THERAPEUTIC LANDSCAPES FOR BIRTH: A RESEARCH SYNTHESIS

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ABSTRACT

NANCY L. HAVILL: Therapeutic Landscapes for Birth: A Research Synthesis
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Place of birth is a contested and controversial topic worldwide. The World Health Organization (WHO, 1996) recommended that a woman should be able to give birth in the place of her choice where she feels safe, receives obstetrical care appropriate for her particular needs, and is located as close as possible to her home and culture. Missing from previous reviews on the topic of place and childbirth is an evaluation of environmental aspects or place characteristics that might contribute to experiential birth outcomes, synthesized from findings from both qualitative and quantitative methodologies. Evidence-based practice requires an understanding of birthplace in relation to birth experience that is more methodologically inclusive and theoretically informed.

The purpose of the proposed study was to synthesize empirical evidence regarding the relationship between place and the experiences of labor and childbirth. The guiding framework for this study was Therapeutic Landscapes. Mixed research synthesis methods were used to achieve the purpose of the proposed study.

Included in this synthesis were 77 English-language reports of empirical research conducted in 30 countries, published in peer-reviewed journals between January 2000 and September 2010, and available online through UNC libraries.

The findings from this research synthesis indicated that women across all geographic regions shared a common vision of a therapeutic landscape for birth. Women viewed or experienced those birth landscapes as therapeutic that were private, permitted freedom of movement and choice of delivery position, and accommodated family members and other support persons. Included within the landscape was a competent, confident and caring provider who was able to be with women

throughout labor, regardless of where the birthplace was situated, and who did not impose what women saw as unnecessary interventions. Therapeutic landscapes for birth incorporated the active involvement of support persons. Therapeutic landscapes for birth provided women with a sense of safety. Women from all regions faced barriers to accessing therapeutic landscapes for birth. Women across regions chose the birthplace they believed would provide the most therapeutic landscape for birth, even if this meant avoiding hospitals and potentially life-saving resources.

DEDICATION

This dissertation is dedicated to the memory of

Sandra S. Havill, MSN, PNP

An unequaled role model for life.

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CHAPTER 1

BACKGROUND & SIGNIFICANCE

Place of birth is a contested and controversial topic worldwide. Most women in industrialized countries now give birth in hospitals (MacDorman, Menacker, & Declerq, 2010), but these are not necessarily places where "all the attention and care are focused on (women's) needs and safety" (World Health Organization [WHO], 1996, p. 12). Modern health facilities are not available to all women. Particularly isolated from modern facilities are women who live in underdeveloped locations where the home birth rate ranges from 30-90% (WHO, 2005b; WHO, 2005c; WHO, 2005d). Many women have strong preferences for where they give birth. Some women prefer being in a hospital where sophisticated monitoring and pain relief technologies are available and employed, even for uncomplicated labor and birth (Zwelling, 2008). Other women strongly desire to labor and give birth at home or in a birth center. Some of these women are willing to engage undocumented midwives who practice outside the bounds of state regulation as their birth attendant; plan and experience labor and birth unassisted; or even risk adverse legal action in order to achieve a home birth (Block, 2007; Lynch, 2007; Nolan, 2008). In between these two extremes, the majority of women in industrialized countries and increasing numbers of women in non-industrialized countries labor and deliver in hospitals where the focus is primarily on medical surveillance and intervention, regardless of individual preferences and needs (El-Nemer, Downe, & Small, 2006; Maternity Center Association, 2004; McCallum & Dos Reis, 2008; Sandin-Bojo, Larsson, & Hall-Lord, 2008).

Until approximately a century ago, almost all births occurred in the home (Declerq, 1993; McCool & Simeone, 2002). Before that time, hospitals were seen as places of filth where people went to die and poor people went for care as a last resort (Hosimer, 2001; Wertz & Wertz, 1977). During the twentieth century, the place of birth in industrialized countries migrated rapidly from home to

hospital. By 1935, 75% of births in urban areas in the United States occurred in the hospital (Thomasson & Treber, 2004) and by 1970, 99% of all births occurred in the hospital (Declerq, 1993; Pearse, 1982). This statistic has remained relatively stable over the past 40 years (MacDorman, Menacker, & Declerq, 2010).

Many factors have contributed to the migration of place of birth from home to hospital, including concern for the safety of mothers and newborns (Thomasson & Treber, 2004; Wertz & Wertz, 1977), newly available medical interventions such as anesthesia, ergot, and cesarean delivery (Jackson & Bailes, 1995), professional turf battles between physicians and midwives (Craven, 2005; Hosmer, 2001; Jackson & Bailes, 1995), and national/cultural (especially American) preferences for technological innovations (Davis-Floyd, 2003).

Decreases in rates of maternal, fetal, and neonatal mortality that occurred during this time of transition strengthened arguments in favor of the hospital as the preferred place of birth. Historically, high maternal mortality from infection and hemorrhage made childbirth a dangerous event for women. Although mortality rates were decreasing throughout the late nineteenth and early twentieth centuries in Europe and North America, they rarely fell below 5 percent, although many health professionals were engaged at the time in well-intended attempts to try and reduce poor outcomes (McCool & Simeone, 2002). Records from that period indicate, however, that during the transition to the hospital for childbirth, rates for infant mortality resulting from birth injuries increased and maternal mortality rates remained flat; they were higher in urban areas (Cahill, 2001; Thomasson & Treber, 2004). Historians have observed that improvements in maternal survival achieved through the use of ergot to stop postpartum hemorrhage were offset by increases in maternal deaths due to puerperal fever likely to have occurred from iatrogenic causes (Thomasson & Treber, 2004). Significant decreases in maternal mortality rates did not occur until the introduction of sulfonamide drugs during the 1940's (Cahill, 2001; Thomasson & Treber, 2004).

Although medications such as ergot that could be used to control postpartum hemorrhage and antibiotics to fight infection arguably had the greatest effect on maternal survival of childbirth, once

those dangers were largely alleviated, attention turned to medications used to control the pain of childbirth (McCool & Simeone, 2002; Sandelowski 1984; Wertz & Wertz, 1977). First with chloroform and ether, followed by scopolamine, women, primarily in the United States, accepted the promise of a pain-free birth, or at least the opportunity not to remember it, now available in hospitals. Medical innovations, along with the opportunity to remain at the hospital for a standard 2-3 week recovery following delivery, away from household and childrearing responsibilities, made hospital deliveries increasingly desirable for middle- and upper-class women who could afford them (Thomasson & Treber, 2004).

Eventually scopolamine fell out of favor as a labor anesthetic due to adverse and at times dangerous reactions to it (Brodsky, 2006; Sandelowski, 1984). As women regained consciousness of the experience of labor and childbirth, they began advocating for improvements to the experience of labor and birth (McCool & Simeone, 2002; Sandelowski, 1984), including alternative methods of pain relief and choice of place. Home and homelike birth centers once again became desirable choices for some women to give birth. Yet attempts at establishing home and birth centers as available venues for birth have been hampered by continuing questions regarding their safety (McLachlan, 2009; Pesce, 2009), even though the migration of birth place from home to hospital occurred without evidence demonstrating that hospitals were safer places to deliver (Olsen & Jewell, 2009), or that home was an inherently unsafe place for women to deliver.

Physicians in the United States who themselves practiced primarily in the home up until the early 1900's standardized their education and adopted a model of hospital-based training (Thomasson & Treber, 2004). This resulted in a preference by physicians for hospitals as the primary site for birth due to economies of scale and the opportunity to employ more sophisticated medical interventions (Thomasson & Treber, 2004). In order to ensure the supply of patients, American physicians recently organized under the American Medical Association began to systematically discredit home as a safe place for birth, promoted hospitals as the safest place for birth, and sought to eliminate competition posed by midwives using legislative processes to restrict midwifery practice by promoting the view

that midwives provided unsafe and sub-standard care (Cahill, 2001; McCool & Simeone, 2002; Thomasson & Treber, 2004; Wertz & Wertz, 1977). Although these statements were subsequently discredited by the work of the Frontier Nursing Service and Maternity Center Association (Dawley, 2003; Raisler & Kennedy, 2005; Thomasson & Treber, 2004), widespread adoption by physicians practicing obstetrics of medical innovations such as ergot, forceps, and anesthesia added to the scientific credibility and therefore desirability of physician-assisted birth in hospitals (McCool & Simeone).

Concurrent with the resurgence of interest in out-of-hospital birth and "natural" birth in the United States (Sandelowski, 1984) was the emergence of the fetus as a patient, viewed as a separate entity from the mother (Stormer, 2003). Ultrasound and other technologies devised to test and monitor the fetus along with a newly vocal pro-life segment of society with an interest in protecting the life of the unborn, combined to focus attention on the wellbeing of the fetus and therefore created a novel sense of fetal patient rights. Focus on the fetus has increased the sense of ambivalence surrounding place of birth as some fetal advocates see women opting for out-of-hospital births as placing the woman's desire for satisfaction above safety concerns for the fetus (Craven, 2005).

Childbirth continues to be a dangerous event for women in many developing countries (WHO, 2005a). Efforts to decrease maternal and neonatal morbidity and mortality have been aimed primarily at increasing women's use of health facilities for birth, although facility capacity and skilled health workers have not been available in sufficient number to meet demand (WHO, 2005a).

National and international health and professional organizations concerned with the health, safety and wellbeing of mothers and babies have articulated varying opinions on the topic of place of birth. The World Health Organization (WHO, 1996) recommended that a woman should be able to give birth in the place of her choice where she feels safe, receives obstetrical care appropriate for her particular needs, and is located as close as possible to her home and culture. Safety in this instance refers not only to outcome goals of healthy mother and baby—the primary rationale physicians give when advocating for hospital birth—but also to the stated desire of many women to avoid unwanted,

unnecessary, and often harmful interventions (Olsen & Jewell, 2009), an opinion shared by the WHO (1996). The American College of Nurse Midwives (ACNM, 2005, p. 1) "supports the right of women who meet selection criteria to choose home birth." A joint statement by the Royal College of Obstetricians and Gynaecologists, the Childbirth Trust, and the Royal College of Midwives (2007) in England supports choice of place of birth, which includes home, birth center, as well as hospital settings with both midwifery and medical facilities. The Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN, 2009) supports a woman's right to choose and have access to a full range of providers and settings for pregnancy, birth, and women's health. The American College of Obstetricians and Gynecologists (ACOG, 2008) strongly opposes home birth, recommending only hospitals and accredited birth centers as birthplaces.

Safety has been used to justify strong polar positions on the best place for birth. Although no one discounts the benefits to mothers and babies that modern medical technologies have provided, the questions remain whether the advances most responsible for improved health and wellbeing are linked exclusively to particular places of birth or whether they can be successfully employed in all birth places; and if these advances can be successfully employed in all places, what other place-based factors might account for divergent experiences in different places of birth. Gaining further insight into the role of the different factors that contribute to the labor and birth process, such as specific physical characteristics and locales, people, or practice philosophies, is important and a necessary prelude to understanding better the benefits each place offers the laboring woman, her baby, and her family. Furthermore, identification of factors that benefit the birth process, currently linked to specific places, might lead to their adoption in a greater variety of birthplaces.

Overview of Completed Systematic Reviews

Previous reviews conducted on the topic of place and childbirth have been focused on establishing the safety of planned home birth (Fullerton, 2007; Olsen, 1997; Olsen & Jewell, 2009; Stotland, 2002) or alternative hospital settings (Hodnett, 2005). Safety has generally been defined as maternal, perinatal, and neonatal morbidity and mortality rates as low as those experienced in the

hospital. These reviews have also demonstrated that women experiencing labor and birth outside of the standard hospital setting undergo significantly fewer interventions such as episiotomy (Hodnett, 2005), epidural anesthesia (Hodnett, 2005), and cesarean section (Fullerton, 2007; Hodnett, 2005) while delivering newborns with higher Apgar scores (Hodnett, 2005; Olsen, 1997). These women were more likely also to initiate and continue breastfeeding (Hodnett, 2005) than their hospitalized counterparts.

Two of the reviews present a summary of individual research reports without synthesizing, either quantitatively or qualitatively, the findings across reports (Fullerton, 2007; Stotland, 2002). Two of the reviews were produced by the Cochrane Collaboration, which restricts inclusion to reports of research on controlled trials (Hodnett, 2005; Olsen & Jewell, 2009). Both of these reviews included small numbers of studies; Hodnett (2005) included six reports in her review and Olsen & Jewell (2009) included two in their review. The final review on the topic of place of birth included both qualitative and quantitative research on freestanding birth centers, defined as birth facilities geographically separate from hospitals, and integrated birth centers, which are birth centers located within hospitals (Walsh, 2004). This review included findings from five reports on freestanding birth centers and six reports from an earlier Cochrane review of births in home-like settings. As with the other reviews, this one indicated that births occurring in freestanding birth centers and integrated birth centers were associated with less intervention. Findings from the reports of two qualitative research studies indicated that birth centers, both freestanding and integrated, demonstrated philosophies of care that likely affected the labor experience. As a final note, without citing literature from the review, the author suggested that size of birth facility likely affected the treatment women received. The larger the unit, and consequently the more women who receive care there, the more likely an individual woman will experience interventions during her labor and the less likely to experience high quality care relationships (Walsh & Downe, 2004).

