), college (n=1) or associate degree (n=1); income ranged from $22,000-$95,000; have had no prior (n=5); or one (n=4), three (n=1) or four (n=1) children	Stigma related to the choice to birth at home can be a significant source of chronic stress during pregnancy	Need for midwives and mental health practitioners to examine tools that can help identify women who are struggling with stigma related to home birth and develop interventions to increase their coping resources and processes	60%
Borrelli et al., 2017	England, UK	To explore first-time pregnant women's expectations and factors influencing their choice of birthplace	Grounded theory using semi-structured interviews in participant's homes.	Fourteen women expecting their first baby, av. Age of 29 years (range 19- 43 years); gestational age of 38 weeks (range 36-40 weeks); planned to give birth at OU(n=5); FMU (n=7) and at home (n=2). Ethnic breakdown not specified	Each woman's expectations and approach to birth should be considered beyond the chosen planned birthplace, as these are often influenced by an intersection of various influencing factors	Different birthplace options should be made available in each maternity service during antenatal consultations to enable women make informed choices regarding where to deliver their babies.	100%
Brailey et al. 2015	Switzerland	To explore factors influencing the decision of Swiss women to give birth at home	Qualitative Descriptive Study using semi-structured interviews. Interview setting not specified but participants were recruited through Swiss Midwifery Association	Six women (five Swiss and one American) aged between 28 -40 years old, gestation: 22-39 weeks, parity: 0 (n=1); 1 (n=1); 2 (n=3) and 3 (n=1). Ethnic breakdown not reported.	Women's decision for home birth could be seen as opposing social norms and 'swimming against the tide'. However, their inherent knowledge enabled them to challenge the normal medicalisation of birth in the Swiss setting.	There is need to prioritise the involvement of midwives in Swiss maternity care service in order to change a culture reliant on medical care and facilitate a more normalised view of reproductive health	70%

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Authors/year	Study Setting (Country)	Study Aim	Methodology	Sample Characteristics	Key conclusions	Recommendation for practice	Quality Appraisal Score (CASP)
Coburn and Doering 2021	United States	To explore the decision-making processes of women who planned home births and to generate an emerging theoretical description of these processes	Grounded theory using semi-structured interviews conducted with women recruited through home birth midwifery and women's health practice	11 non-Hispanic White women aged 28-40 years (mean age 34.7 years) who were currently planning home births or had planned home births within the last 10 years in the United States and chose CNMs as their home birth providers. Women were either married or partnered, educated to at least college level	Deciding on home birth in the United States calls for high levels of agency by woman planning the birth	Perinatal care providers can advocate for an increased sense of agency during pregnancy and birth and foster understanding between the home birth community and conventional perinatal care settings through family-centred care. Future researchers should explore how social, economic, racial, and gender dynamics affect women's decision-making processes for home birth, because agency may not be distributed equally among various subpopulations in the United States	80%
DiFilippo et al. 2015	Greater Toronto Area of Ontario, Canada	To explore women's learning in their challenging transformative decision to give birth at home with midwives in Ontario, Canada	Critical feminist approach using semi-structured interviews with women recruited through midwifery practice groups in greater Toronto area of Ontario	Seven women who had planned mid-wife attended home birth in the last two years aged 20-40 years old, multiparous (1-5 children), educated, middle-class and in paid work (n=6), mostly White (n=6), mostly married with long term partner (n=6)	Women's resistance and relearning about home birth was shaped by replacing their misconceptions and myths about midwife-led home birth with more current and evidence-based information as well as their own life experiences and those of women they trusted	Personal experiences are a fruitful starting place for individual and social change. Further research is needed to explore the experiences of more diverse participants in order to develop a deeper understanding of women's learning processes and decisions	60%
Fleming et al. 2017a	Washington State, USA	To explore and construct meaning from the experiences of childbearing women who chose to have a planned homebirth in Washington State	Heideggerian phenomenology using interviews in participants' homes; recruitment was done through personal and professional contacts, and by snowballing through research participants	Nine English-speaking childbearing women with a mean age of 29 years (age range 24-39years) who had experienced at least one birth between 2010 and 2014. Ethnicity not reported	Women valued having a trusted midwife/childbirth educator/doula who supported them to have a safe and natural birth within their own environment and control. These contributed to positive home birth experiences and good physical and mental postnatal wellbeing for women in the study	Quality prenatal education is needed and warranted to educate childbearing women, providers and staff members of safe birthing practices based on the current evidence	80%

