The Experience of Planned Home Birth: Views of the First 500 Women

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ABSTRACT: Background: Home birth remains a contentious issue in North America. Professional regulatory bodies are in conflict about the safety of home birth as an option for healthy women. The voices of women have largely been ignored in this debate. The purpose of this study is to report on the experiences of 559 women who had a planned home birth over a 2-year period in British Columbia, Canada. Methods: We asked all women in the Province of British Columbia who had planned for their birth to be at home with a regulated midwife in attendance to answer an open-ended question about positive and negative aspects of their birth. The qualitative method of interpretive description was used to understand what women believed to be the essence of their experience. Results: Women felt strongly positive about their trust in their midwife’s skill and knowledge, a sense of emotional support and empowerment attained through their relationship with the midwife, perceptions of relaxation in their own home, being informed and included in the planning of their care, and the amount of time the midwife spent with their family. They believed that the confidence arising from their intense preparation and partnership with their midwives permitted them to choreograph their birth experience to a degree that would not be possible in a formal setting. Conclusions: Women who planned a home birth with a registered midwife in British Columbia were overwhelmingly positive about their experience. Our qualitative report underscores the value women place on having the choice to give birth at home. (BIRTH 36:4 December 2009)

Key words: home birth, labor, midwifery, postpartum, qualitative research

Midwifery in Canada has emerged as an independent regulated profession within the last 15 years. Although midwifery has generally been welcomed by the community of maternity care providers in North America, home birth as an option within midwifery care has not. In Canada, the Society of Obstetricians and Gynecologists has stated that more research on the safety of home birth is needed (1). In the United States, the American College of Obstetricians and Gynecology have issued a position paper opposing home birth (2).

This debate has not subsided in the presence of large population-based studies that have failed to demonstrate excess risk associated with home birth (3–12). Controversy continues, given the absence of randomized controlled trials and inability to draw conclusions from observational studies because outcomes are attributed to actual versus planned place of birth (13–15), difficulty in ascertainment of qualifications of caregivers (16), nonrepresentative sampling (8,9), lack of an appropriate comparison group (3,9,11), inadequate

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statistical power (4,10), inability to exclude unplanned home births from the study sample (4,16,17) inability to sort out the effect of place of birth as opposed to the type of caregiver (18,19), and differing qualifications of midwives (lay versus direct entry versus nurse-midwives) (4).

The voices of women who have chosen to give birth at home have largely been ignored in this debate. No large-scale studies have examined the experiences of women who give birth at home and their reasons for choosing home birth. Without this knowledge, there is a disconnect between the active discouragement on the part of many obstetrical caregivers to women who would consider home birth and women’s concepts of what the home birth setting offers to them. In this paper, we present the experience of women who planned home birth with a registered midwife attendant over a 2-year period in British Columbia, Canada.

Methods

Setting

In British Columbia, Canada, midwifery is regulated by The College of Midwives of British Columbia. Midwives are fully reimbursed for a course of antepartum, intrapartum, and postpartum care through a provincially administered health care system. All midwives have hospital privileges and carry malpractice insurance. Midwives are educated through a 4-year direct-entry (nonnursing) baccalaureate degree program at an accredited university or, if trained outside Canada, through a previous learning assessment including written, oral, and practice exams. As part of their mandate of care, all midwives offer women the choice to give birth at home or in hospital. Women choosing home birth meet strict eligibility requirements for low-risk status, including carrying a singleton fetus at term in a cephalic presentation, absence of preexisting health problems including renal or cardiac disease or diabetes, and absence of pregnancy-related complications, such as placenta previa or abruptio, pregnancy-induced hypertension with proteinuria, or active genital herpes (20).

We elicited feedback from women as to the nature of their birth experience as part of a Ministry of Health-legislated evaluation of the first 2 years of regulated midwifery in British Columbia, the Home Birth Demonstration Project, conducted in 1998 to 2000 (20). At this time approximately 60 midwives were registered in British Columbia. All were provided with a questionnaire and a preaddressed and stamped envelope to hand to their clients who had planned a home birth. The questionnaire was completed before 6 weeks postpartum and mailed anonymously to the evaluation coordinator.