Reviews completed in developing countries on childbirth and birthplace have been devoted to issues related to maternal mortality (Bhutta et al., 2010). The focus of these reviews has been on access to and utilization of health facilities (Filippi et al., 2009; Gabrysch & Campbell, 2009).

As the focus in these reviews was primarily on establishing the safety of planned home birth, planned birth in home-like settings, or access to health facilities in developing countries, they did not address environmental aspects or place characteristics that might have contributed to the women's experiences in the reports of the studies reviewed. Furthermore, none of these reviews included efforts to synthesize findings within or across the range of qualitative and quantitative methodologies used. Evidence-based practice requires an understanding of the place of birth and its relation to birth experience that is more methodologically inclusive and theoretically informed.

CHAPTER 2

RESEARCH DESIGN AND METHODS

Mixed research synthesis methods were used to achieve the aim of the proposed study, that is, to integrate the findings from empirical qualitative and quantitative studies of the relationship between place and the experience of labor and childbirth. Mixed research synthesis is the qualitative and quantitative integration of empirical findings from qualitative and quantitative studies conducted in a target domain of inquiry (Voils, Sandelowski, Barroso, & Hasselblad, 2008). The specific techniques used in the study were drawn largely from Cooper (2010), Cooper, Hedges, & Valentine (2009), Sandelowski & Barroso (2007), and Voils et al (2008).

Conceptual Framework

The concept of place has received increasing attention in healthcare (Kearns & Moon, 2002) and nursing (Carolan, Andrews & Hodnett, 2006) research. *Place* can be used to mean an actual geographical location as well as a "sense of place" or the situatedness persons feel being in a familiar place such as their homes (Carolan et al. 2006). Place is recognized as being an active agent with human activity, rather than a passive container where activity takes place (Kearns & Moon, 2002), and as affecting the experience of health and illness (Gesler & Kearns, 2002). Places acquire reputations as being healing or illness places (Carolan et al. 2006; Gesler, 1992). Investigators have been interested in discovering what components of place contribute to healing and wellness, and have been able to demonstrate that various aspects of healthcare environments such as pleasant views affect pain perception and health outcomes (Ulrich, Zimring, Quan, & Joseph, 2006). Investigations have been conducted on the effect place, or "being in place," has on various healthcare situations and health conditions such as mental illness, home care, death, and birth (Carolan et al. 2006).

The guiding framework for this study was therapeutic landscapes, a conceptualization that represents a synthesis of ideas from cultural, humanistic, and structuralist geography applied to health (Conradson, 2005; Dunkley, 2008; Williams, 2002). Therapeutic landscapes are defined as places, settings, situations, locales, and milieus with reputations for providing environments associated with physical, mental, and spiritual healing, and the maintenance of health and wellbeing (Kearns & Gesler 1998; Williams, 1998). Such landscapes may encompass natural places such as waterfalls or mountain vistas, or built places such as temples, spas, retreats, and, most relevant for the purposes of this inquiry, places of birth such as hospitals, homes, or birth centers.

As shown in Figure 1, therapeutic landscapes encompass three interacting elements: human-environment interaction, social construction, and psychological/symbolic construction (Conradson, 2005; Gesler & Kearns, 2002). *Human-environment interaction* refers to the physical/material properties of the built environment and how these influence human behavior, such as the presence of a bathtub, shower, or an inviting place to walk in a place of birth offering a laboring woman the opportunity to experience alternative pain relief methods. *Social construction* refers to the products of social processes, hierarchies of social relationships and interactions among people (Gesler, 1992), and underlying social forces that shape human activity in particular times and places (Gesler & Kearns, 2002). An example of social construction is the hierarchical relationship between doctors and nurses, and between healthcare providers and laboring women and their families, which often characterize hospital birth. *Psychological/symbolic construction* refers to the associations people make within their social and cultural lives to draw meaning out of experience (Gesler & Kearns, 2002). For example, if women associate home birth with danger, they might be more likely to perceive hospital birth as offsetting that danger and as an experience promoting wellness. Any specific place is considered a therapeutic landscape when individuals' particular set of relations and interactions—or their embodied encounters with a socio-environmental setting—produces what is perceived to be a healing outcome (Conradson, 2005). Places of birth become therapeutic for individual women when the aggregate of their own labor, birth, and postpartum experiences are perceived to be positive.

The therapeutic landscape idea was a useful framework for a research synthesis of findings on the relationship between birthplace and birth experiences as it served to focus data collection and analysis on three distinct areas, namely, the physical, social, and symbolic aspects of birthplace. Physical aspects of birthplaces that were of interest in this study included such factors as air, water, odors, noise, color, light, temperature, cleanliness, views, size (scale), furniture (comfort, placement, adequacy to accommodate all present), access (ease of getting into environment, as well as access to outside), provision for privacy, food, equipment, and proximity of others. Many of these aspects were first identified by Florence Nightingale (1860/1992) as environmental factors important in the care and recovery of sick individuals. Some of these same factors have been incorporated into Birth Territories, a framework Fahy et al. (2008) developed to describe how to set up places of birth where birthing women feel safe and nurtured. Social factors of interest were those that influenced the birth experience including interpersonal relationships between laboring women and others, in addition to social hierarchies deriving from gender, class, or race/ethnicity (Gesler, 1992). Symbolic aspects of landscapes of interest were those cultural or spiritual factors that influence people's belief systems (Gesler, 1992) such as views of what constitutes nature as opposed to artifice and wellness versus illness. In the specific instance of birth, the symbolic environment encompassed beliefs about whether pregnancy, labor, and birth were viewed as normal life processes of essentially well individuals or as medical conditions requiring close supervision and intervention. This symbolic apparatus affected interpretations of whether the birth environment was perceived as therapeutic or not.

The three dimensions, physical, social, and symbolic, interact to form unique landscapes in different places and times, and for different people. Each of the dimensions can affect the others. For example, the social dimension of a particular place of birth might differ depending upon the health professional present for a particular labor and birth. This change in the landscape might occur even though the physical setting remains the same. A professional caregiver might behave differently in different settings, indicating that the physical, social and symbolic dimensions affect professionals as

well as the woman in labor. Even the same setting with the same practitioners might be experienced differently by the same women during labors in different pregnancies.

Sampling (Search & Retrieval of Relevant Reports)

The following databases were searched for English-language reports of empirical research published in peer-reviewed journals between 2000 and the final week of September 2010. Several combinations of search terms were tried before deciding upon the following search strings: (SU(labor or birth or childbirth)) and (SU(hospital or home or birth center or place or environment) OR TX(experience)). See Table 2.1 for a complete list of search strings and limits for all databases searched.

This search yielded 15,498 reports of research. The titles of these reports were examined for relevance to the topic. After eliminating irrelevant reports, 3186 unique reports were downloaded to Refworks from the following databases: Academic Search Premier (758), CINAHL (775), Cochrane (0), EMBASE (590), Family & Society Worldwide (178), Global Health (194), PsycInfo (426), PubMed (1299), Social Work Abstracts (2), Sociological Abstracts (49), and Women's Studies International (100). The abstracts of these reports were reviewed; an Excel database was created to track the status of reports. In order to capture the three elements of the therapeutic landscapes framework in interaction, reports included in the synthesis were those full-length reports of empirical research published between January 1, 2000 and the final week of September 2010 in a peer-reviewed journal that contained information about all three domains of the therapeutic landscapes model (physical, social, symbolic). Reports with data collected prior to 1995 were excluded as likely containing less timely results (Barroso, Sandelowski, & Voils, 2006). To enhance the feasibility of this dissertation study, only reports meeting inclusion criteria that were available online through UNC Libraries were included. The final data set was comprised of 77 reports.

Data Collection (Extraction of Information from Reports)

Data were extracted from the 77 selected reports using the data extraction guide (Table 2.2) and saved as separate Word files. Complete statements were written to express the findings related to

birthplace. Matrices were created organized by geographical region. This first set of matrices contained detailed information about each study and the findings in complete sentence form from each study (Tables 3.1 to 3.8).

Data Analysis

The findings extracted from each study were then consolidated into summary sentences for each region. These sentences were placed into a second set of matrices, one for each region, with corresponding citations to the reports from which they were derived (Tables 3.9 to 3.16). Frequency effect sizes were calculated based upon the number of reports having similar findings within each region. Frequency effect sizes for each finding were calculated by counting the number of reports containing that finding in each region minus the number of reports from the same study population with the same finding, then dividing this number by the total number of reports for that region minus the number of reports from same study population with the same finding (Sandelowski, Barroso, & Voils, 2007).

$$\frac{\text{\# reports having similar findings} - \text{\# reports from same study pop with same finding}}{\text{total \# of reports} - \text{\# reports from same study pop with same finding}}$$

For example, data from Europe were extracted from 20 reports. If a finding appeared in eight reports, and two of those reports came from the same study population, then the calculation would be:

$$\frac{8-1}{20-1} = \frac{7}{19} = \text{frequency effect size} = 0.37$$

The findings were then ranked by effect size and given labels reflecting their region and rank order.

Data Synthesis Within Regions

Findings with similar content were then grouped into data-derived topical categories. The following list of topical categories (and definitions) was used to capture all of the findings across all regions, although all regions did not have findings in all topical categories: a) physical environment (the physical characteristics of a place); b) familiarity (how well known a place was to a woman); c) safety (attributes that contributed to a sense of safety in a birthplace); d) intervention (activities performed by a labor attendant to alter the course of labor, including pain management, often through

medical or surgical means); e) pain management (methods employed to lessen, alter the perception of, distract, or otherwise assist women to cope with the pain of labor and delivery); f) caregiver behavior (actions, including speech, of labor attendant, not support persons, during labor and delivery); g) active participation in decision-making (women's opportunity and ability to influence decisions during labor and delivery; h) support persons (family members and friends of laboring women); i) barriers (obstacles women encountered in accessing or achieving a therapeutic landscape for birth); j) avoidance/preference (specific place attributes that women voiced the desire to avoid, or conversely, preferred in their birthplaces); k) relocation (movement from one place to another during labor or the postpartum); l) freedom of movement/position (opportunity to move freely during labor and choose position for delivery); and m) knowledge (information about birth available to women and attendants). Findings were ranked within each topical grouping by effect size.

Regional summaries were written addressing the general topics of the findings in each region. The order of discussion was determined by the rank of individual findings rather than the number of findings associated with the topic. Most findings had small effect sizes, so their relative standing was considerably less than the 10-15 findings with the largest effect sizes in each region. For example *familiarity* was the finding with the largest effect size in Europe (0.42); it was included in two topics, physical environment and familiarity. Physical environment was discussed first because it had the finding with the largest effect size. The topic of familiarity was discussed before safety because E1 had a larger effect size than E2, a finding about safety, even though safety had a larger number of associated findings, albeit less prevalent.

Metasynthesis Across Regions

Topics identified during the within-regional analyses were placed along the top border of a matrix (Table 4.1); regions were listed along the left border according to how many research reports were represented in the analyses for each region. The following information was placed into corresponding cells for each region: a) ranked order of that topic; b) the number of reports that addressed that topic; and c) the number of findings associated with that topic. Displayed in this matrix

were the instances topics were identified across regions. Individual tables for the five topics with the greatest across-region representation were then constructed to display the occurrences of findings for each region related to the topics: physical environment (Table 4.2); caregiver behavior (Table 4.3); safety (Table 4.4); barriers (Table 4.5); and interventions (Table 4.6). An overall metasynthesis addressing the similarities and differences between the different geographical locations was then developed.

Measures to Optimize Validity

Strategies for optimizing the descriptive, interpretive, and theoretical validity (Maxwell, 1992; Sandelowski & Barroso, 2007) of study procedures and outcomes were used. *Descriptive validity* refers to the comprehensive identification of reports relevant to the study and the accurate characterization of information from each report (Sandelowksi & Barroso, 2007). *Interpretive validity* refers to the fair representation of what the authors of the reports included intended to communicate. *Theoretical validity* refers to the credibility of the reviewer's methods as appropriate to the studies reviewed and of the research synthesis as encompassing the findings (Sandelowksi & Barroso, 2007, p. 228).

The strategies that were used to optimize these validities included the maintenance of an audit trail during the entire course of the synthesis project. Recorded in the audit trail was the succession of decisions made about procedures and interpretive processes. An Excel database was maintained to track whether reports met inclusion criteria as well as reasons for those that were excluded. Extracted findings and details of each individual study as well matrices for the management of extracted and synthesized findings were created using Word. Refworks was used manage the references for the study. A total of six reports were selected for inter-rater reliability (with the dissertation chair) to ensure consistency in extraction of relevant data and analysis of findings. Weekly consultations with the dissertation chair were held to review all procedures and outputs and to discuss successive stages in analysis.

CHAPTER 3

SYNTHESIS OF FINDINGS WITHIN REGIONS

What follows is a presentation of the findings synthesized within geographic regions. Study profiles and background information for each region including key information about contextual factors for birth during the time period of the included research reports are presented first, followed by the regional synthesis of findings. The presentation of these findings is organized first by prevalence (effect size of first finding) and then by thematic line. The number of research reports that addressed each topic as well as the number and list of synthesized findings about that topic are given.

Europe

Regional Description

Geographic distribution of studies. Findings were extracted from 20 reports of studies conducted in seven countries: Belgium (1); Finland (3); Germany (1); Lithuania (1); Netherlands (6); Sweden (8); Turkey (1); Belgium and the Netherlands (1); and England and the Netherlands (1). Two reports from Finland were from the same study population of women (Table 3.1).