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Authors/year	Study Setting (Country)	Study Aim	Methodology	Sample Characteristics	Key conclusions	Recommendation for practice	Quality Appraisal Score (CASP)
Fox et al. 2018a	South-eastern Australia	To explore the views and experiences of women, midwives and obstetricians on the intra-partum transfer of women from planned homebirth to hospital in Australia	Constructivist grounded theory using face-to-face and telephone interviews with women and midwives recruited from private midwifery practices, two publicly funded homebirth programmes and personal networks	Ten women who had planned a home birth in the past three years and were subsequently transferred to hospital during labour or with their baby soon after birth; Midwives who in the past three years cared for women at home (HBM) (n=13); Midwives working in a hospital who in the past three years, experienced receiving women as described above (=8); and medical staff working in a hospital who, in the past three years experienced receiving women as described above Obstetricians (n=5). Women's demographic details not reported	Supporting woman centred care in home birth transfers means acknowledging the social challenges of collaborating with hospital staff. To facilitate a successful transfer, there is need to understand the power of the midwife-woman partnership, and its value to the health and well-being of each woman and her baby.	Processes and interactions involved in home birth transfers need to amalgamate: midwife-woman partnership, woman centred care, intergroup collaboration among midwives, and mutual respect for their respective roles and responsibilities; in order to ensure a smooth and successful homebirth transfer which leads to positive health outcomes for the woman and her baby.	80%
Fox et al. 2018b	South - eastern Australia	To explore how women and midwives prepare during the antenatal period for the possibility of intrapartum transfer from planned home birth	Constructivist grounded theory using face-to-face and telephone interviews with women and midwives recruited from private midwifery practices, publicly funded home birth programmes and personal networks	Homebirth women with a privately practicing midwife (n=7); homebirth women from publicly funded programmes (n=3); privately practicing homebirth midwives (n=7); publicly funded homebirth midwives (n=6) hospital midwives (n=8). Demographic details not reported	To reduce women's uncertainty about home birth, they were prepared through, information provision and emotional support around the possibility of transfer. Women were also supported to book into a back-up hospital.	Aligning women's and midwives' needs with hospital policies could improve interactions and processes during transfers. Collaborative working between home birth midwives and hospital colleagues should be encouraged and supported	90%

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Authors/year	Study Setting (Country)	Study Aim	Methodology	Sample Characteristics	Key conclusions	Recommendation for practice	Quality Appraisal Score (CASP)
Hinton et al. 2018	England, UK	To explore the information needs of women when choosing where to give birth in England	Qualitative study using online and face-to-face focus groups (n=8) with women recruited through a local women's group who support disadvantaged and vulnerable pregnant women in London	Women aged 18+ (n=69) in the last trimester of their pregnancy and either planning a home birth (group 1) or living in areas with lots of choice (group 2) or limited choice (group 3) or first-time mothers (group 4) or living close to an FMU (group 5) or an opt-out AMU (group 6) or living in socioeconomically disadvantaged areas (group 7) and planning to give birth in an OU (group; 8); Primiparous (n=40) or Multiparous (n=29) Choice of planned birthplace: Homebirth (n=15), AMU (n=17), OU (21), AMU or FMU or Homebirth (n=6), OU/AMU (n=1) OU or homebirth (n=2), FMU (n=7); Age < 30 years (n=15); 30-35 years(n=36); >35 years (n=8); NK (n=9) Ethnicity: Black African (n=2); Bengali-speaking (n=2); Indian (n=1); Eastern European (n=1); NK (n=63)	Women's main sources of information were non-professional sources, not midwives; Women identified the need to be able to discuss their birth options and preferences with their midwives regardless of other sources of information available to them.	Midwives to provide women with detailed verbal and written information regarding birthplace options from early on in the pregnancy to help guide informed decision-making on where to give birth; Midwives to signpost women to credible online sources to ensure that information women receive from such sources are reliable to help guide their birthing decisions	80%
Hollander et al. 2017	Amsterdam, Netherlands	To examine women's motivations for choosing homebirth in a high-risk pregnancy or UC and their approach to realise the intended birth of their choice	Grounded theory using interviews at participant's homes or a medical centre. Participants were recruited through certain nationally known advocates or famous 'cases', online maternity care user's forum, referral by other participants or midwives	28 women. Demographic details not provided	Compared with other developed countries, maternity care in the Netherlands has low rates of interventions and a relatively high home birth rate.	There is need for maternity care providers to be flexible and unbiased in their approach to negotiating birth plans with women, by respecting women's autonomy and engaging them in shared decision-making regarding their birth plan choices	100%