The results of specific aspects of the questionnaire are reported elsewhere (21). The present paper reports on responses to the following invitation:

“Please use this space for any comments you would like to make about your pregnancy care, including those aspects you liked or those areas in which you would like to see improvement.”

The purpose of asking this question was to encourage women to comment on aspects of the experience that were important to them without being directed to respond to any particular focus. In this way, we hoped to uncover what women themselves believed to be the essence of their experience.

Our method of data analysis was an adaptation of interpretive description (22). As in most qualitative approaches, interpretive description is intended to discover the underlying meaning of experiences. Some authors warn against using complex coding systems that focus on small segments of data. Georgi states that the choice of analytic steps is less important than the transparency and clarity of those steps to the reader (23). Using this method, the narrative is read at least twice and the transcript is divided into blocks that seem to express a self-contained meaning. In interpretive description, these blocks may be several sentences that seem to be concerned with an underlying meaning, but these blocks can still be equated with coding. Meaning units are examined in terms of the specific topic of the study. They are then synthesized and tied together into a descriptive statement called a theme. Different themes consist of essential, nonredundant meanings. The particulars of the specific situation are left out and the focus is on aspects of the experience that are transsituational or that characterize the topic in general. The focus, rather than on complex coding systems, is on understanding the overall picture. It extends beyond what any individual might see in their own situation, because, whereas the individual has great depth of understanding of her own circumstances, the researchers have access to the insights of many participants. This overview allows an understanding of commonalities within a range of instances of a phenomenon. Two of the investigators undertook the coding, labeling, and categorizing. Agreement on themes was achieved by consensus; credibility of themes and consistency of approach to data analysis were assessed by the third investigator.

The analyst in interpretive description must be aware of the way in which prevalence of meanings can influence pattern recognition, and account for that in some auditable manner. With this in mind, we reported frequencies of responses. We elected to report all negative responses to home birth to illuminate those experiences that were different from those most frequently reported. Validity in interpretive description means that those who have expert knowledge of the phenomenon find that
the claims are plausible and confirmatory of “clinical hunches” at the same time as they illuminate new relationships and understandings (24).

Approval for the study was provided by the University of British Columbia Clinical Research Ethics Board. Women gave their written informed consent before participation in the study.

Results

Of the 862 women in the Home Birth Demonstration Project, 670 (77.7%) received a questionnaire from their midwife. In the early stages of the project, some midwives forgot to hand out the questionnaires. Among women receiving a questionnaire, 559 (82%) returned their responses to our study question with an overall rate of 64 percent. No cases occurred in which a client stated that she did not want to return the questionnaire. All women participating in the project spoke and read English. Age was distributed as follows: 15 to 19 years (1.9%); 20 to 24 (16.1%); 25 to 29 (32.2%); 30 to 34 (29.7%); and over 35 (20.2%). Very few were single mothers (4.8%); 402 participants (46.6%) were primiparous, and quintiles of median household income, derived from Statistics Canada according to postal codes, were evenly dispersed among the group from first (lowest: 23.7%), second (22.3%), third (20.4%), and fourth (19.5%) to fifth (highest: 14.2%) (5).

The themes reported in this study were, for the most part, the ones that occurred with the most frequency and about which the women stated that they felt most strongly. We included the frequency with which the theme was raised in the women’s accounts to allow for some understanding of consistency, but this strategy does not imply any attempt to look for an “average” response. Rather, it is intended to illustrate the multiple ways in which women express similar concerns. All these women had chosen to have a birth attended by a midwife; therefore, it is reasonable to assume that they had generally positive feelings toward midwifery. As expected, these women reported appreciation of both the opportunity to choose midwifery and the experience itself. Here we report on the specific points that were most consistently raised among overwhelmingly positive findings. Their value lies in underlining what knowledgeable women considered to be the most important aspects of this service.

Midwives’ Knowledge, Skill, Competence, and Professionalism

An overriding theme was the confidence that clients had in the ability of their midwives to take care of them (157 responses). The women obviously thought of themselves as being able to judge the competence of their midwives against specific criteria. This finding is not surprising considering that in British Columbia, where midwives only attend 6 percent of births, women have to put some effort into finding a midwife. They are therefore motivated toward seeking information and making informed choices about their caregiver. As the following quotations demonstrate, these women knew the importance of evidence-based practice, familiarity with current literature, and professional competence. The fact that they were comfortable that their midwives had these attributes is reflected in their accounts of their births.