Study populations. The data featured in these reports were collected from 2270 women who delivered at home, 7976 women who delivered in the hospital, 64 women who delivered in a birth center (located in a hospital), 90 pregnant women, and 17 partners of women, for a total of 10417 participants.

Data collection techniques. Data for the individual studies were generated using interviews (10); questionnaire/survey/measures (9); and discrete choice experiment (1).

Aim of studies. Most of the studies (*n*=16*)* were focused on comparisons of different birthplaces: home versus hospital/birth center, familiar versus unfamiliar hospital; two different

hospitals; and hospitals representing two systems of perinatal care. In four studies, researchers addressed what women wanted in a birthplace.

Background information and description of birth practices. Approximately 99% of births occurred in a hospital (WHO, 2009). Exceptions included the Netherlands where 30% of births took place in the home, and Turkey where only 83% of births were attended by professional caregivers, either in or out of the hospital (Borquez & Wiegers, 2006; WHO, 2009). Maternal mortality ranged from 7/100,000 in Finland and Germany to 9/100,000 in Belgium (Hogan et al., 2010). Midwives attended approximately 75% of births (Benoit et al., 2005). Most countries had some form of nationalized health care, including maternity care. Government health insurance in Finland covered the costs of hospital births, but not home births (Viisainen, 2001). Almost all midwives in Finland were government employees (Viisainen, 2001).

Findings

The 20 research reports addressing birthplace yielded 59 synthesized findings in the following topical groups: (a) physical environment; (b) familiarity; (c) safety; (d) avoidance of interventions; (e) pain control; (f) caregiver behavior; (g) active participation in decision-making; (h) support people; (i) barriers; and (j) preparation.

Physical environment. Women preferred certain environmental characteristics in their birthplaces and wanted the opportunity to manage their physical environment. Sixteen of the 20 reports addressed environmental characteristics related to birthplace; 13 of the 59 synthesized findings were about the physical environment (Table 3.9: E1, E7, E9, E13, E14, E16, E21, E26, E27, E34, E39, E40, E48). Women wanted to manage the physical environment of their birthplace such as lighting, temperature, access of others, and noise, in all birthplaces (Borquez & Wiegers, 2006; Johnson, Callister, Freeborn, Beckstrand, & Huender, 2007; Lindgren, Hildingsson, & Radestad, 2006; Lindgren, Radestad, Christensson, Wally-Bystrom, & Hildingsson, 2010; Melender, 2006; Neuhaus, Piroth, Kiencke, Gohring, & Mallman, 2002; Sjoblom, Nordstrom, & Edberg, 2006; Wiklund, Matthiesen, Klang, & Ransjo-Arvidson, 2002). Women listed specific physical

characteristics they wanted in their birthplaces, such as soothing colors, warmth, quiet, and adjustable lighting (Borquez & Wiegers, 2006; Johnson et al., 2007; Kukulu & Oncel, 2009; Melender, 2006; Pavlova, Hendrix, Nouwens, Nijhuis, & van Merode, 2009). Women also described psychological characteristics of the ideal birth environment as natural, peaceful, private, or intimate (Johnson et al., 2007; Melender, 2006; Neuhaus et al., 2002; Pavlova et al., 2009; Sjoblom et al., 2006; Viisainen, 2001; Viisainen, 2000). Women who labored and delivered at home were more likely to have been satisfied with their birth environment than women who labored and delivered in the hospital (Borquez & Wiegers, 2006; Christiaens & Bracke, 2009; Neuhaus et al., 2002; Nilsson, Bondas, & Lundgren, 2010; Rijnders et al., 2008; Rudman, El-Khouri, & Waldenstrom, 2007; Waldenstrom, Rudman, & Hildingsson, 2006). Women who delivered at home also believed home was a better birthplace for the baby (Kukulu & Oncel, 2009; Neuhaus et al., 2002).

Familiarity*:* Women wanted to deliver in a familiar birthplace of their choosing. Nine of the 20 reports addressed the importance of familiarity of birthplace; 5 of the 59 synthesized findings were about familiarity (Table 3.9: E1, E15, E20, E23, E33). The importance of being in a familiar place to give birth was a finding appearing most often in reports of studies with or about women who planned to deliver at home or in a freestanding birth center (Borquez & Wiegers, 2006; Johnson et al., 2007; Lindgren et al., 2006; Lindgren et al., 2010; Neuhaus et al., 2002; Sjoblom et al., 2006). Yet, women planning hospital deliveries also reportedly felt a sense of familiarity with their intended birthplace, either because they had delivered there in the past or because they had visited the hospital during pregnancy (Melender, 2006; Wiklund et al., 2002). Women who did not feel this sense of familiarity with their birthplace were more likely to report difficult or traumatic birth experiences (Lindgren et al., 2006; Nilsson et al., 2010) or greater levels of pain (Borquez & Wiegers, 2006; Wiklund et al., 2002).

Safety. Safety was an important issue to women when planning as well as evaluating their birth experiences in all birthplaces. Fifteen of 20 reports addressed safety; 11 of the 59 synthesized findings were about safety (Table 3.9: E2, E10, E11, E22, E24, E42, E43, E47, E49, E51, E52).

Safety was an issue important to women regardless of their intended birthplace. Women who planned to deliver in the hospital felt a sense of safety being surrounded by personnel and technology that could be mobilized to intervene in the event complications occurred during labor and delivery (Borquez & Wiegers, 2006; Pavlova et al., 2009). In contrast, women who planned home deliveries felt home was safer because they could avoid complications resulting from routine interventions and infection (Kukulu & Oncel, 2009; Neuhaus et al., 2002; Viisainen, 2000) and because they experienced a sense of comfort, safety and security being in their own homes (Borquez & Wiegers, 2006; Lindgren et al., 2010; Sjoblom et al., 2006; van Der Hulst, van Teijlingen, Bonsel, Eskes, & Bleker, 2004). Having hospitals located close to their homes increased feelings of safety in women planning home births (Johnson et al., 2007; Lindgren et al., 2006; Viisainen, 2001). Women in the Viisainen (2001) study who planned home deliveries used medical technology during their pregnancies for reassurance that their pregnancies were normal and that delivering at home would be safe. Poor communication and inadequate attention by professional caregivers made hospitals feel unsafe for women delivering there (Borquez & Wiegers, 2006; Nilsson et al., 2010; Viisainen, 2001; Wiklund et al., 2002). Women planning hospital births felt unsafe being at home during prolonged early labor (Carlsson, Hallberg, & Odberg Pettersson, 2009). Close association between hospitals and sickness made hospitals seem unsafe to women in Germany (Neuhaus et al., 2002).

Interventions and technology. Women considered the presence of technology and the routine use of interventions when choosing and evaluating birthplaces. Nine of the 20 reports addressed technology and interventions; 7 of 59 synthesized findings were related to interventions and technology (Table 3.9: E3, E31, E34, E35, E36, E37, E50). Women wanted a birthplace where they could avoid unnecessary or routine interventions and use of technology (Lindgren et al., 2010; Melender, 2006; Neuhaus et al., 2002; Nilsson et al., 2010; van Der Hulst et al., 2004; Viisainen, 2001; Viisainen, 2000; Wiklund et al., 2002). Rates of intervention and technology use differed for low-risk women who planned to deliver at home when compared to low-risk women who planned to deliver in the hospital (van Der Hulst et al., 2004). Multiparous women who intended to deliver at

home, but delivered in the hospital under the care of a physician, were significantly less likely to experience physician intervention than women who planned a hospital delivery with a midwife (van Der Hulst et al., 2004). Rates of intervention and use of technology also varied between women delivering in two hospitals having different perinatal policies (Chalmers & Jeckaite, 2010).

Pain control. Women wanted to be able to control pain during labor and delivery in all birthplaces. Eight of the 20 reports addressed pain control; 4 of the 59 synthesized findings were about pain control (Table 3.9: E4, E19, E20, E46). Women described an ideal birth environment as one that provided them with the opportunity to control pain (Chalmers & Jeckaite, 2010; Melender, 2006; Neuhaus et al., 2002; Nilsson et al., 2010; Pavlova et al., 2009; Rijnders et al., 2008). Pain control was addressed most often in reports of studies with or about women who delivered in hospitals (Chalmers & Jeckaite, 2010; Melender, 2006; Nilsson et al., 2010; Pavlova et al., 2009; Rijnders et al., 2008), but pain control was important also to women who delivered out of the hospital (Neuhaus et al., 2002; Rijnders et al., 2008). Uncontrolled pain during labor and delivery contributed to negative or traumatic birth experiences in all birthplaces (Neuhaus et al., 2002; Nilsson et al., 2010). Women reported less pain when they labored in familiar birthplaces, whether in the home or hospital (Borquez & Wiegers, 2006; Wiklund et al., 2002).

Caregiver behavior. Women wanted competent, supportive, personalized care in the birthplace of their choice. Thirteen of the 20 reports addressed relationships with professional caregivers; 7 of the 59 synthesized findings targeted professional caregivers (Table 3.9: E5, E8, E10, E20, E26, E38, E59). Women wanted a caring, attentive, knowledgeable caregiver throughout labor, wherever they delivered (Carlsson et al., 2009; Melender, 2006; Nilsson et al., 2010; Sjoblom et al., 2006). Women who delivered at home were more likely to perceive the professional care they received by their midwife to be confident, competent, supportive, intensive, personalized and satisfying (Borquez & Wiegers, 2006; Christiaens & Bracke, 2009; Johnson et al., 2007; Kukulu & Oncel, 2009; Neuhaus et al., 2002; Sjoblom et al., 2006). Conversely, women who delivered in the hospital were more likely to state their personal needs were not met (Borquez & Wiegers, 2006;

Nilsson et al., 2010; Viisainen, 2001; Wiklund et al., 2002) and described professionals as rude, hostile, and uncaring (Kukulu & Oncel, 2009; Lindgren et al., 2006; Lindgren et al., 2010; Viisainen, 2001; Wiklund et al., 2002).

Active participation in decision-making. Women wanted a birthplace where they could actively participate in decision-making. Eleven of the 20 reports and 6 of the 59 synthesized findings addressed women's desire to manage the physical environment of birth and actively to participate in decision-making (Table 3.9: E6, E17, E24, E29, E41, E47). Women wanted active participation in decisions about the timing of hospital admission; activity, nutrition, and pain control during labor; and labor augmentation and delivery assistance (Carlsson et al., 2009; Lindgren et al., 2010; Melender, 2006; Neuhaus et al., 2002; Nilsson et al., 2010; Viisainen, 2001; Viisainen, 2000; Waldenstrom et al., 2006; Wiklund et al., 2002). Women who did not experience their desired involvement in decision-making were unsatisfied with their hospital birth experience (Carlsson et al., 2009; Nilsson et al., 2010; Waldenstrom et al., 2006; Wiklund et al., 2002) and often planned to deliver subsequent babies at home or in a free-standing birth center (Lindgren et al., 2010; Neuhaus et al., 2002; Viisainen, 2001; Viisainen, 2000).

Support people. The ideal birth environment included supportive family members. Six of the 20 reports addressed support persons in the birthplace; 4 of the 59 synthesized findings targeted support persons (Table 3.9: E12, E56, E58, E59). Women wanted a birthplace that accommodated their families and other supportive persons, which is one reason women chose to deliver at home (Johnson et al., 2007; Kukulu & Oncel, 2009; Neuhaus et al., 2002; Sjoblom et al., 2006). Family members influenced women's choice of birthplace, sometimes deciding that women would deliver at home (Kukulu & Oncel, 2009) and other times, voicing reluctance about home delivery (Lindgren et al., 2006). In the Nilsson et al. (2010) study, support persons felt compelled to fulfill unmet care needs of women delivering in the hospital.

Barriers. Women encountered barriers in gaining access to birthplaces. Ten of the 20 reports addressed some form of barrier related to birthplace; 8 of the 59 synthesized findings were about

barriers (Table 3.9: E17, E28, E29, E53, E54, E55, E56, E57, E58). The women in the Borquez & Wiegers (2006), Kukulu & Oncel (2009), Lindgren et al. (2010) and Sjoblom et al. (2006) studies delivered at home because it was too difficult or disruptive to travel to the hospital during labor. The women in the Pavlova et al. (2009) study felt the hospital was too far away to provide a safety net for home delivery and therefore delivered in the hospital. The women in the Lindgren et al. (2006), Lindgren et al. (2010), Viisainen (2001), and Viisainen (2000) studies faced barriers to delivering at home because professional care providers and family members did not support their birth choices. In the Kukulu & Oncel (2009) study, women delivered at home because it was the place their family members chose for them, or because they could not afford hospital care. Women in the Carlsson et al. (2009) and Nilsson et al. (2010) studies had difficulty gaining access to the hospital if they were judged to be too early in labor to be admitted.

Preparation. Women weighed convenience and the work of preparation in choosing their birthplace. Five of the 20 reports and 4 of the 59 synthesized findings addressed convenience or preparation related to birthplace (Table 3.9: E17, E30, E44, E45). The women in the Borquez & Wiegers (2006), Lindgren et al. (2010), and Sjoblom et al. (2006) studies chose to deliver at home to avoid having to travel during labor. Yet, there were women in the Borquez & Wiegers (2006) study who believed that delivering in the hospital offered greater convenience because no preparation was necessary. Women planning home births prepared their home environment; they prepared mentally by breathing exercises and prepared for complications by arranging for travel and child care (Lindgren et al., 2006; Lindgren et al., 2010). Women who planned to deliver at home also prepared themselves to assume responsibility in the event of poor outcomes (Viisainen, 2000).