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Authors/year	Study Setting (Country)	Study Aim	Methodology	Sample Characteristics	Key conclusions	Recommendation for practice	Quality Appraisal Score (CASP)
Holten et al. 2018	Netherlands	To explore how the wish to birth outside the system was negotiated in consultation/clinical encounters between pregnant women and their healthcare professionals	Case study using interviews. Women were recruited through nationally known advocates or famous ' cases', online maternity care users' forum and referral	Ten women who choose a homebirth, and had had a high-risk pregnancy, aged 25-40 years, all multiparous, employed (n=8), unemployed (n=2), married (n=6) or living with partner (n=4). Sample also included partners (n=10), community midwives (n=5, all females), holistic midwives (n=8, all females), and obstetricians (n=8, 2 females, 6 males). Women's ethnic details not reported	Women experienced conflicts with their maternity care providers in negotiating a birth plan. Lack of flexibility between women their maternity care providers influenced women's decision that the hospital was no longer a birthplace option for them	Maternity care providers need to be more aware of their own concepts of risk perception, engage women in shared decision-making and pursue continuity of care in an equal, respectful, and trusting relationship with the women	100%
Keedle et al. 2015	New South Wales, Western Australia, South Australia, Victoria and Queensland Australia,	To explore women's reasons and experiences of choosing a homebirth after caesarean section (HBAC)	Feminist framework approach using face-to-face, telephone and Skype interviews with women recruited through home birth specific webpages, social network sites and through informal network techniques	Twelve Women who had achieved a vaginal birth after caesarean (VBAC) at home within the last five years in Australia; Aged 26 -40 years; Married (n=9) or with partner (n=3); had their birth with a Privately Practicing Midwife (n=10), or an Unregistered birth worker (n=1), or Freebirth (n=1); Previous births: NVB- (n=1) CS- (n=12), VBAC – (n=4), HBAC – (n=12) Education: High school certificate (n=1), Certificate/Diploma (n=7), University Degree (n=3), Postgraduate Degree (n=1). Women's ethnic details not reported	Women expressed a reluctance for the medical model of maternity care. Their preference for natural birth served as a catalyst for resilient problem-solving and taking positive actions to actualise a planned homebirth.	There is need for a shift in expectation within the health professional community, towards encouraging and supporting women who wish to have vaginal birth after caesarean (VBAC).	100%

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Authors/year	Study Setting (Country)	Study Aim	Methodology	Sample Characteristics	Key conclusions	Recommendation for practice	Quality Appraisal Score (CASP)
Lee at al. 2016a	South East England, UK	To examine the perception of risk among a group of women with high risk pregnancies who were either planning to give birth in hospital or at home despite medical advice to the contrary	Qualitative study using semi-structured face-to-face interviews at women's choice locations and after 32 weeks of pregnancy recruited through a maternity department in a NHS service	Twenty-six women with high risk pregnancies planning home births (n=13) and hospital births (n=13); Nulliparous (n=7), Multiparous (n=19); White European (n=23), Hispanic (n=1)and Mixed race (n=2); Married/living with partner (n=25) and Separated (n=1); having medical/obstetric conditions including: Diabetes (n=1), Previous CS (n=13), Hypothyroidism (n=3), Von Willebrand's disease ((n=1), Previous postpartum haemorrhage (n=1), Twin pregnancy (n=1), Osteoarthritis and hypermobility (n=1), Polycystic kidneys (n=1), Cardiac condition (n=1).	Women's decision to have a planned home birth was motivated by their perception of it as being less risky due to previous experience of successful vaginal or home births. Women also viewed their home environment as more relaxing to reduce birth risks	Healthcare professionals should consider how women's subjective perceptions of risk influence their decision-making regarding birthplace and engage them in open communication to enhance positive birth choices and experiences for them	90%
Lee et al. 2016b	South East England, UK	To investigate women's perceptions of interactions with obstetricians and midwives during high risk pregnancies	Qualitative study using interviews with women at their chosen locations and after 32 weeks of pregnancy recruited through a maternity department in a NHS service	Twenty-six women with high risk pregnancies planning homebirths (n=13) and hospital births (n=13); Nulliparous (n=7), Multiparous (n=19); White European (n=23), Hispanic (n=1)and Mixed race (n=2); Married/living with partner (n=25) and Separated (n=1); having medical/obstetric conditions including: Diabetes (n=1), Previous CS (n=13), Hypothyroidism (n=3), Von Willebrand's disease ((n=1), Previous postpartum haemorrhage (n=1), Twin pregnancy (n=1), Osteoarthritis and hypermobility (n=1), Polycystic kidneys (n=1), Cardiac condition (n=1)	Similarities and differences in women's perceptions of having a home or hospital birth for a high-risk pregnancy should be duly considered and respected by HCPs.	Healthcare professionals should acknowledge women's concerns through open communication and provide unbiased information to enable women make an informed choice regarding their preferred birthplace	90%

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Authors/year	Study Setting (Country)	Study Aim	Methodology	Sample Characteristics	Key conclusions	Recommendation for practice	Quality Appraisal Score (CASP)
Leo-Larios et al. 2019	Andalucía, Spain	To explore the perceptions, beliefs and attitudes of women who opted for a homebirth in Andalusia (Spain)	Phenomenology using individual interviews. Women were recruited through home birth midwives	Thirteen women aged 28-39 (mean age 30 years old), primiparous(n=7) or multiparous(n=6), all Caucasian, Spanish-speaking, resident in rural (n=8) or urban (n=5) areas.	Women who opted for a home birth expressed dissatisfaction with the care offered as part of the Spanish National Health Service in hospitals. In contrast, they wanted to have personalised births and control over the decision-making in labour, which were not offered to them in hospital settings	There is need for a clear national policy regarding birth place, training on personalised care and human rights in hospital settings and information directed to the public on home birth and midwifery units in Spain.	100%
Russell et al. 2021	Australia	To explore the experiences of women who had given birth in a rural environment and the factors that influenced their choices regarding their maternity care.	Individual interviews, face to face, via telephone and via skype Women were recruited via rural midwives and information posted on the Victorian rural homebirth network Facebook page	10 women in study; aged 27-40 years Four women were first-time mothers, one woman had given birth twice, three women had given birth three times, one woman had had her fourth child, and one woman had just had her fifth child. Two women had homebirths with a midwife or midwives in attendance (Participants #3 and #8	Previous experience of hospital may shape decision to have home birth Women want midwifery care to trust, guide and support decisions, Women feel safe with home birth midwives who have knowledge & experience of home birth Both women felt it was important to feel supported in their choices by midwives	Information about all models of maternity care should be presented to rural women to assist them with making an informed decision regarding the birth of their baby. Further research is needed with larger and varied samples of women in rural communities.	100%
Sassine et al. 2021	Australia	To understand the characteristics, needs and experiences of women choosing to have a homebirth in Australia	Survey with qualitative and quantitative questions	1835 participants with average age of 32 years, mostly born in Australia (81.7%) or English -speaking countries (11.3%), educated to University level (65.8%)	Research findings indicate that tighter regulation of the practice of midwives in Australia could drive homebirth underground, with half of participants in the survey reporting they would freebirth or find a UBW to support them if a midwife could not be found	Government support for homebirth in the form of Medicare funding would improve access to midwife-attended homebirth for many women who currently cannot afford it. Guidelines on decision-making in pregnancy and birth, and the use of Maternity Care Plans in the hospital, is needed to address women's experiencing of lack of informed consent, and coercion in the hospital setting	42%