Midwives practice was evidence based—able to answer questions referencing latest research. She was aware of, able to direct us to further reading.

My birth experience was everything I wished it to be. I believe that this was greatly due to the fact that I had complete confidence, far in advance, that I would be cared for and well supported by my midwives who had demonstrated competence throughout my prenatal care.

The two themes of midwife competence and receptivity to the input, wishes, and choices of both the woman and her partner were frequently twinned in the women’s analyses of their experiences.

Their professionalism will always be remembered. They took no risks, offered an array of literature, answered questions simply, making sure I understood procedures and my choices, were always on time, included my partner in discussion, worked swiftly and skillfully, and sincerely cared about our well-being.

The midwives were more knowledgeable, experienced, receptive, patient, and wise than I could possibly have imagined. I believe that it is because all they do is deliver babies that they have developed phenomenal expertise and skill.

I felt that my needs/wishes were so well recognized by my midwife that I could completely tune out my surroundings and concentrate on my labour—that is something that, as a nurse, I find extremely difficult to do in any medical environment.

This theme, detailing perceptions of the characteristics of the individual midwife, was most frequently alluded to in the women’s accounts. Clearly, this aspect of their care was the most important to them and the one they did not take for granted. Rather, they knew the criteria by which to judge competence and were watching for them to be demonstrated.

Empowerment

Women felt strongly about their own ability to contribute actively to decision-making during their births. The words “power” or “empowerment” were used by...
several women to describe the many ways in which midwives contributed to a feeling of empowerment in their clients (70 responses).

I had a wonderful experience with my home birth. Delivering my baby at home with my family was truly empowering and unifying. I am very proud of myself. I very much appreciated being at the centre of the decision-making process. Our midwife always consulted with us throughout the process making sure we knew our options. When it was critical, she stepped in.

My membranes did not deliver with the placenta so they transferred me to the hospital. The whole time I felt my midwives always gave me information and choices (something that in the end still made me feel in control) and that I had a very positive labour and birth experience.

They made me feel that I could accomplish anything I put my mind to. They were very supportive of every decision I made.

This feeling of empowerment and self-confidence allowed the mothers to relax and experience their births with the clear understanding that their input would be listened to and honored whenever possible. This understanding led them to feel emotionally supported by the midwives. This theme arose frequently.

**Emotional Support**

Women expressed a feeling of being supported and cared for, special, and important. At times they characterized it as feeling treasured, or having a spiritual or healing experience (44 responses). The women alluded to the importance of this support in relation to the period of their pregnancy, during birth, and throughout the postpartum period.

For me during this pregnancy there were many emotional issues that arose. Our midwife met these with skill and confidence, which enabled me to work through them. This was extremely important to me.

I especially like the personal touch that they offer. I felt I was treated with love and respect, and the prenatal visits were like visiting a friend.

I always felt that she truly cared about me and my baby, and that I was not just another client.

Many women commented on how much they would miss their midwives after the postpartum care period was over (88 responses).

The postpartum period was magical—we became so fond of and close to the midwives. Remembering this time just a few short weeks ago always brings tears to my eyes. This will always be an experience to take out of my memories, relive, and cherish. Truthfully, we are all sad that this wonderful time with the midwifery clinic is drawing to a close as our 6-week check-up draws near.

Women stated that the caring exhibited by the midwives increased their sense of confidence in themselves.

I had a perfect labour and delivery that only took 4- and half hours. I honestly believe that my midwife had a major part in that. The love and confidence she made me feel was incredible. It was completely nonintrusive and I feel like a capable, strong woman, not an object.

**Relevant to emotional support was the recurring mention of respect.**

We felt respected as individuals, as well as cared for physically.

My fears were never ridiculed and I was encouraged to be honest. I think this directly influenced my state of mind and helped my labour be the beautiful experience it was.

The emotional support couples received was important to them, but again, it was crucial that it was coupled with a professional level of expertise.