Sub-Saharan Africa

Regional Description

Geographic distribution of studies. Findings were extracted from 16 reports of studies conducted in 11 countries: Angola (1), Burkina Faso (1), Ghana (3), Ivory Coast (1), Kenya (1), Malawi (1), Nigeria (4), Tanzania (5), Uganda (2), Zambia (1), Zimbabwe (1). The Stephenson et al.

report contained data from six countries: Burkina Faso, Ghana, Ivory Coast, Kenya, Malawi, and Tanzania (Table 3.2).

Study population. Data were collected from 33,278 women, 469 men, 35 focus groups, 50 providers, 108 traditional birth attendants, and 540 elders.

Data collection techniques. Data for the individual studies were generated using interview (10); focus group (7); questionnaire (6); and participant observation (4).

Aim of studies. The studies were aimed primarily at discovering why women did not use health facilities for delivery (*n*= 12). Other studies addressed choice of birth attendant (*n* = 2), barriers to accessing emergency care during birth (*n* = 1), and effectiveness of clean delivery kits in different birthplaces (*n* = 1).

Background information and descriptions of birth practices. Out-of-hospital birth rates ranged from 30-98% (Amooti-Kaguna & Nuwaha, 2000; Ekele & Tunau, 2007; Izugbara & Ukwayi, 2004; Mathole, Lindmark, & Ahlberg, 2005; Mrisho et al., 2007; Spangler & Bloom, 2010; WHO, 2005b; WHO, 2005c; WHO, 2005d). Maternal mortality rates in 2000 from the countries represented ranged from a low of 456 per 100,000 in Burkina Faso to a high of 1662 per 100,000 in Malawi (Hogan et al., 2010). Access to modern health facilities was not available to all women (Amooti-Kaguna & Nuwaha, 2000; Izugbara & Ukwayi, 2004; Osubor, Fatusi, & Chiwuzie, 2006) and skilled attendance at births ranged from 35% to 73% (WHO, 2005b; WHO, 2005c; WHO, 2005d).

Findings

The 16 research reports yielded 50 synthesized findings in the following topical groups: (a) barriers; (b) avoidance/preference; (c) caregiver behavior; (d) intervention and technology; (e) social support; (f) safety; and (g) physical environment (Table 3.10).

Barriers. Fourteen of 16 reports addressed barriers women encountered accessing care in health facilities; 16 of 50 synthesized findings were about barriers (Table-3.10: SS1, SS3, SS5, SS6, SS10, SS15, SS16, SS17, SS20, SS26, SS32, SS33, SS34, SS43, SS44, SS47). Women faced several barriers accessing care in health facilities. Physical barriers included distance, lack of transportation,

and unavailability of facilities (Amooti-Kaguna & Nuwaha, 2000; Ekele & Tunau, 2007; Jansen, 2006; Magoma, Requejo, Campbell, Cousens, & Filippi, 2010; Mathole et al., 2005; Mrisho et al., 2007; Osubor et al., 2006; Spangler & Bloom, 2010; van den Boogaard et al., 2008). Women encountered other barriers including facility and professional fees, opposition by family members, necessary preparations such as gathering supplies and arranging for childcare, an admittance card, and an onerous referral process (Adamu & Salihu, 2002; Amooti-Kaguna & Nuwaha, 2000; Bazzano, Kirkwood, Tawiah-Agyemang, Owusu-Agyei, & Adongo, 2008; Ekele & Tunau, 2007; Izugbara & Ukwayi, 2004; Magoma et al., 2010; Mathole et al., 2005; Mrisho et al., 2007; Pettersson, Christensson, de Freitas, & Johansson, 2004; Spangler & Bloom, 2010; Weeks, Lavender, Nazziwa, & Mirembe, 2005). Women experienced barriers to therapeutic landscapes for birth when they were turned away from health facilities by healthcare workers (Bazzano et al., 2008).

Avoidance/preferences. Fifteen of 16 reports and 18 of 50 synthesized findings addressed reasons women avoided certain birthplaces and preferred others (Table 3.10: SS2, SS4, SS7, SS8, SS9, SS24, SS25, SS27, SS29, SS36, SS37, SS38, SS39, SS40, SS41, SS44, SS45, SS48). Most women reported they avoided hospitals, preferring to deliver at home or in traditional birth homes. Reasons women gave for avoiding hospitals included rude behavior of staff, presence of male staff, belief in predestination regarding outcomes, and stigma associated with hospital deliveries (Adamu & Salihu, 2002; Bazzano et al., 2008; Ekele & Tunau, 2007; Magoma et al., 2010; Mathole et al., 2005; Mrisho et al., 2007; Pettersson et al., 2004; Spangler & Bloom, 2010; Weeks et al., 2005). Women preferred to deliver at home because their pregnancy was healthy and delivering at home was the norm, they received affectionate and skilled care, it was more convenient, they could choose their delivery position, they could care for their placenta, and delivering at home increased their status (Adamu & Salihu, 2002; Amooti-Kaguna & Nuwaha, 2000; Bazzano et al., 2008; Izugbara & Ukwayi, 2004; Jansen, 2006; Magoma et al., 2010; Mrisho et al., 2007; Osubor et al., 2006; Pettersson et al., 2004; Stephenson, Baschieri, Clements, Hennink, & Madise, 2006; van den Boogaard et al., 2008).

Women in the Spangler and Bloom (2010) study reportedly preferred to deliver in a health facility because they wanted to appear modern.

Caregiver behavior. Thirteen of 16 reports addressed caregiver behavior: 6 of 50 synthesized findings were about caregiver behavior (Table 3.10: SS8, SS9, SS13, SS14, SS39, SS50). Women wanted affectionate, confident, and skilled care during labor (Adamu & Salihu, 2002; Amooti-Kaguna & Nuwaha, 2000; Bazzano et al., 2008; Jansen, 2006; Magoma et al., 2010; Mrisho et al., 2007; Osubor et al., 2006; Pettersson et al., 2004). They believed they were more likely to receive this kind of care at home when they were accompanied by traditional birth attendants (Adamu & Salihu, 2002; Amooti-Kaguna & Nuwaha, 2000; Izugbara & Ukwayi, 2004; Jansen, 2006; Magoma et al., 2010; Mathole et al., 2005; Osubor et al., 2006). They reported receiving poor quality care by professionals who treated them rudely in health facilities (Adamu & Salihu, 2002; Amooti-Kaguna & Nuwaha, 2000; Bazzano et al., 2008; Ekele & Tunau, 2007; Jansen, 2006; Mrisho et al., 2007; Pettersson et al., 2004; Spangler & Bloom, 2010; Weeks et al., 2005).

Safety. Eleven of 16 reports addressed issues related to safety; 11 of 50 synthesized findings were about safety (Table 3.10: SS11, SS18, SS22, SS28, SS30, SS31, SS35, SS42, SS43, SS46, SS49). Women considered safety when evaluating birthplaces. Women were more likely to perceive increased risks when delivering in health facilities including high rates of intervention, loss of privacy, and being targeted by witchcraft (Bazzano et al., 2008; Jansen, 2006; Magoma et al., 2010; Mathole et al., 2005; Osubor et al., 2006; Pettersson et al., 2004; Spangler & Bloom, 2010). Yet, hospitals were considered safer places to deliver when there were known complications or prolonged labor (Amooti-Kaguna & Nuwaha, 2000; Jansen, 2006; Magoma et al., 2010; Mrisho et al., 2007; Pettersson et al., 2004; Spangler & Bloom, 2010). Facilities charged higher fees for complicated deliveries, which increased risk-taking among laboring women because they and their families weighed the likelihood of survival against the increased costs of emergency care (Bazzano et al., 2008; Pettersson et al., 2004). Use of clean delivery kits in all birthplaces decreased the rate of infection in women and newborns (Winani et al., 2007).

Intervention and technology. Seven of 16 reports addressed interventions; two of 50 synthesized findings were about interventions (Table 3.10: SS12, SS23). Women avoided hospitals and clinics for childbirth because of the high rate of interventions that occurred there (Adamu & Salihu, 2002; Bazzano et al., 2008; Izugbara & Ukwayi, 2004; Magoma et al., 2010; Mathole et al., 2005; Osubor et al., 2006; Pettersson et al., 2004).

Support people. Nine of 16 reports addressed supportive family members; 2 of 50 findings were about women's support during labor (Table 3.10: SS14, SS21). Women preferred to labor and deliver at home or in traditional birth homes because of the high quality of care they could count on receiving from their female relatives (Adamu & Salihu, 2002; Amooti-Kaguna & Nuwaha, 2000; Izugbara & Ukwayi, 2004; Jansen, 2006; Magoma et al., 2010; Mathole et al., 2005; Osubor et al., 2006; Pettersson et al., 2004; Spangler & Bloom, 2010).

Physical environment. Five of 16 reports addressed the physical environment: 1 of 50 synthesized findings was about the environment (SS19). Women disliked hospital birth environments because there was no privacy; there were typically several women, and sometimes men, being cared for in the same space (Adamu & Salihu, 2002; Ekele & Tunau, 2007; Izugbara & Ukwayi, 2004; Mrisho et al., 2007; Spangler & Bloom, 2010).

United Kingdom

Regional Description

Geographic distribution of studies. Findings were extracted from 14 reports of studies conducted in the following countries: England (9); Scotland (3); Wales (1), and unspecified (1). Three reports were from the same study population of women (Table 3.3).

Study population. The data featured in these reports were collected from 602 women who delivered in the hospital, 30 women who delivered in a free-standing birth center, 8 women who delivered at home, 6 couples who experienced hospital birth, 71 women with an unspecified birth place, and 464 providers.

Data collection techniques. Data for the individual studies were generated using interview (8); diary (2); focus group (3); survey (2); and participant observation (1).

Aim of studies. The studies were focused on the following topical areas: women's experiences gaining admission to hospital (*n*=4); birth experiences at hospitals (*n*=3), home (*n*=1), or free-standing birth center (*n*=1); decision making about birthplace (*n*=2); and medical professional's contribution to pain management through place (*n*=1).

Background information and descriptions of birth practices. The maternal mortality rate was 8 per 100,000. Two and a half percent of all births occurred in the home (Symon, Paul, Butchart, Carr, & Dugard, 2007) typically with midwife attendance. Midwives attended approximately 62% of in-hospital deliveries in the United Kingdom between 2005-2007, the period of most of the studies (National Health Service, 2009). There were four distinct types of birthplaces: (a) midwife-led hospital units; (b) physician-led hospital units; (c) free-standing birth centers; and (d) women's homes.

Findings

The 14 research reports yielded 68 synthesized findings in the following topical groups: (a) support people; (b) caregiver behavior; (c) relocation; (d) pain control; (e) barrier; (f) physical environment; (g) safety; (h) decision making; (i) position/movement; and (j) intervention (Table 3.11).

Support people. Eight of 14 reports addressed some aspect of family support; 6 of 68 synthesized findings were about family (Table 3.11: UK1, UK16. UK31. UK32, UK33, UK34). Family members of women who planned to deliver in the hospital were anxious being at home during early labor and were unable to provide the kind of support women needed while at home (Barnett, Hundley, Cheyne, & Kane, 2008; Cheyne et al., 2007; Houghton, Bedwell, Forsey, Baker, & Lavender, 2008; Nolan & Smith, 2010). Husbands of women who planned to deliver at home reported greater confidence and involvement in the process compared to previous hospital births (Andrews, 2004). Women appreciated the presence of their family members in other birthplaces (Barnett et al., 2008; Walker, 2000), and preferred birthplaces that accommodated their family (Pitchforth et al., 2009; Walsh, 2006a; Walsh, 2006b).

Caregiver. Eight of the 14 reports addressed caregiver behavior or relationships with women; 11 of 68 synthesized findings were about caregivers (Table 3.11: UK2, UK8, UK11, UK27, UK28, UK30, UK42, UK47, UK48, UK49, UK56, UK60). Women wanted knowledgeable, kind, and confident care throughout labor in all birthplaces (Andrews, 2004; Barnett et al., 2008; Cheyne et al., 2007; Nicholls & Ayers, 2007; Nolan & Smith, 2010; Pitchforth et al., 2009; Symon et al., 2007; Walsh, 2006a). Women who delivered at home (Andrews, 2004), in midwife-led units (Pitchforth et al., 2009), or in birth centers (Walsh, 2006a) reported receiving more care and nurturing compared to earlier hospital experiences. Women who planned hospital births missed having professional assessment and care during early labor at home (Barnett et al., 2008; Cheyne et al., 2007; Nolan & Smith, 2010).

Relocation. Women resisted having to move during labor or the postpartum period. Six of 14 reports addressed having to relocate during labor or postpartum; 4 of 68 findings were about relocation (Table 3.11: UK3, UK25, UK50, UK53). Women who planned to deliver in the hospital were greatly dissatisfied when they were sent away from the hospital to continue laboring at home (Barnett et al., 2008; Cheyne et al., 2007; Nolan & Smith, 2010). Women were also upset when they had to transfer to an unfamiliar birthplace (Walker, 2000). After delivery, women appreciated the opportunity to remain in place for a prolonged period of time, whether it was in a free-standing birth center (Walsh, 2006a) or at home (Andrews, 2004).