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Authors/year	Study Setting (Country)	Study Aim	Methodology	Sample Characteristics	Key conclusions	Recommendation for practice	Quality Appraisal Score (CASP)
Skrondal et al. 2020	Norway.	To gain knowledge regarding how Norwegian nulliparous women experience planned home birth and why they choose this route of giving birth	Qualitative approach using interviews. Participants were recruited through private practicing midwives throughout Norway	Ten Norwegian women aged 19-39 years who had gone through successful planned homebirth of their first child within the last two years; lived with partners (n=9), held college/university degrees	The choice to plan for a home birth is not within the norm of society but was well-thought-through.	Preparations in pregnancy should have an individual focus, and include mental and emotional support. There is need to make the birthing space safe while ensuring continuity of care for women.	100%
Volpato 2021	Brazil	To understand how information about PHB motivates or discourages women's decisions on this location of birth	Descriptive exploratory qualitative design. Data collection by semi-structured interviews	14 women aged between 24 and 38 years old, mostly educated to University degree, in stable relationship, primiparous (n=11) or had previous CS (n=3)	The woman's choice for the place of birth is not isolated, but happens through information and influences from the context in which she experiences this choice. Hence it is essential to discuss the security of PHB in the Brazilian scenario in order to optimize decision making.	It is essential to discuss the security of PHB in the Brazilian scenario in order to optimize decision making.	70%

Hollander *et al.,* 2017; Ávila Moraes *et al.,* 2016; Volpato *et al.*, 2021; Leon-Larios *et al.,* 2019; Skrondal, Bache-Gabrielsen & Aune, 2020). Women reported being perceived by some members of their social circle (including family, friends and wider society) as '*irresponsible*' and *'selfish'* for planning a home birth as they perceived it as too risky and could jeopardise the baby's life (Bonmarito, 2018; Hollander *et al.,* 2017; Skrondal, Bache-Gabrielsen & Aune, 2020). Sceptical comments from the women's social circle were mostly borne out of societal aversion for a home birth due to the associated perceived risk (Ávila Moraes *et al.*, 2016; Leon-Larios *et al.,* 2019; Skrondal, Bache-Gabrielsen & Aune, 2020), and the notion that the women were going against the generally acceptable culture of having a hospital birth. Such negative reactions made women feel unsupported, isolated with a low mood:

> *"…The social image of home birth is negative in Spain so my family did not support me. They were draining my positive energies with their negative comments…"* (Participant quote), (Leon-Larios *et al.*, 2019).

Variations existed across the studies in how women responded to and dealt with their experiences of social stigmatisation. Women drew strength and confidence in a personal conviction in their ability to achieve a successful physiological birth at home:

> *"…I had the basic trust [in giving birth at home and the ability of my own body]; hundreds of thousands of births have already taken place, why shouldn't it work?…"* (Participant quote) (Brailey *et al.*, 2015).

Women reported concealing their plan to have a home birth from their family and friends, and avoided any related discussions (Keedle *et al.,* 2015; Fox, Sheehan & Homer, 2018b; Bonmarito, 2018; Coburn & Doering, 2021; Holten, Hollander & de Miranda, 2018; Leon-Larios, 2019; Skrondal, Bache-Gabrielsen, & Aune, 2020). Some women reported declining participation in antenatal preparation activities classes to avoid being put in a situation where they may be asked to talk about their birthplace plan:

> *"…It was a very conscious decision for me – to not do prenatal yoga, prenatal childbirth education classes, read a million books, watch a million videos. I didn't want to do any of that." She went on, "I didn't want to go to prenatal yoga class where you sit in the beginning and everybody goes around and says how many weeks pregnant they are and where they are having their baby. I didn't want to have to say, 'at home.' And have people say, 'Oh, that is so brave of you. I would love to do that, but I'm too afraid.' Or 'I could never do that.' That is what most people say to me, 'Oh, that is so brave' or 'Oh, that is so bold.' I don't like that kind of comment…"* (Participant quote) (Bonmarito, 2021).