**Informational Support**

The midwives’ ability to provide appropriate information to the couples was central to the satisfaction with the experience. In their responses, women stressed that they received adequate information about the birth (54 responses).

The midwives provided an open, caring, and informative service. I enjoyed the resource library of books and videos as well as file folders on specific topics regarding childbirth and childcare, which included newspaper clippings, excerpts from medical journals, magazine articles, etc. This provided a broad spectrum of research in which I was free to make up my own mind as to what I felt would be right for myself and my child.

A key component of information support was the time that midwives spent with clients. Clearly the fact that the midwife was able to devote much more time to each individual couple was not lost on the women.

I appreciated the long office visits. All of my questions and concerns were addressed and answered thoroughly. This is one of the reasons that I felt well prepared to give birth.

The reason for the switch [to midwifery care and home birth] was the feeling of being a burden when we asked questions that took up more than the 15–20 minutes allotted to each visit. I’m most pleased to say that every appointment with our midwife lasted no less than 45 minutes and some were as long as 2 hours. All our questions were answered and we were well educated on things we didn’t even know existed.

I have a wonderful doctor; however, she simply could never give me (and my family) that one-on-one time that my midwives could.

It was not that they expected that their doctors would provide the same service and were disappointed; rather,
they recognized that this element was part of the reason to seek care by a midwife.

**Holistic Care**

It is not always clear what is implied when the word “holistic” is used, but some women described their care this way (25 responses). Several factors seemed to contribute to this characterization, including increased access to care, familiar surroundings, a view of the birth as truly family-centered, a noninterventionist approach, and the comprehensive nature of care. The next few themes all illustrate this relationship.

She [midwife] was absolutely fantastic and is the best example, in my opinion, of a licensed midwife who embodies both the emotional, spiritual, and grassroots of childbirth, balanced with the medical and technical aspects. She marries two sides (that would have been opposed in the past) perfectly.

The midwife’s prenatal care included all aspects of my life (stresses, diet, exercise, marital relationship) instead of the standard pee-in-a-cup and do-an-internal-exam care I received from doctors [for] the previous 3 babies.

Women’s accounts emphasized both the philosophical and the physical and pragmatic aspects of what they described as holistic care.

**Access to Midwife**

Women believed that their midwife would respond to their calls for information and assistance at any time (33 responses), which further enhanced their confidence in their ability to handle their early labor and postpartum periods.

It is very reassuring to have access to this support 24 hours a day.

At a time when it is so hard to get out of the house (postpartum) it was most helpful to have the ease of calling and having the support immediately.

Knowing I could reach the midwives by pager gave me a sense of security.

**Birth at Home—a Familiar Environment**

Although these themes spoke of the competence and caring that was ascribed to midwifery care in general, women also commented on aspects of the birth that were specific to the home environment (41 responses).

Familiar surroundings of our home environment helped me to relax.

My family and I are also very happy to have been at home, being in a familiar environment that we prepared, and having all the personal touches that we had planned.

Because I do not drive and my partner had to be out of town in my early postpartum period, my midwife visited me at home; this meant so much to me.

Another theme that emerged in connection with the home setting was the perception of participating in a natural process (25 responses).

Home birth allows your baby to come to the world in a more natural and private environment.

Compared to the hospital birth of my first child, I would say this is a better way—more natural, more inclusive of all aspects of childbearing, and more enjoyable for me, the mother.

The ability to relax at home was mentioned by several women.

Having my baby at home made me feel relaxed and comfortable, and I think that is a big reason my labour went so smoothly. I never felt pressured to have my baby quicker.

**Birth at Home as Family-Centered**

Women described the care at home as involving the whole family (12 responses).

The understanding that they had about me, seeing me through this whole experience, definitely is a type of care that I wish all new mothers could experience. The concern for my health, baby’s health, the father, other siblings. A genuine concern for the whole family.

My 6-year-old daughter had a very positive experience of her brother’s birth and is bonding beautifully. The home birth made adjusting to a new family member easier for the older children and not so much of a juggling act for my husband.

**Home Birth as a Way of Maintaining Control, Avoiding Intervention**

Participants made 181 comments involving direct comparisons between home and hospital care, some of which related to a comparison between midwifery and medical care, with women generally feeling that midwifery care was more comprehensive and supportive.