Pain. Six of 14 reports addressed pain experience or pain management in different birthplaces: 6 of 68 synthesized findings were about pain (Table 3.11: UK4, UK12, UK13, UK20, UK41, UK45). Women who planned hospital deliveries experienced significant pain while at home in early labor (Barnett et al., 2008; Cheyne et al., 2007; Nolan & Smith, 2010). Women received instruction to stay at home as long as possible, but pain relief advice from hospitals was inadequate to cope with pain at home (Barnett et al., 2008; Cheyne et al., 2007; Nolan & Smith, 2010). Therefore, they described their pain as severe in order to gain admission to the hospital so they could receive pain medicine (Burges Watson, Murtagh, Lally, Thomson, & McPhail, 2007; Nolan & Smith, 2010).

Some women's need for pain medicine subsided after hospital admission (Burges Watson et al., 2007). Professionals viewed pain as a ladder to climb (Burges Watson et al., 2007); women had to achieve a certain level of pain to be admitted (Burges Watson et al., 2007; Cheyne et al., 2007; Nolan & Smith, 2010). Professionals associated different pain relief measures with different birthplaces; they tended to offer measures using place as overriding justification for the choices they offered (Burges Watson et al., 2007). For example, professionals would not offer medical pain relief measures, such as morphine, to women at home, because they viewed home as a natural setting, and only natural measures, such as a shower, would have been offered. On the other hand, once admitted to the hospital, professionals were more likely to suggest medical pain relief regardless of the quality or intensity of pain (Burges Watson et al., 2007). Women who delivered at home or in midwife-led units were better able to cope with the pain and used less pain medicine (Andrews, 2004; Symon et al., 2007).

Barriers. Five of 14 reports addressed barriers women faced accessing the birthplace of their choice; 8 of 68 synthesized findings were about barriers (Table 3.11: UK5, UK15, UK29, UK32, UK61, UK62, UK63, UK64). Women had difficulties being admitted to the hospital for labor if they were not in enough pain or sufficiently advanced in labor (Barnett et al., 2008; Burges Watson et al., 2007; Cheyne et al., 2007; Nolan & Smith, 2010). Women also faced barriers of distance, cost, risk status, and provider preference in delivering in the birthplace of their choice (Pitchforth et al., 2009; Walker, 2000).

Physical environment. Nine of 14 reports contained information about the physical birth environment: 23 of 68 synthesized findings were about environment (Table 3.11: UK6, UK10, UK14, UK16, UK17, UK23, UK24, UK26, UK34, UK35, UK39, UK40, UK41, UK42, UK43, UK44, UK46, UK51, UK57, UK58, UK59, UK60, UK65). Women preferred birthplaces that were familiar, relaxed, calm, friendly, homey, small, private, intimate, that allowed them to feel comfortable arranging it to suit their needs, did not impose time restraints on labor, and welcomed family members (Andrews, 2004; Cheyne et al., 2007; Walker, 2000; Walsh, 2006a; Walsh, 2006b). Women were more likely to

find these environmental characteristics in their own homes, in free-standing birth centers, or in midwife-led birth units (Nicholls & Ayers, 2007; Walsh, 2006a; Walsh, 2006b). Women who delivered in birthplaces with these characteristics delivered more quickly with fewer interventions (Symon et al., 2007). Yet, professional caregivers resisted attributing therapeutic effects to the environment such as when women's level of pain diminished after being admitted to the hospital (Burges Watson et al., 2007), and women who planned hospital deliveries doubted the birth setting would alter their psychological or social journey into motherhood (Houghton et al., 2008). Women who planned hospital deliveries appreciated the clinical environment they found in the hospital (Houghton et al., 2008; Pitchforth et al., 2009).

Safety. Six of 14 reports addressed the topic of safety: 3 of 68 synthesized findings were about safety (Table 3.11: UK7, UK10, UK38). Women who planned to deliver in the hospital believed hospitals were safer (Houghton et al., 2008; Pitchforth et al., 2009), and felt particularly insecure while at home in early labor (Cheyne et al., 2007; Nolan & Smith, 2010). Women maintained belief in their own low-risk status, even when complications developed, in order to avoid being transferred to a physician-led unit (Walker, 2000).

Active participation in decision-making. Seven of 14 reports addressed decision-making; 6 of 68 synthesized findings were about decision-making (Table 3.11: UK9, UK22, UK44, UK52, UK54, UK68). Women preferred to be in a birthplace where they were actively involved in decision-making (Nicholls & Ayers, 2007; Walker, 2000; Walsh, 2007). Women were less likely to experience involvement in decision-making in the hospital (Houghton et al., 2008; Pitchforth et al., 2009), and more likely to be satisfied with their level of participation at home, in free-standing birth centers, or in midwife-led units (Andrews, 2004; Symon et al., 2007; Walsh, 2007).

Position/movement. Two of 14 reports addressed position changes during labor; 4 of 68 findings were about changing position during labor (Table 3.11: UK18, UK19, UK21, UK37). Women who progressed quickly to delivery reported frequent position changes throughout labor

(Walsh, 2009). Women in the Nicholls and Ayers (2007) study who were forcibly restrained during labor developed posttraumatic stress disorder following birth.

Intervention and technology. Three of 14 reports contained information about interventions; 4 of 68 synthesized findings were about intervention (Table 3.11: UK36, UK55, UK66, UK67). Women who planned hospital deliveries viewed interventions as a necessary and normal part of birth (Houghton et al., 2008), although not all women appreciated interventions being imposed on them (Nicholls & Ayers, 2007). Conversely, midwives practicing in a free-standing birth center were able to avoid biomedical interventions in most labors by maintaining an attitude of normalcy and not anticipating problems.

North America

Regional Description

Geographic distribution of studies. Findings from North America were extracted from 13 reports of studies conducted in two countries: Canada (7) and the United States (6). Two reports from Canada were from overlapping study populations (Table 3.4).

Study population. The data featured in these reports were collected from 809 women who delivered in the hospital, 947 women who delivered at home, 7 women who delivered at a free-standing birth center, and 28322 medical records of hospital deliveries.

Data collection techniques. Data for the individual studies were generated using interview (7), questionnaire/survey (6), participant observation (1), narratives downloaded from the Internet (1), and medical records database (1).

Aim of studies. Studies were directed at comparing different birth environments; home versus hospital birth environments, (*n*=8) and patient-centered versus provider-centered in-hospital birth environments (*n*=2). The rest of the studies were focused on differences in labor outcomes between own versus on-call provider (n=1); women's experiences of early labor at home (*n*=1); and birth experiences in a free-standing birth center (*n*=1).

Background information and descriptions of birth practices. Maternal mortality was 7 per 100,000 live births in Canada and 11 per 100,000 in the United States (WHO, 2009). Midwives attended approximately 7% of deliveries in Canada (Hutton, Reitsma, & Kaufman, 2009) and 11% of deliveries in the United States (Declercq, 2011). Almost all deliveries occurred in hospitals in both countries; only about 1% of births occurred at home (Declercq, 2011; Hutton et al., 2009). The government provided health care for women delivering in Canada, regardless of birthplace. Women in the United States were covered by various private health insurance plans that partially covered the costs of childbirth. Poor women had state-sponsored health insurance for childbirth in the United States.

Findings

The 13 research reports yielded 40 synthesized findings in the following topical groups: (a) caregiver behavior; (b) intervention; (c) physical environment and support; (d) knowledge; (e) active participation in decision making; (f) pain control; (g) safety; (h) relocation; (i) avoidance of hospital/preference for home; and (j) barriers (Table 3.12).

Caregiver behavior. Women wanted support from knowledgeable, competent, and caring individuals throughout labor. All 13 reports addressed the relationship between women and their professional caregivers; 5 of 40 synthesized findings were about caregivers (Table 3.12: NA1, NA7, NA8, NA22, NA33). Women wanted support from knowledgeable, competent, and caring individuals, throughout labor, regardless of where they planned to deliver (Beebe & Humphreys, 2006; Boucher, Bennett, McFarlin, & Freeze, 2009; Cheyney, 2008; Janssen, Henderson, & Vedam, 2009; Kornelsen, 2005; Kornelsen, Kotaska, Waterfall, Willie, & Wilson, 2010; Low & Moffat, 2006; Miller, 2009; Pewitt, 2008). Women's birth experiences were improved when their birth attendant was familiar and supported their wishes during labor and delivery (Abenhaim, Benjamin, Koby, Kinch, & Kramer, 2007; Boucher et al., 2009; Cheyney, 2008; Janssen et al., 2009; Kornelsen, 2005; Kornelsen et al., 2010; Miller, 2009; Pewitt, 2008). Some women planned home deliveries in order to avoid all health professionals (Miller, 2009).

Interventions and technology. Women wished to avoid unnecessary interventions. Ten of 13 reports contained findings related to interventions; 3 of 40 synthesized findings were about interventions (Table 3.12: NA2, NA24, NA25). Women preferred a birthplace that supported their wish to avoid unnecessary interventions (Abenhaim et al., 2007), which is one reason women gave for planning home births (Boucher et al., 2009; Kornelsen, 2005).

Physical environment. Women considered qualities of the physical environment when choosing and evaluating their birth experience. Ten of 13 reports addressed the physical environment; 5 of 40 synthesized findings were about environment (Table 3.12: NA3, NA4, NA10, NA15, NA28). The ideal birth environment was familiar, comfortable, private, peaceful, safe, permitted freedom of movement, and incorporated family members and other support people in the experience (Beebe & Humphreys, 2006; Boucher et al., 2009; Cheyney, 2008; Hodnett, Stremler, Weston, & McKeever, 2009; Janssen et al., 2009; Janssen, Klein, Harris, Soolsma, & Seymour, 2000; Kornelsen, 2005; Kornelsen et al., 2010; Miller, 2009; Pewitt, 2008). Women perceived differences in provider behavior, such as amount of time spent with women and receptivity to input by women and families, in different birthplace environments (Hodnett et al., 2009; Janssen et al., 2000; Janssen et al., 2009; Kornelsen, 2005). Women wanted to be able to manage aspects of their birth environments such as light and noise (Hodnett et al., 2009; Miller, 2009).

Knowledge. Nine of 13 reports addressed knowledge; 4 of 40 synthesized finding were about women's use of knowledge during labor (Table 3.12: NA5, NA9, NA12, NA16). Women wanted to deliver in a birthplace that recognized multiple sources of knowledge about childbirth including their intuition and bodily experiences in addition to biomedical knowledge (Beebe & Humphreys, 2006; Boucher et al., 2009; Cheyney, 2008; Janssen, Carty, & Reime, 2006; Janssen et al., 2009; Kornelsen, 2005; Kornelsen et al., 2010; Low & Moffat, 2006; Miller, 2009). Women who planned hospital deliveries attempted to use biomedical guidelines to measure their progress during early labor at home (Beebe & Humphreys, 2006; Low & Moffat, 2006), as did women in the Cheyney (2008) and

Miller (2009) studies who planned to deliver at home because they wanted to avoid hospitals, physicians, and midwives.

Active participation in decision-making: Women wanted active participation in decision-making during childbirth. Eight of 13 reports addressed decision-making; 1 of 40 synthesized findings was about decision-making (Table 3.12: NA6). Women's desire to participate in decision-making during labor caused many of them to seek home or birth center births (Boucher et al., 2009; Janssen et al., 2009; Kornelsen, 2005; Miller, 2009; Pewitt, 2008). Yet, women planning to deliver in the hospital also wanted to participate in decision-making (Beebe & Humphreys, 2006; Janssen et al., 2006; Low & Moffat, 2006).

Pain control. Women wanted to deliver in a place that respected their wishes regarding pain control. Eight of 13 reports addressed pain control; 3 of 40 synthesized findings were about pain control (Table 3.12: NA11, NA23, NA27). Women wanted a birthplace environment that supported their desire to avoid pain medicine (Boucher et al., 2009; Cheyney, 2008; Hodnett et al., 2009; Kornelsen, 2005; Kornelsen et al., 2010; Pewitt, 2008). Conversely, women in the Beebe and Humphreys (2006) and Low and Moffat (2006) studies wanted to be admitted to the hospital as soon as their contractions became painful in order to avoid being admitted too late to receive pain medicine.

Safety. Women considered safety issues when choosing their birthplaces. Seven reports addressed issues of safety; 4 of 40 synthesized findings were about safety (Table 3.12: NA13, NA26, NA32, NA35). Women who chose to deliver at home did so because they thought it was safer; they could avoid risks associated with hospital birth (Boucher et al., 2009; Cheyney, 2008; Janssen et al., 2009; Kornelsen, 2005; Kornelsen et al., 2010). Conversely, women delivering in the hospital believed their chosen birthplace was safer, and felt unsafe at home once they were in labor (Beebe & Humphreys, 2006; Low & Moffat, 2006).

Relocation. Women wanted to avoid relocating during labor. Seven of 13 reports addressed relocation during labor; 3 of 40 synthesized findings were about relocation (Table 3.12: NA14, NA19, NA40). Women experienced discomfort and distress when they had to relocate from home to hospital

during labor (Beebe & Humphreys, 2006; Boucher et al., 2009; Low & Moffat, 2006) and were more satisfied with their birth experiences when they could avoid or minimize relocation during labor, regardless of where they delivered (Boucher et al., 2009; Janssen et al., 2006; Janssen et al., 2000; Kornelsen, 2005; Kornelsen et al., 2010).