In more than half of the studies (Hinton *et al.,* 2018; Keedle *et al.,* 2015; Sassine *et al.,* 2021; Fleming *et al.,* 2017; Coburn & Doering, 2021; Holten, Hollander & De Miranda, 2018; Ávila Moraes *et al.*, 2016; Brailey *et al.,* 2015; DiFilippo, 2015; Leon-Larios *et al.*, 2019; Skrondal, Bache-Gabrielsen, & Aune, 2020), women empowered themselves by doing personal research, reading scientific and non-scientific literature on childbirth and proactively seeking information from other like-minded women via their social media networks . Women in these studies reported feeling inspired and encouraged by other women's success stories of having a home birth. This provided reassurance for women in their decision to have a planned home birth. Some women highlighted the importance of keeping an open mind regarding the possibility of transfer to a hospital during the birthing process. Hence, they educated themselves on possible complications which may arise from having a home birth and prepared themselves mentally and practically:

> *"…I think the decisions to research and understand risk and act in what you see as your best interest in understanding them… so that taking that control, understanding the risks, making those decisions I think is really important…" (Participant quote) (Keedle et al., 2015).*

Preparing their homes for the birth, further helped to promote some women's psychological readiness for the home birth as their privacy, control and comfort were prioritised. Notably, only one of the studies (Bonmarito, 2018) reported a few women experienced social acceptance for their planned home birth decision. Such social acceptance was expressed via verbal and physical support for the women's planned home birth decision.

Accessing support from social contacts

In most of the studies (Keedle *et al.,* 2015; Fox, Sheehan & Homer, 2018a; Sassine *et al.,* 2021; Bonmarito, 2018; Coburn & Doering, 2021;Hollander *et al.,* 2017; Holten, Hollander & de Miranda, 2018; Ávila Moraes *et al.*, 2016; Volpato *et al.*, 2021; Brailey *et al.*, 2015; DiFilippo, 2015; Leon-Larios *et al.,* 2019; Skrondal, Bache-Babrielsen & Aune, 2020), women recalled receiving support from a variety of sources including other women who had experienced a natural birth, their partners, family and friends who believed in home birth. The internet and social media further played an important role in women's support experience across many of the studies (Hinton *et al.,* 2018; Keedle *et al.,* 2015; Fleming *et al.,* 2017; Coburn & Doering, 2021; Holten, Hollander & de Miranda, 2018; Brailey *et al.,* 2015; DiFilippo, 2015; Leon-Larios *et al.*, 2019; Skrondal, Bache-Babrielsen & Aune, 2020; Ávila Moraes *et al.*, 2016). For example, some women reported connecting with other women via online platforms, including social media groups like Facebook, blogs; and identified home birth midwives via the internet:

> *"…After finding out the baby was breech] And then I cried in the car. [...] And then I thought: yes, now it won't be a home birth anymore. […] Then I cried for I think another hour. Then I went on the internet and joined the birth movement […]. And then within an hour I had somebody who said: 'I will help you at home together with your [own] midwife…"* (Participant quote) (Hollander *et al.*, 2017).

Women further reported accessing support from local home birth support groups where they drew confidence and encouragement from their peers and connected with midwives who support home birth (Hinton *et al.,* 2018, Keedle *et al.,* 2015). Word of mouth enlightenment, information and support received from other women further helped to normalise home birth and increased women's confidence in their decision-making. In some studies (Keedle *et al.,* 2015; Coburn & Doering, 2021; Brailey *et al.,*2015; Volpato *et al.*, 2021; DiFilippo, 2015; Leo-Larios *et al.*, 2019), women described their partners as supportive of their planned home birth which made the decision-making easier for them and enabled them to withstand criticism from others:

> *"...And you know he had fears about that kind of stuff … and he had come to the point to where he was able to say: "This is a good thing. Let's try it. Let's do this." … He became my biggest encourager"* (Participant quote) (DiFilippo, 2015).

A few women also reported receiving support from their mothers as home birth was a family tradition (Bonmarito 2018; Hinton *et al.,*2018; Keedle *et al.,* 2015; Skrondal, Bache-Gabrielsen & Aune, 2020).

> *"Home birth is all I really know." She continued, "My mother had her first home birth [with one of my siblings] in 1990. So, that's how I found out about it. It's kind of in the family, I guess." (Participant Quote* (Bonmarito, 2018).

Woman-provider interactions in home birth planning

The women had to consult with their maternity care providers to plan a home birth and they reported similarities and disparities in their experiences. This category is reported under three themes: 'positive experiences of consultation with maternity care providers', 'negative experiences of consultation with maternity care providers' and 'recommending actions to improve woman-provider relationship in planning a home birth'.