I like my GP (general practitioner) and continue to see her—I just didn’t feel that she could provide the same level of care and access as a midwife, and I wasn’t disappointed with my choice to use a midwife. I had an emergency c-section with my first baby, and knew that I would need a lot of support and encouragement to carry through with my decision to have a VBAC at home for my second child. Even though I ended up having another c-section, I felt we’d tried everything possible.
Some women obviously equated hospital birth with an interventionist approach, whereas others recognized that hospital birth under the care of a midwife was a possible choice.

This birth is my third child. The first was in hospital under the care of a physician—not a satisfactory experience. The second was in the hospital under the care of a midwife—a much better experience. This third pregnancy and birth was at home under the care of a midwife and I wouldn’t change a thing. A wonderful experience with support and care from loving people in a comfortable environment.

Hospitals do not have the time and often the staff to allow delivery to proceed on its own due time, and as one intervention brings on another the whole process becomes a manipulated affair which would often have much better results if left alone. Home birth and midwifery assistance allows for all the best-case scenarios to step forward. Healthy, informed, confident, and trusting mothers benefit as they welcome this wondrous event instead of fearing it.

Again, it is important to clarify that here women are clearly equating hospital birth with birth under the care of a physician and home birth with care by midwife. However, it is clear in several of these accounts that the women were generally distinguishing between care by midwife versus care by physician, rather than between birth at home versus birth in a hospital.

*Comprehensive Postpartum Care at Home*

Care at home after the birth was an important component of home birth (24 responses).

The after care was amazing, and I believe it made such a difference in adjusting to my new baby. I loved having the midwives come into my home to check us and offer caring and nurturing support and information.

Midwives were very knowledgeable about breastfeeding. Nurses in hospital often gave incorrect information and instructions regarding breastfeeding.

Overall, then, women who had care from a midwife throughout their pregnancy, labor, birth, and the postpartum period at home felt the care to be comprehensive, caring, and relaxed. They felt that they had an opportunity for input and that they and their partners were viewed as team members.

*Support While Transferring to Hospital*

As would be expected, not all births were straightforward and some women were transferred to hospital (39 responses). From these accounts women were able to take this event in stride due, in no small part, to the support they received from their midwives.

Our transition from a planned home birth to an emergency c-section during labour was handled in a safe, professional manner.

My midwife gave my husband and me amazing support. The labour started at home but ended in hospital with a cesarean. She was with us all the way. I don’t think we would have made it through the whole experience without her.

These comments underline the importance of communicating the collaborative relationship between the midwifery- and the physician-based care. Couples need to know that their midwife can continue to provide supportive care when consultant care becomes necessary.

**Dissatisfaction with Home Birth**

Only seven comments were negative. One woman referred to the experience of labor at home.

I had a long and difficult labor. I felt exhausted, not empowered. I don’t know how I could have felt differently. It was so painful.

Another comment related to miscommunication between two midwives, and the remaining five comments related to the care of midwives, which was described in one case as disorganized, another as too focused on discussion of fear of labor, inadequate hand washing, provision of inadequate emotional support, and suggestion of use of castor oil which the woman thought was unnecessary. No particular theme appears to occur in these negative views of midwifery-attended home birth, but they are included to illustrate that women did feel comfortable expressing negative views of their experience.

**Discussion**

The focus of this study was on understanding the ways in which women experienced birth after planning a birth at home. Overall, women were extremely positive. Clearly they felt well cared for. Although many of women’s responses are somewhat predictable and expected, what was emphasized throughout these accounts was the emotional and psychological advantage produced by these feelings of contentment. Couples felt that the approach of the midwife was, in most cases, responsible for their feelings of being supported, listened to, respected, and empowered. The tone of the accounts throughout was the feeling that this birth experience was theirs in every sense, supported and enhanced by the midwife, but theirs.
Some themes reflect reactions to both place of birth and the practitioner, for example, reference to the frequency of home births during the postpartum period, which is a feature of midwifery care regardless of the planned or actual place of birth. However, considerable evidence exists that women valued the ability to choose birth at home independent of their response to midwifery care. A woman who had delivered a child in hospital with a physician, one in hospital with a midwife, and the third at home with a midwife, characterized her experience as “a wonderful experience with support and care from loving people in a comfortable environment.” Other comments referred to privacy, and the way that the home environment enhanced relaxation and the ability to concentrate.