Avoidance of hospitals. Women planned home deliveries to avoid aspects of hospital birth environments. Five of 13 reports addressed some aspect of hospital care women wished to avoid; 5 of 40 synthesized findings were about avoidance of hospital care (Table 3.12: NA17, NA18, NA20, NA31, NA34). Women planned home deliveries because they had poor previous hospital birth experiences (Boucher et al., 2009; Cheyney, 2008; Janssen et al., 2009; Kornelsen, 2005). Women particularly wanted to avoid physicians, technology, time limits, and surgery (Boucher et al., 2009; Cheyney, 2008; Miller, 2009).

Preference for home. Four of 13 reports, and two synthesized findings addressed preference for home delivery unrelated to avoidance of any hospital characteristics (Table 3.12: NA21, NA29). Women preferred to deliver at home because they believed it was a normal event that belonged in the home (Boucher et al., 2009; Kornelsen et al., 2010; Miller, 2009), they had a strong trust in God's will to protect them (Cheyney, 2008; Miller, 2009), or because they believed it was better for the baby (Boucher et al., 2009).

Barriers. Women faced barriers delivering in the place of their choice. Five of 13 reports addressed specific barriers women faced; 4 of 40 synthesized findings were about barriers (Table 3.12: NA30, NA36, NA37, NA39). Women found it difficult to be admitted to the hospital for labor if their cervix was not sufficiently dilated (Beebe & Humphreys, 2006; Low & Moffat, 2006). Women in Cheyney's (2008) study who planned home deliveries felt stigmatized when they shared their birth plans. Women also faced barriers of money and distance when wanting to deliver in the hospital (Boucher et al., 2009; Kornelsen et al., 2010).

Asia

Regional Description

Geographic distribution of studies. Findings were extracted from seven reports of studies conducted in six countries: Bangladesh (1); India (1); Pakistan (1); Nepal (2); Tibet (1); and Vietnam (1). Study details are shown in Table 3.5.

Study population. The data featured in these reports were collected from 11,062 women, 13 traditional birth attendants, and 8 mothers-in-law.

Data collection techniques. Data for the individual studies were generated using interview (6); focus group (4); and survey (1).

Aim of studies. Five studies addressed women's decision-making regarding birthplace. One study addressed risk factors for neonatal mortality in relation to birthplace. One study addressed the acceptability of the use of vaginal wipes in home birth as a way to make home birth safer for women.

Background information and descriptions of birth practices. Maternal mortality per 100,000 ranged from 84 (Vietnam) to 574 (Bangladesh) during 2000 (Hogan et al., 2010). Facility birth rates in the countries represented ranged from approximately 10% in Nepal to 79% in Vietnam (WHO, 2005b; WHO, 2005c; WHO, 2005d). Skilled health personnel attended 11% of births in Nepal, 14% of births in Bangladesh, 20% of births in Pakistan, 43% of births in India, and 85% in Vietnam (WHO, 2005b; WHO, 2005c; WHO, 2005d).

Findings.

The seven research reports yielded 47 synthesized findings in the following topical groups: (a) barriers; (b) caregiver behavior; (c) safety; and (d) physical environment (Table 3.13).

Barriers. Six of seven reports addressed barriers women encountered in accessing health facilities for birth: 13 of 47 synthesized findings were about barriers (Table 3.13: A1, A3, A4, A12, A15, A23, A25, A26, A27,A34, A35, A36, A37). Women in Asia faced barriers to accessing health facilities for delivery including costs, family opposition, time away from family, inadequately staffed facilities, and healthcare workers of different casts (Adams et al., 2005; Afsana & Rashid, 2001;

Mutharayappa & Prabhuswamy, 2003; Regmi & Madison, 2009; Sepehri, Sarma, Simpson, & Moshiri, 2008). They also encountered physical barriers of distance and lack of transportation (Adams et al., 2005; Afsana & Rashid, 2001; Mutharayappa & Prabhuswamy, 2003; Sepehri et al., 2008; Thapa, Chongsuvivatwong, Geater, Ulstein, & Bechtel, 2000). Women's use of health facilities for delivery increased with higher education, employment, income, urban residence, and being a member of the ethnic majority (Mutharayappa & Prabhuswamy, 2003; Sepehri et al., 2008).

Caregiver behavior. Six of seven reports addressed caregiving: 7 of 47 synthesized findings were about caregivers (Table 3.13: A2, A6, A7, A18, A19, A24, A45). Women avoided hospitals because the healthcare workers were rude, treated them badly (Adams et al., 2005; Afsana & Rashid, 2001; Mutharayappa & Prabhuswamy, 2003; Regmi & Madison, 2009), and were contaminated (Adams et al., 2005). Instead, they preferred to deliver at home with a familiar, confident, caring, local birth attendant who permitted them a choice in delivery position (Adams et al., 2005; Mutharayappa & Prabhuswamy, 2003; Regmi & Madison, 2009). Women delivering at home in Pakistan were willing to participate in research testing a vaginal cleaning intervention if their traditional birth attendant approved of the practice (Saleem et al., 2010).

Safety. Six of 7 reports addressed issues of safety: 20 of 47 synthesized findings were about safety (Table 3.13: A5, A8, A9, A10, A13, A16, A20, A21, A22, A28, A29, A30, A31, A38, A39, A40, A41, A43, A46, A47). Women perceived more risks associated with delivering in a facility than at home (Adams et al., 2005; Afsana & Rashid, 2001; Regmi & Madison, 2009; Thapa et al., 2000). The women in the Mutharayappa and Prabhuswamy (2003) study believed home was safer than hospitals for childbirth and traditional birth attendants provided protection from evil spirits, while at the same time they believed hospitals could save lives by performing cesarean sections. Women in Nepal and Tibet appeared more concerned about protecting their homes and families from the pollution associated with childbirth than about protecting themselves and their newborns from complications of childbirth and, therefore, delivered alone, in the animal shed (Adams et al., 2005; Thapa et al., 2000). Traditional birth attendants and the women they cared for in Pakistan were

willing to participate in research aimed at lowering maternal and neonatal morbidity and mortality associated with home delivery (Saleem et al., 2010). Women delivering at home in Pakistan experienced better outcomes when their traditional birth attendant treated them with chlorhexine wipes during labor and delivery (Saleem et al., 2010). Women avoided health facilities for delivery because of the stigma associated with hospital delivery (Afsana & Rashid, 2001).

Physical environment. Four of 7 reports contained information about physical environments: 5 of 47 synthesized findings were about the environment (Table 3.13: A11, A14, A17, A32, A33). Women perceived birth to be a natural process that was better suited to the home environment, where the facilities and care were better than at a health facility (Afsana & Rashid, 2001; Mutharayappa & Prabhuswamy, 2003; Thapa et al., 2000). Women in Nepal prepared their birthplace in the animal shed so as to protect their family from the polluting effects of birth (Thapa et al., 2000). Women avoided health facilities for delivery because of the presence of male doctors (Afsana & Rashid, 2001; Mutharayappa & Prabhuswamy, 2003).

Latin America

Regional Description

Geographic distribution of studies. Findings were extracted from three reports of studies conducted in three countries: Guatemala, Brazil, and Bolivia (Table 3.6).

Study population. The data presented in these reports were collected from 26 women who delivered in a Brazilian hospital, and 166 women who delivered at home in Guatemala or Bolivia. Eighteen male partners in Bolivia and 146 hospital staff in Brazil were also included, totaling 356 participants.

Data collection techniques. Data for all three studies were generated by interview and participant observation.

Aim of studies. The aim of the study conducted in Brazil was to describe hospital practices related to normal childbirth. The aim of the other two studies was to explain why women did not use health facilities for childbirth.

Background Information and Descriptions of Birth Practices. Maternal mortality rates were 220/100,000 in Bolivia, 110/100,000 in Guatemala, and 79/100,000 in Brazil (Hutton, Reitsma, & Kaufman, 2009). Birth practices varied widely. In Brazil, almost all deliveries occurred in hospitals attended by physicians (WHO, 2005b). Deliveries in areas of Guatemala and Bolivia were likely to occur at home and were attended by traditional midwives known as iyoms (Berry, 2006; Otis & Brett, 2008). Skilled attendance at deliveries also varied widely:19% among the poorest women in Bolivia (country average 60%, Otis & Brett, 2008; WHO, 2005b); 30% in Guatemala; and nearly 100% in Brazil (WHO, 2005b; WHO, 2005c).

Findings

The three research reports yielded 27 synthesized findings in the following topical groups: (a) safety; (b) barriers; (c) caregiver behavior; and (d) physical environment (Table 3.14).

Safety. Women considered issues of safety when they chose their birthplace. All three reports contained data on safety; 8 of 27 synthesized findings were about safety (Table 3.14: LA1, LA2, LA5, LA8, LA16, LA17, LA18, LA27). Women avoided hospitals for childbirth because they perceived an increased risk of pain, fear, and abandonment (McCallum & Dos Reis, 2008; Otis & Brett, 2008), social stigma (Berry, 2006; Otis & Brett, 2008), surgery, infertility, contradictory information (Berry, 2006), and death (Otis & Brett, 2008). In contrast, hospital birthplaces appealed to other women because they were perceived as safe, modern, hygienic, and having clean air (McCallum & Dos Reis, 2008; Otis & Brett, 2008), Women interpreted information about their pregnancies in ways that minimized their risk status and maintained a sense of safety at home (Berry, 2006; Otis & Brett, 2008).

Barriers. Women encountered many barriers in accessing health facilities for childbirth. All three reports contained information about barriers to care; 8 of 27 synthesized findings were about barriers (Table 3.14: LA9, LA19, LA20, LA21, LA22, LA23, LA24, LA25). Barriers women encountered that prevented them from delivering in hospitals included: (a) cost (Berry, 2006; Otis & Brett, 2008); (b) distance and transportation (Otis & Brett, 2008); (c) bed availability (McCallum &

Dos Reis, 2008; Otis & Brett, 2008); and (d) the major preparations required for hospital deliveries (Otis & Brett, 2008).

Caregiver behavior and knowledge. All three reports addressed issues of caregiver behavior and knowledge; 9 of 27 synthesized findings were about caregiving (Table 3.14: LA3, LA4, LA6, LA10, LA11, LA12, LA14, LA15, LA26). Women reported that hospital caregivers were rude, demeaning, and provided poor quality of care (Berry, 2006; McCallum & Dos Reis, 2008; Otis & Brett, 2008). Women in Brazil appreciated the technical skill of physicians (McCallum & Dos Reis, 2008). Women in Guatemala, however, believed that complications during childbirth were often symptoms of social or spiritual problems that could not be treated in hospitals, but could only be treated at home by traditional birth attendants known as iyoms (Berry, 2006). Women who delivered in the hospital underwent routine care procedures such as pubic shave, oxytocin augmentation, and episiotomy (McCallum & Dos Reis, 2008).

Physical environment. Women preferred that their birthplaces had certain qualities. Two reports addressed the physical environment; 4 of 27 synthesized findings were about the physical environment (Table 3.14:LA7, LA8, LA12, LA13). Women preferred an environment that permitted them to move and change position (McCallum & Dos Reis, 2008; Otis & Brett, 2008). Women also liked environments that were modern, clean, warm, and provided free meals and clean clothes (McCallum & Dos Reis, 2008; Otis & Brett, 2008). Women preferred birthplaces that allowed family members in the room (Otis & Brett, 2008).

Middle East

Regional Description

Geographic distribution of studies. Findings were extracted from two reports of studies conducted in two countries: Egypt and Iran (Table 3.7)

Study population. The data featured in these reports were collected from 621 women.

Data collection techniques. Data for the individual studies were generated using interview (1); non-participant observation (1); and survey (1).

Aim of studies. Studies were focused on women's birth experiences in home (n = 1) and hospital (n = 2).

Background information and descriptions of birth practices. Maternal mortality ranged from 35 per 100,000 in Iran to 74/100,000 in Egypt (Hogan et al., 2010). Skilled health personnel attended 90% of births in Iran and 69% of births in Egypt. Egypt had a health facility birth rate of 52% (WHO, 2005b; WHO, 2005c). The health facility birth rate was not available for Iran.

Findings

The two research reports yielded 26 synthesized findings in the following topical areas: (a) intervention; (b) management of birthplace environment; (c) caregiver; (d) pain; and (e) safety (Table 3.15).

Intervention. Both reports addressed interventions in birthplaces; 2 of 26 synthesized findings were about intervention (Table 3.15: ME1, ME3). Women who delivered in hospitals reported that they preferred to avoid birthplaces with routine interventions (El-Nemer et al., 2006; Pirdel & Pirdel, 2009).

Physical environment. Both reports and 10 of 26 synthesized findings addressed the physical environment (Table 3.15: ME2, ME6, ME11, ME13, ME15, ME16, ME18, ME22, ME23, ME25). Women preferred to deliver in a place where they had freedom of movement, no time constraints, and could eat and drink when they wanted (El-Nemer et al., 2006; Pirdel & Pirdel, 2009). Women wanted to deliver in a birthplace that was private and quiet, but they did not want to be left all alone and wanted their family members present for support (El-Nemer et al., 2006; Pirdel & Pirdel, 2009).