Positive experiences of consultation with maternity care providers

In most of the studies (n=14), women recounted positive experiences of their consultation with maternity care providers to plan a home birth. However, this was mostly in relation to their midwife whom they described as more empathetic and supportive compared with the obstetricians (Lee, Ayers & Holden, 2016a; Lee, Ayers & Holden, 2016b; Borrelli, Walsh & Spiby, 2017; Hinton *et al.,* 2018; Fox, Sheehan & Homer, 2018a; Fox, Sheehan & Homer, 2018b; Fleming *et al.,* 2017; Holten, Hollander & De Miranda, 2018; Brailey *et al.,*2015; Skrondal, Bache-Gabrielsen & Aune, 2020). There were reiterations across the studies that midwives' support, trust and expertise empowered women's autonomy and confidence in their planned home birth decision. Women particularly felt empowered and in control due to their midwife's respect for their autonomy and willingness to facilitate their home birthing preference:

> *"…with the midwives there's more of an understanding, more respect around the mother's intuition; the knowledge and the wisdom and the faith in the body to do what it needs to do…"* (Participant quote) (Lee, Ayers & Holden, 2016b).

Midwives' positivity and expertise to manage the birth process was further highlighted as reassuring for the women and improved their confidence to have a positive home birth experience. Fourteen of the studies (Lee, Ayers & Holden, 2016a; Lee, Ayers & Holden, 2016b; Hinton *et al.,* 2018; Fox, Sheehan & Homer, 2018a; Fox, Sheehan & Homer, 2018b; Sassine *et al.,* 2021; Fleming *et al.,* 2017; Coburn & Doering, 2021; Holten, Hollander & De Miranda, 2018; Ávila Moraes *et al.,* 2016; Volpato *et al.*, 2021; Leon-Larios *et al.,* 2019; Russell et al. 2021; Skrondal, Bache-Gabrielsen & Aune, 2020), reported on the communication aspects of the woman-provider relationship and highlighted that open communication and information from midwives provided reassurance regarding the birth process and enhanced a trustful woman-midwife relationship. Women reported communication with home birth midwives around the pain of childbirth helped them to feel empowered. Understanding the transfer plan further enhanced women's trust in their midwife's judgement to transfer them to hospital only if necessary. This and made them feel safe:

> *"…very safe because I had [my home birth midwife] there…"* (Participant quote) (Fox, Sheehan & Homer, 2018a).

Only one study reported women receiving advice from birthing classes with home birth midwife, doula, or child educators (Hinton *et al.,* 2018). Women who attended prenatal clinical monitoring (Lee, Ayers & Holden, 2016a; Hinton *et al.,* 2018; Ávila Moraes *et al.,* 2016) reported feeling reassured by having additional tests (blood test, scans) and consultations with their maternity care providers.

Negative experiences of consultation with maternity care providers

Women in some of the studies (n=7) reported negative experiences of consultation with their maternity care providers (particularly obstetricians) (Lee, Ayers & Holden, 2016b; Keedle *et al.,* 2015; Bonmarito, 2018; Hollander *et al.,* 2017; Holten, Hollander & De Miranda, 2018; Leon-Larios, 2019; Skrondal, Bache Gabrielsen & Aune, 2020). Negative perceptions were mostly attributed to maternity care providers lacking consideration and respect for women's autonomy to have a planned home birth. This was expressed through maternity care providers' criticism of the women's decision to have a planned home birth which resulted in major conflicts over the birth plans (Lee, Ayers & Holden, 2016b; Keedle *et al.,* 2015; Bonmarito, 2018; Hollander *et al.,* 2017; Holten, Hollander & De Miranda, 2018; Leon-Larios, 2019; Skrondal, Bache Gabrielsen & Aune, 2020) and psychological distress for the women as they felt threatened and victimised:

> *". . . at first I sent my birth plan and then we talked again, and that was when he let me know that they were not willing to make any concessions and that continuous [foetal] monitoring was an absolute requirement . . .Then we said: ok, well then, we will do things differently. And that is when the telephone conversation became distinctly unpleasant. That he said: "Yes, well, that is not allowed, and a midwife who does this is acting against the law. Your child has rights too." That was unpleasant. . . One and a half hours later he phoned and said: "I am going to report you to child protective services, because you want to have a home birth" . . . As far as we were concerned, that definitely closed the door to the hospital. It was quite intense too because I was thirty-nine weeks at the time. I found that very threatening…"* (Participant quote) (Holten, Hollander & De Miranda, 2018).

There were also disparities between women's and maternity providers' perception of risk associated with childbirth which informed their prioritised birthplace (Lee, Ayers & Holden, 1016a; Hollander *et al.,* 2017, Leon-Larios *et al.,* 2019). Maternity care providers' prioritisation of medicalised and intervention-driven hospital birth further made women perceive mainstream maternity as unsuitable to meet their needs for a planned home birth. Hence women reported feeling unsupported and avoided discussions with their obstetricians regarding their planned home birth:

> *"…They made me feel that I was putting my baby at risk. I did not feel any rapport with my healthcare professionals, so I avoided telling them my decision about home birth when I attended the antenatal clinic…" (Participant quote) (Leon-Larios et al., 2019).*

Women reported switching their care from their obstetrician to a home birth midwife whom they perceived as more willing to accommodate their birthing preferences and having the necessary skills to deal with any complication that may occur during the home birth. This enhanced the women's confidence in their planned home birth decision, regardless of the opposition they faced from their social circle:

> *"…Just basically daring to choose something different. So, it was very nice to be confident that this was the right thing for us…"* (Participant quote) (Skrondal *et al.,* 2020).