Themes identified in this cohort of women planning home birth have been reported in other descriptive studies using questionnaire data. A study of 193 women giving birth at home in the Netherlands reported the importance of being in one’s own home with one’s own belongings in contributing to a feeling of comfort and relaxation (25). The home setting was seen as being trustworthy and dependable. A phenomenological study of 12 women in Sweden reported that giving birth at home preserved authority and autonomy. The main themes were having faith in one’s own competence and choosing support on one’s own terms (26). A second qualitative study from Sweden of five couples who had planned home births reported a fundamental trust that the birth would take place without complications and an experience of meaningfulness in the event itself (27). Categories of responses that were identified as counterbalancing the risk of possible complications, similar to ours, included trust in the woman’s ability to give birth, trust in intuition, confidence in the midwife, confidence in the relationship, and physical and intellectual preparation.

An Australian phenomenological study of 10 home birth couples reported that participants placed a high value on their ability to manipulate the environment, including lighting, ventilation, and temperature (28). Although this factor was perceived as exerting external control, women described internal control as working to accept pain and being in charge of their own health, both physically and mentally. This theme was echoed in an Irish study of nine women using qualitative methods similar to ours. Pain was viewed as a steppingstone toward a natural birth, to be mastered instead of relieved, and with mastery came a sense of achievement (29). In Britain, interviews with 25 women within 6 years of a home birth reported that women emphasized the normality of having their babies at home; the relaxed, peaceful, and quiet atmosphere; the nonintrusive nature of midwifery care; and a sense of control. Again, pain was described in terms of its function (30).

Our study supports these findings in a much larger sample of women and adds the themes of emotional support, holistic care, access to the midwife, family-centered nature of care, and comprehensive postpartum care. In addition, women felt supported if transport to hospital was required. Not all responses were positive. One person identified inadequately managed pain as the source of her discontent. The transfer rate to hospital in this cohort was 17.9 percent overall and only 1.3 percent for pain relief (5).

The findings are limited by our inability to attribute all aspects of the experience to the home environment in that we did not do a direct comparison with women who had planned a hospital birth. Although other work on this cohort identified that women with similar low-risk status in pregnancy were more satisfied after planning a home versus hospital birth (21), our intent here was to simply document the experience of women planning home birth. Women’s reports in our study are not biased by previous experiences of home birth, either positive or negative, since home birth by registered midwives was not available in British Columbia before our study. We were limited by an inability to undergo member-checking with our participants to verify the validity of our findings, due to the anonymous nature of the surveys. The findings are supported, however, by the overwhelmingly positive findings on other aspects of a survey reported elsewhere (21). Our study is further limited by an overall response rate of 64 percent. We are not aware of any bias associated with the failure of midwives in the early stages of the study to provide questionnaires to their clients; among those receiving questionnaires the return rate was high at 82 percent. Our survey did not document demographic information because it was meant to be anonymous; hence we are not able to compare responders with nonresponders.

The strength of our study is the representativeness of its sample, in that the return rate was 82 percent among midwifery clients who were offered participation and that our sampling frame was population based. The large sample size should add to confidence in our findings that women valued home birth as a positive experience.

Conclusions

Women who planned a home birth with a registered midwife in British Columbia were overwhelmingly positive when invited to respond, in an open-ended fashion, about their maternity care, regardless of where they actually gave birth. The home environment was reported to enhance a sense of empowerment, control, emotional support, and comfort for the parturient and her family. Women expressed the trust and confidence they had in
their midwives’ competence to undertake delivery in the home environment.

Maternity caregivers who counsel women on the risks and benefits of home birth may wish to consider these findings in the context of perceived benefits to women who have experienced planned home birth. This documented experience of over 500 women representing a population of women choosing home birth underscores the value women place on having the choice to give birth at home. It must be considered in the ongoing debate on the safety and desirability of offering planned home birth. Improved understanding of the importance women place on aspects of home birth identified in this report may allow for a more meaningful engagement in the discussion on both sides.

References