Caregiver behavior. One of the reports addressed caregiver behavior; 9 of 26 synthesized findings were about caregiver behavior (Table 3.15: ME4, ME7, ME8, ME9, ME10, ME17, ME19, ME20, ME21). Women who labored and delivered in the hospital described their caregivers as rude and distant, while women who labored and delivered at home described the care they received from

their dayas, or traditional birth attendants, as personalized, compassionate and confident (El-Nemer et al., 2006).

Pain control. Both reports addressed pain management; two of 26 synthesized findings were about pain experience or management (Table 3.15: ME12, ME26). Women described their hospital birth experiences as physical suffering and attributed their pain experiences to stress from the environment (El-Nemer et al., 2006; Pirdel & Pirdel, 2009).

Safety. One of the reports addressed issues of safety: 1 of 26 synthesized findings was about safety in the birthplace (Table 3.15: ME14). Women in Egypt perceived a sense of safety from the technology and skilled providers found in hospitals, however, they also believed they were exposed to increased risk resulting from interventions in the hospital (El-Nemer et al., 2006).

Australia/New Zealand

Regional Description

Geographic distribution of studies. Findings were extracted from two reports of studies conducted in Australia and New Zealand (Table 3.8).

Study population. The data featured in these reports were collected from 21 women.

Data collection techniques. Data for the two individual studies were generated by interview.

Aim of studies. The aims of the two studies were to describe women's experiences in specific physical birth environments: a Snoezelen room (n = 1) and water immersion (n = 1).

Background information and descriptions of birth practices. Maternal mortality was 6 /100,000 in Australia, and 7/100,000 in New Zealand (Hogan et al., 2010). Almost all births occurred in health facilities and skilled attendance at birth was 100% in Australia and New Zealand (WHO, 2005b; WHO, 2005c).

Findings

The two research reports yielded six synthesized findings, all about the physical environment (Table 3.16).

Physical environment. Both reports addressed physical environment (Table 3.16: ANZ1, ANZ2, ANZ3, ANZ4, ANZ5, ANZ6). Women wanted a birthplace environment that was quiet, private, comfortable, provided for freedom of movement, accommodated support people, and had medical support available while at the same time avoiding a clinical atmosphere (Hauck, Rivers, & Doherty, 2008). Immersion in water during labor and/or delivery provided all the environmental conditions women wanted in a birthplace and lessened their pain perception (Maude & Foureur, 2007).

CHAPTER 4

METASYNTHESIS ACROSS REGIONS

Findings from the eight world regions addressed 13 distinct topics related to birthplace that women indicated were important considerations in choosing or evaluating their birthplace (Table 4.1). Displayed in Table 4.1 are the topics ranked according to prevalence in each region. The regions are listed according to the number of reports containing findings on birthplace that were included in this analysis. The four regions with the most research results in topical categories were Europe, Sub-Saharan Africa, the United Kingdom, and North America. The three largest sets of synthesized findings, in the topical categories of physical environment, caregiver behavior, and safety, were extracted from reports of research conducted in all eight world regions.

Although there seemed to be a general consensus in the range of topics important to women, what seemed most important to women (based upon the prevalence of findings) varied among the regions. For example, physical environment was the most highly ranked topic, based upon prevalence of findings, in reports from Europe and Australia, while barriers was the topic that was most highly ranked in Sub-Saharan Africa and Asia. The topic that appeared most often in reports from the United Kingdom was about support people. Caregiver behavior was the most prevalent topic in North America.

Sometimes topics that seemed important to women in one region, based upon prevalence of individual findings, did not appear at all in other regions. For instance, delivering in a familiar place was very important to women in Europe, and familiarity was implicated in birth outcomes there. Women from other regions did not emphasize familiarity as a birthplace characteristic. Likewise, the topic of relocation during labor and after birth was the third highest rated topic in the United Kingdom, but the only other place it appeared was in North America, where it was ranked eighth.

Pain management was consistently ranked in the middle in the regions of Europe, the United Kingdom, North America and the Middle East, but was not at all addressed in reports from the other regions. The second-ranked topic based upon findings from Sub-Saharan Africa was that women had specific reasons for avoiding certain birthplaces and preferring others. North American reports also yielded findings related to specific things women either avoided or preferred, but the topic ranked ninth for North America.

Physical Environment

The topic of birthplace environment was addressed by synthesized findings from all eight regions (Table 4.2). Women in seven of the eight regions wanted the physical environment of their birthplace to be private, permit freedom of movement and choice of delivery position, and accommodate family members. Women in five of the regions also wanted to control aspects of the environment such as lighting or who had access to their birthplaces. Synthesized findings from Europe, the United Kingdom, North America and Australia included many physical birthplace characteristics women wanted such as quiet, warm, peaceful, comfortable, familiar, and intimate; synthesized findings from Sub-Saharan Africa, Latin America, and Asia did not. Synthesized findings from Sub-Saharan Africa and Asia addressed women's desire to avoid birthplaces where men were present.

Caregiver Behavior

Caregiver behavior was also an important topic, derived from synthesized findings from reports originating in seven of the eight regions (Table 4.3). The synthesized findings related to caregiver behavior were very consistent in that women wanted a caregiver who was supportive, competent, and confident, and was present throughout labor. Also consistently reported was that women often encountered the opposite behavior in caregivers working in hospitals, leading women in Europe, Sub-Saharan Africa, North America, and Asia specifically to mention caregiver behavior in hospitals as a reason they wanted to deliver at home. Laboring women recognized competence in labor attendants with a variety of backgrounds, particularly traditional birth attendants in Sub-Saharan

Africa, the Middle East, and Latin America. The finding that women wanted skilled care throughout labor came from studies in Europe, the United Kingdom, and North America that specifically addressed women's experiences of early labor and found the time women spent laboring at home, prior to hospital admission, to be particularly stressful and unsettling in the absence of a knowledgeable, competent caregiver.

Safety

Synthesized findings from seven of the eight world regions represented in this synthesis addressed safety issues women considered when explaining their choice of birthplace, whether the birthplace was located in the hospital or at home (Table 4.40). Although safety was important to women across all regions, the birthplace characteristics or features that imparted a sense of safety for women varied greatly. Women who planned hospital deliveries felt a sense of safety from the technology and personnel available to intervene if complications developed. The same technology that provided a sense of safety for those women made other women feel unsafe in the hospital because routine use of the technology could lead to complications. Women throughout all regions of the world believed pregnant women with known complications should deliver in the hospital. Yet, they resisted acknowledging their own elevated risk status in order to deliver where they wanted. Women in Sub-Saharan Africa, Asia and Latin America recognized that some complications had social or spiritual causes that could not be treated in the hospital. Therefore, women in Asia and Latin America believed traditional birth attendants were better equipped to handle them at home. Women in Europe and North America who planned hospital deliveries felt unsafe at home prior to hospital admission when they were without a skilled attendant. Furthermore, women laboring in the hospital felt unsafe when they were left without the presence of a knowledgeable and caring attendant, even if they had family members present. Secrecy in the birthplace was an important safety consideration for women in Sub-Saharan Africa and Asia and, therefore, a reason for avoiding hospitals for birth. Without secrecy, women in Sub-Saharan Africa and Asia felt unsafe delivering in the hospital

because they were easier targets of witchcraft and evil spirits there. Secrecy and witchcraft were not addressed anywhere else.

Barriers

Women in many parts of the world faced barriers to access the birthplace of their choice, although the barriers took different forms. Cost was the barrier addressed most often by women causing them to choose one birthplace rather than another. Women in six of the regions stated fees, which often had to be paid in advance, prevented them from delivering in health facilities (Table 4.5). In Europe where most governments pay the hospital costs, home birth costs must be paid out of pocket. Distance was another barrier women in many places encountered. For women in some parts of Sub-Saharan Africa, the United Kingdom, North America, Asia and Latin America, hospitals were located too far from where women lived for them to get to the hospital during labor. Yet, being located too far from a hospital prevented women from planning home births in Europe and the United Kingdom, because they relied upon the hospital to serve as a safety net in the event complications occurred during labor or birth. Women in many European countries and North America encountered strong opposition from health professionals and some family members when planning home births. Women in Sub-Saharan Africa, Asia and Turkey faced opposition to hospital birth from family members who had decision-making power. Women in many regions were turned away from the hospital if they were not sufficiently advanced in their labor to gain admission. Finally, in order to deliver in hospitals in Sub-Saharan Africa or Latin America women first had to complete lengthy preparations that included gathering medical supplies, obtaining an admittance card, and arranging for transport and child care.

Interventions

Women in five of the eight regions wanted to deliver in a birthplace that did not routinely impose unnecessary interventions during labor and birth (Table 4.6). Women in the United Kingdom who planned to deliver in the hospital stated their understanding that interventions were a necessary and normal part of birth. Other women stated their wish to avoid hospitals in order to avoid the

unnecessary interventions. Women in Asia and Sub-Saharan Africa accepted interventions designed to decrease maternal and neonatal morbidity and mortality in all birthplaces as long as their traditional birth assistants recommended them.

Pain Control

Women in four regions addressed their pain experiences and pain control. Discussion of pain control was most frequently addressed in reports about hospital births. Pain control was also important to women laboring outside of the hospital, particularly for women laboring at home early in labor who desired hospital admission in order to gain access to pain medicine that was only available in the hospital. Women appreciated having multiple options for pain relief. Uncontrolled pain during labor and deliver resulted in bad birth experiences regardless of where the birth occurred. Pain management was not addressed by women from Sub-Saharan Africa, Asia, or Latin America, places where medical pain relief was not routinely administered during labor.

Active Participation In Decision-Making

Women in Europe, the United Kingdom, and North America wanted active participation in decision-making during their labors. They particularly wanted a voice in decisions about the timing of hospital admission, pain control, and interventions such as labor augmentation or assisted delivery. Women in these three regions planned to deliver outside of the hospital if they believed they would not have adequate involvement in decision-making in the hospital.

Support People

Women had a variety of experiences with their support persons depending upon where they delivered. Women in Europe, Sub-Saharan Africa and North America who experienced planned home deliveries received high quality and confident care from their relatives. On the other hand, women who planned to deliver in the hospital felt their families were unable to provide the kind of care and support they needed at home during early labor. Family members sometimes had to fulfill unmet care needs of women laboring in the hospital, but felt insecure and uncomfortable doing so.

Framing the Findings in the Three Elements of Therapeutic Landscapes

Physical environment

Women identified three physical properties of birthplaces they desired and that were therefore considered therapeutic in all birthplaces (Figure 1). First, women wanted their birthplace to be private. Privacy occurred when the physical layout of the birthplace shielded women from the view of individuals not participating in the labor and birth activities. Privacy meant that women had chosen who the participants were and could control access to the birthplace. Secondly, women wanted their birthplaces to permit them to move freely and choose their delivery position. For this to occur, birthplaces needed to be spacious enough to accommodate movement and provide support for women in various positions. Women used material objects and sometimes other people for physical support. Thirdly, women wanted their family members, or other support persons, present with them during their labor and birth, and wanted the birthplace to accommodate them. Accommodations needed to be available for family members throughout labor, as women in early labor wanted their supporters with them as much as women in active labor. Synthesized findings that addressed these topics indicated that birthplaces with these physical attributes influenced behavior because the laboring women were able to relax and focus on the work of labor, and their family members were better able to provide physical and social support.

Social environment

Women identified three social aspects of birthplaces they desired and were, therefore, considered therapeutic in all birthplaces. First, a birthplace became therapeutic for most laboring women when there was a competent, confident and caring caregiver present with them throughout labor. All three qualities, competence, confidence, and caring, were important. For instance, although women appreciated the technical skill of surgeons able to operate for obstructed labor or other emergencies, what they also wanted was someone who provided affectionate and personalized attention continuously throughout labor; women believed they were more likely to accomplish a normal birth attended by such a person. Women recognized competence, confidence and caring in

birth attendants with various backgrounds and training. The caregiver was typically not a family member or support person.

Interventions affected women's birth experiences. Interventions were anything a caregiver did to or with the laboring woman, typically for the purpose of speeding the process or alleviating pain, and were often medical or surgical in nature. Interventions were categorized as part of the social environment because women's experiences of intervention were affected by caregiver type (physician, midwife), and by where the woman intended to deliver, as well as by birthplace location (home, birth center, hospital). For example, midwives were more likely to sweep membranes or perform an amniotomy when caring for low-risk women who planned to deliver at home compared to low-risk women who planned a hospital delivery. There was also evidence that caregivers, particularly in Europe and the United Kingdom, associated different pain-relieving therapies with different places. Therefore, woman's choices for pain relief were limited by caregivers based upon where the woman was laboring, rather than what might be most effective for an individual woman's labor. Support person behavior is also part of the social environment. Support persons were most effective providing psychological and physical support when they had confidence in their abilities to provide needed support. Support persons' level of confidence and behavior differed in different birthplaces and under different circumstances.

Psychological/Symbolic Environment

Findings were derived from regions with very diverse cultures, making it difficult to find consensus about meaning. One topic important to all women, regardless of birthplace, was safety. Safety was a component of the psychological/symbolic environment because, although all women considered safety to be important, women's opinions about what constituted a sense of safety or danger varied greatly both within and between different regions and cultures. For instance, some women experienced a sense of safety laboring in a place where technological equipment was visible. Other women experienced a sense of danger from this same environment because they felt more at risk from unnecessary interventions. Women in some cultures associated hospitals with illness and

death. Women in other cultures viewed hospitals as places where lives could be saved. Sometimes both views were held within the same culture. Women interpreted physical and social qualities present in birthplaces as providing safety or inviting danger.