Recommending actions to improve woman-provider relationship in planning a home birth

In three of the studies (Borrelli, Walsh & Spiby, 2017; Hollander *et al.,* 2017; Leon-Larios *et al.,* 2019), women offered useful suggestions on how to improve woman-provider relationship in aspects related to planning a home birth. Notably, women expressed a desire for maternity care providers to complement their professional knowledge with compassionate care, friendliness and empathy, highlighting they valued the emotional support even more than medical checks and interventions. Some women rated a '*compassionate attitude*' from healthcare professionals above any medical qualification:

> *"…It's more like the moral support for them to be there for me other than doing checks…" (Participant quote) (Borrelli, Walsh & Spiby, 2017).*

Women further recommended the inclusion of home birth as an option within publicly funded healthcare system (Leon-Larios *et al.*, 2019), so they have the autonomy to choose their preferred birthplace option without having to pay for private midwife or experience criticisms from maternity care providers:

"*…I would recommend home birth to anyone if it was a publicly funded option, because not all women can afford it…*" (Participant quote) (Leon-Larios *et al.*, 2019).

A few women highlighted the importance of maternity care providers having open unbiased discussions about place of birthplace options with women from about 20 weeks of pregnancy (Hinton *et al.*, 2018; Fox, Sheehan & Homer, 2018b):

If I hadn't mentioned home birth I don't think anyone would have presented it to me as an option, we always get asked which hospital we want to go to" (Participant quote) (Hinton *et al.*, 2018).

This would provide women with opportunity to develop a relationship with the midwives and to feel safe in their care. This is particularly important if the birth does not go to plan, and necessary to transfer to hospital from a planned home birth:

"If you have to go to a hospital, having someone there who you know is on your side, who shares your values, who you've chosen to be on your team, that you've spent time with leading up to the birth and then who would continue to be with you afterwards, is just so, so worth [it]…having familiar faces there, people you trust, whose opinion you trust, I think that is the key to having a positive birth experience at a hospital" (Participant quote), (Fox, Sheehan & Homer, 2018b).

Discussion

This review aimed to synthesise findings from published studies on women's experiences of consulting with their maternity care providers to plan their birth at home, including their information and support needs. Women's positive experiences of planning their home birth with maternity care providers was one of the main themes in this review with the desire for birth without unnecessary interventions (Lee, Ayers & Holden. 2016a; Borrelli, Walsh & Spiby, 2017; Keedle *et al.*, 2015; Fleming *et al.*, 2017; Hollander *et al.*, 2017; Holten, Hollander & de Miranda, 2018; Brailey *et al.*, 2015; Leon-Larios *et al.*, 2019; Skrondal, Bache-Gabrielsen, Aune, 2020) and continuity of carer being motivating factors in choosing to plan a home birth (Borrelli, Walsh & Spiby, 2017; Keedle *et al.*, 2015; Hollander *et al.*, 2017; Holten, Hollander & de Miranda, 2018; Brailey *et al.*, 2015; Leon-Larios *et al.*, 2019; Skrondal, Bache-Gabrielsen, & Aune, 2020).

There were also accounts of negative experiences and social stigma, not only from consultations with maternity care providers, but also family and friends (Lee, Ayers & Holden, 2016b; Keedle *et al.*, 2015; Bonmarito, 2018; Hollander, *et al.*, 2017; Ávila Moraes *et al.*, 2016; Leon-Larios *et al.*, 2019; Skrondal, Bache- Gabrielsen & Aune 2020). This led to women hiding their plans for home birth and seeking support from like-minded women. Women did appreciate the opportunity to get information from their maternity care professionals and valued forming a trusting relationship with them where they felt supported in their choice. However, they were not willing to accept generalised advice that was derived from hospital policy but wanted information which was specific to them (Lee, Ayers & Holden, 2016a; Lee, Ayers & Holden, 2016b). The Royal College of Midwives (2022) have produced guiding principles for midwives providing personalised care for women who are seeking care that sits outside of guidance. This may go some way in helping midwives to be more receptive to women planning a home birth (both inside or outside guidance). Building a trusting relationship with the midwife or home birth midwifery team was also an important factor in helping women to accept the possibility of a transfer into hospital during labour or after birth (Fox, Sheehan & Homer, 2018b). Although a possibility, transfer rates from a planned home birth during labour and after birth are low with a review reporting rates of transfer ranging from 9.9% to 31.9% across the studies (Blix *et al.*, 2014). Most commonly, the reasons for transfer are non-emergency. Transfers related to fetal distress range from 1.0% to 3.6% with the percentage of emergency transfers ranging from 0% to 5.4%. It is important to note that all women who go into spontaneous labour at home and who are planning to birth in a Midwife Led Unit (MLU) or an Obstetric Unit (OU), also transfer in labour as their labour progresses, so transfer from a home birth should not be an anxiety provoking aspect of care (Gillen & Clausen, 2017). However, Cheyney, Everson & Burcher (2014, p 444) highlights that "*the contested space of home-to-hospital transfers*" is often a source of anxiety for both the woman and the midwife with the transfer being perceived as a failure rather than an example of appropriate assessment and care.

Positive experiences about consultation with maternity care providers, particularly midwives, were reported in 14 out of the 20 included studies, and this was viewed as encouraging and supportive, with women feeling safe in the care of the midwives. However, 7 of the studies reported overt criticism of the women's decision to plan a home birth. Discussions with maternity care providers often turned 'unpleasant' and the conversation turned to what part of the woman's birth plan would be facilitated or not. In part, this lack of support for a planned home birth arose from a disparity of perception of risk between the maternity care providers and women. Unfortunately, this led to women not feeling at ease with discussing their plans with the maternity care provider and adopting an avoidance strategy similar to the one used with friends and family who were not supportive of their plans (Vedam *et al.*, 2014). The importance of trust, having exchanged information and reached agreement on the woman's values are vital to helping the women to have the best birth experience.

The incidence of freebirth (giving birth unattended by a midwife or unassisted birth-without aid of health professional) is rising as some women who are faced with a lack of support from health care professionals, family and friends for their plan to birth at home, feel that their only option is to choose to birth without a midwife present (Knight *et al.*, 2020). Greenfield *et al.*, (2021) highlighted that giving birth without a maternity healthcare professional (midwife) present is unusual in most countries, and the reasons to do so can be complex. The research found a higher incidence of women who were lesbian, bisexual, pansexual or queer considering freebirthing than heterosexual women, with the COVID-19 pandemic an added reason. Birthrights (2021) clearly state that 'women cannot be compelled to go to hospital to give birth, and it is not illegal for a woman to give birth without assistance'. Birthrights (2021) highlight that not respecting women's choices about where and how their birth takes place, may violate their human rights. In countries where home birth is not publicly funded, it was considered important that planned home birth provision should be included within universal maternity care provision. Otherwise, planned home birth is not an affordable choice for some women.

Women's ethnicity was not reported in most of the studies. It is important to report the ethnicity of research participants to enhance a contextual understanding of study findings and implications particularly for underrepresented groups. Recent evidence from the UK highlights maternal mortality rate is 3.7 times higher amongst Black women and 1.8 times higher for Asian women compared with white women (Knight *et al.*, 2022). Whilst maternal deaths are rare in the UK occurring in fewer than 10 per 100,000 pregnancies, nevertheless, a recent national learning report from

maternal death investigations during the first peak of the COVID-19 pandemic, showed that all the six maternal deaths related to COVID-19 involved black or brown women (Healthcare Safety Investigation Branch National Learning Report, 2021). Racial disparity needs to be addressed immediately and high-risk women such as those from Black and minority ethnic communities should be invited and supported to participate in relevant research studies such as planning birth at home.

Strengths and Limitations

This is the first systematic review (to the best of our knowledge) to synthesise published evidence that focuses on women's experiences of planning home birth in consultation with maternity care providers. The systematic review incorporated the GRADE-CERQual approach as a transparent framework for assessing the confidence in each of the individual review findings. Few of the included papers reported on experiences of women from black, Asian and ethnic minorities. While the papers were from a range of upper middle and high-income countries, all the included papers were published in English.

Conclusion

Women value the opportunity to plan their home birth in consultation with maternity care providers. However, where women feel that the information and support for their planned place of birth do not meet their needs, they sought information and support from like-minded people. In some instances, this meant distancing themselves from obstetric care and seeking out a supportive midwife or employing a private home birth midwife. Many of the pressures associated with planning home birth come from a woman's friends and family. Therefore, in addition to resources for women and partners, evidence-based planning home birth resources that can be shared with or are freely available for family and friends are important to prevent women being stigmatised. Provision of services that are woman-centred and optimise midwife continuity of care and carer are essential for all women when planning birth and have been shown to improve outcomes for mother and baby. In the absence of choice and respect for a woman's plan for a home birth, there is growing evidence that freebirth may be the only alternative. This is not an easy choice but a decision a woman may feel she has to take due to poor communication and a breakdown in her relationship with maternity care providers. Maternity care systems including adequate resourcing and investment in continuity of care and midwife-led services are vital to ensure that women are provided with options for their planned place of birth, in consultation with maternity care providers. Hospital services for healthy women should not be prioritised over home birth as has been the case in the UK both prior to, and during the COVID-19 pandemic.

Ethical approval

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CRediT authorship contribution statement

Patricia Gillen: Conceptualization, Methodology, Data curation, Formal analysis, Investigation, Resources, Project administration, Writing – original draft, Writing – review & editing, Funding acquisition. **Olufikayo Bamidele:** Data curation, Formal analysis, Writing – review & editing. **Maria Healy:** Conceptualization, Methodology, Data curation, Formal analysis, Writing – review & editing, Investigation, Funding acquisition.

Anonymized for peer review.

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Supplementary materials

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