CHAPTER 5

SUMMARY & CONCLUSION

Brief Summary Of Findings

Women across geographic regions viewed or experienced as therapeutic those birth landscapes that were private, permitted freedom of movement and choice of delivery position, and accommodated family members and other support persons. Included within the landscape was a competent, confident and caring provider who was able to be with women throughout labor, regardless of where the birthplace was situated, and who did not impose what women saw as unnecessary interventions. Therapeutic landscapes for birth incorporated the active involvement of support persons. Therapeutic landscapes for birth provided women with a sense of safety. Women in all places faced barriers to accessing therapeutic landscapes for birth.

Women across geographic regions were remarkably similar in their views or experiences regarding therapeutic birth landscapes despite variations in culture and healthcare delivery practices. Both home and hospital were viewed or experienced as therapeutic or nontherapeutic. Women who avoided hospitals did so for common reasons in all regions. Women avoided hospitals in order to avoid rude caregivers, unnecessary interventions, lack of privacy, exclusion of support persons, and restricted movement. Women who preferred hospitals did so because they viewed or experienced hospitals as providing life-saving services. Women in all regions found it nontherapeutic to have to move from one place to another during labor. Women experienced particularly nontherapeutic landscapes when they were denied hospital admission because they were not in active labor.

Social stigma was a powerful sanction experienced universally by women when they chose birthplaces out of the norm for their culture. Women in regions with low rates of maternal mortality felt stigmatized when they chose to deliver at home, because they were seen as placing their desire for

comfort over the safety of their baby. Women in places with high maternal mortality felt stigmatized when they chose to deliver in the hospital, because it indicated the presence of some personal defect that they were not able to deliver on their own.

Women in all regions understood the concept of risk and they applied it selectively to their own situation. Women articulated an understanding of obstetrical risk, and the conditions or situations that were considered to be at increased risk. Yet when women developed signs of increased risk conditions, they typically evaluated their new status subjectively by incorporating their assessment of their own ability to cope with the condition and their desire to remain in their desired birthplace. This meant that for women who chose to deliver at home, the safety and comfort they perceived in their home birthplace was more therapeutic to them than the potential for increased safety represented by hospitals, because hospitals represented a different set of risks making them appear less therapeutic.

Evident in the findings from all regions is that the nature of the care provider could transform a birth landscape viewed or experienced as therapeutic to one viewed or experienced as nontherapeutic, and a birth landscape viewed or experienced as nontherapeutic to one viewed or experienced as therapeutic. The arrival of a confident, caring and competent midwife during early labor transformed women's homes into therapeutic landscapes for birth for women who planned hospital deliveries. Hospitals became nontherapeutic for women cared for by unfamiliar physicians because they were subjected to a different set of interventions compared to women cared for by their own physicians. Women who labored and delivered in hospitals experienced nontherapeutic landscapes when they were left alone without the presence of a caring provider.

Women across all geographic regions included a sense of safety in descriptions of therapeutic birth landscapes. Remarkable was the difference in how women perceived safety. Some women perceived safety from visible technological equipment and the presence of highly skilled medical personal. Other women viewed this landscape as dangerous, and experienced a sense of safety in their own homes. Examples of this dichotomy were evident in most regions.

Key variations in what women viewed or experienced as therapeutic were, however, evident largely on the basis of whether the region was developed with generally low maternal mortality or developing with generally high maternal mortality. Secrecy was most valued in places where the maternal mortality was high. These were also places where women worried about witchcraft and other spiritual forms of danger and sought to deliver in private places where the birth could be kept a secret. Women in places with relatively low rates of maternal mortality had no desire to keep birth a secret. They used the Internet to inform their family and acquaintances of their status and progress. Pain relief options were wanted by women in areas of low maternal mortality, but were not addressed by women in areas of high maternal mortality. Women did not voice a wish to avoid home for delivery in any region as they did for hospitals, but women in regions of low maternal mortality felt uneasy laboring at home when they wanted to deliver in the hospital.

Women across geographic regions viewed or experienced barriers to achieving therapeutic birth landscapes. Women in regions with high maternal mortality experienced barriers such as distance, lack of facilities, and cost. Women in regions with lower maternal mortality experienced barriers including difficulty gaining hospital admission during early labor.

Home and hospital birthplaces do not have mutually exclusive characteristics, and even though women chose one place or another, they often wanted their birthplaces to have components associated with those they wanted to avoid. For instance, women who planned to deliver in hospital birthplaces wanted those places to become more like home in terms of comfort, privacy, and the company of support people. Women who labored and/or delivered at home relied upon labor progress measures used in hospitals such as timing contractions, assessing cervical dilation, or monitoring fetal heart rates.

Limits and Caveats

There are several limitations of this study or caveats in interpreting the findings. First, only reports addressing all three elements of the therapeutic landscapes framework were included in this study. Excluded were many reports that addressed one or two aspects.

There was an uneven number of reports in different regions with some regions only represented by 1-3 reports. Europe, Africa, the United Kingdom, and North America were all represented by 13 or more reports. There were seven reports from Asia. Latin America, the Middle East and Australia/New Zealand were all represented by three or fewer reports.

Study women were not representative of the women giving birth in the regions represented. The samples included in this investigation from Europe, the United Kingdom, and North America were disproportionately drawn from populations of women who delivered outside of the hospital. This is due to the nature of sampling in the studies themselves and the inclusion criteria for this synthesis study. Indeed, the criterion that reports include findings on all three elements of the therapeutic landscapes framework favored findings derived from qualitative methods, making this research synthesis less "mixed" than anticipated. There were not many reports available that presented information on women's positive hospital birth experiences and addressed all three aspects of the model.

Cultural norms influenced how studies were conducted. In studies conducted in places with high maternal mortality where home birth was the norm, researchers tended to ask women why they did not go to health facilities for delivery. This line of questioning resulted in reasons why women avoided hospitals and preferred home. In North America, the women who were asked why they delivered where they did were women who delivered at home. Data collected from women who experienced planned hospital deliveries in places where hospital deliveries were the norm, and not collected just from women who had negative experiences, would have likely altered the findings of this study. Myths were addressed in developing regions with high maternal mortality, especially if the myths were perceived as contributing to women's avoidance of facilities for birth. Myths were not discussed in reports from research conducted in developed regions with low maternal mortality where myths exist too but are often not seen to operate as myths.

Researchers also used people or practice philosophies as proxies for place. This research practice made it difficult to identify reports for inclusion because place-based words such as hospital

or birth center appeared in the titles. In these studies, findings were focused on providers' practices or philosophies without any demonstrated tie to place.

Finally, many of the studies were conducted in countries where English was not the primary language, although the reports included in this synthesis were all written in English. The English words used in the research reports may have imprecisely reflected the nuances of meanings conveyed to the researcher, which made it difficult at times to determine the exact meaning of findings. Difficult was knowing whether words, such as *familiar* or *comfort* or *privacy* used in reports translated from different languages meant the same thing.

Implications for Research and Practice

Future research efforts into therapeutic landscapes for birth should be directed at furthering the work of this synthesis by performing systematic reviews of research reports that pertain to the individual aspects of the therapeutic landscape model. Focusing on individual aspects, such as the physical environment, will increase the clarity of what women want by incorporating a larger group of research reports with findings specific to that aspect; this will allow researchers better to ascertain the relationships of these elements to each other.

Research and practice aimed at identifying ways to reduce or eliminate barriers to therapeutic landscapes for birth in all regions will benefit women and their families. A recent Home Birth Consensus Summit (2011) was convened in the US for the purpose of fostering dialogue between stakeholder groups in maternity care. The ultimate goal of the summit was to determine what the entire maternity care system could do to support women who choose homebirth, and what those who provide care, consultation, collaboration, and referral services could do in order to make homebirth the safest and most positive experience for all involved. The Common Ground Statements developed at the summit address key findings from this research synthesis and highlight the need for research on the topic of birthplace. First of all, investigating ways to improve communication and collaboration between home-based birth attendants and facility-based attendants, and continuing to investigate ways to equip home birth attendants with the knowledge, skills, and materials necessary to increase

the safety of home birth landscapes across all regions, will diminish barriers women face in obtaining a safe and therapeutic birth throughout the continuum of birth landscapes. Secondly, finding ways to support women who desire hospital births during early labor, either by providing competent, caring, and confident caregivers in their homes prior to hospital admission, or altering hospital admission policies and landscapes to permit earlier admission, would likely lessen the unease women feel at this stage of labor and validate their autonomy to make decisions, as women would be the ones to determine when they required help. Finally, research focused on ways to make the social aspects of hospital landscapes, such as caregiver behavior and appropriately utilized interventions, more woman-centered, will likely result in making birth landscapes in hospitals more therapeutic for women and their families so women, including those planning home births, will have fewer reasons to want to avoid the hospital.

Conclusion

Women across all geographic regions shared a common vision of a therapeutic landscape for birth. Women viewed or experienced as therapeutic those birth landscapes that were private, permitted freedom of movement and choice of delivery position, and incorporated family members and other support persons in the birth process in meaningful ways. Therapeutic landscapes for birth included a competent, confident and caring provider who was able to be with women throughout labor. Women across all regions chose birthplaces that provided them with a sense of safety. Barriers existed in all regions preventing women from accessing therapeutic landscapes for birth.

TABLES

Table 2.1. Databases Searches

Database	Search terms	Limits	Total Hits	Potentially relevant Transferred to RefWorks
CINAHL	(SU (labor or birth or childbirth)) and SU (hospital or home or birth center or place or environment) or TX experience	1995 – 9.2010 English Peer reviewed Research article	1733	775
Academic Search Premier	(SU (labor or birth or childbirth)) and SU (hospital or home or birth center or place or environment) or TX experience And TX (research or interview) not SU (work* or employ*)	1995 – 9.2010 Peer reviewed	5997	758
Family & Society Worldwide	(SU (labor or birth or childbirth)) and SU (hospital or home or birth center or place or environment) or TX experience And TX (research or interview)	1995 – 9.2010 Peer reviewed	384	178
PsycInfo	(SU (labor or birth or childbirth)) and SU (hospital or home or birth center or place or environment) or TX experience	1995 – 9.2010 English Peer reviewed Empirical study	1624	426
Social Work Abstracts	SU (labor or birth or childbirth)) and SU (hospital or home or birth center or place or environment) or TX experience	1995 – 9.2010	11	2
Women's Studies International	SU (labor or birth or childbirth)) and SU (hospital or home or birth center or place or environment) or TX experience	1995 – 9.2010 Peer reviewed	536	100
Global Health	SU (labor or birth or childbirth)) and SU (hospital or home or birth center or place or environment) or TX experience	1995-2010 Human sciences English	880	194
Cochrane	(hospital or home or birth center) and (birth or delivery)	2000-2010	2519	0
Sociological Abstracts	KW=(labor or birth or childbirth) and KW=(hospital or home or (birth center)) and not (employ* or work*)	1995- 2010 limited to: journal articles only, English only	340	49
Embase	(labor or birth or childbirth).mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer] 2. limit 1 to (human and English language and yr="1995 - 2010" and article) 3. (hospital or home or birth center or place or environment).mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer] 4. 2 and 3 5. limit 4 to (human and English language and yr="1995 - 2010" and article) 6. limit 5 to (adolescent <13 to 17 years> or adult <18 to 64 years>)		9265	
	limit 6 to (clinical trial or randomized controlled trial or controlled clinical trial or multicenter study)		889	478
	21. limit 20 to "qualitative studies (1 term high specificity)"		196	90
PubMed	"Hospitals"[Mesh] OR "Home Care Services, Hospital-Based"[Mesh] OR "Hospital Design and Construction"[Mesh] OR "Nursing Staff, Hospital"[Mesh] OR "Obstetrics and Gynecology Department, Hospital"[Mesh] OR "Health Facility Size"[Mesh] OR "Hospitals, Urban"[Mesh] OR "Hospitals, Rural"[Mesh] OR "Hospitals, Maternity"[Mesh]	* see below for limits	1905	929

	OR "Birthing Centers"[Mesh] OR "Delivery Rooms"[Mesh] OR "Home Childbirth"[Mesh] AND "Labor, Obstetric"[Mesh] OR "Obstetric Labor Complications"[Mesh] OR "Labor Stage, Third"[Mesh] OR "Labor Stage, Second"[Mesh] OR "Labor Onset"[Mesh] OR "Labor Stage, First"[Mesh] OR "Labor Pain"[Mesh] OR "Trial of Labor"[Mesh] OR "Labor, Induced"[Mesh] OR "Labor Presentation"[Mesh] OR ("Parturition"[Mesh] OR "Uterine Monitoring"[Mesh] OR "Vaginal Birth after Cesarean"[Mesh] OR "Uterine Contraction"[Mesh] OR "Analgesia, Obstetrical"[Mesh] OR ("Oxytocics"[Mesh] OR "Natural Childbirth"[Mesh] OR "Postpartum Hemorrhage"[Mesh] OR "Dystocia"[Mesh] OR "Birth Injuries"[Mesh] OR "Term Birth"[Mesh] OR "Live Birth"[Mesh] OR "Midwifery"[Mesh]			
PubMed	"Environment"[Mesh] OR "Health Facility Environment"[Mesh] OR "Environment Design"[Mesh] OR "Social Environment"[Mesh] OR "Environment, Controlled"[Mesh] AND "Labor, Obstetric"[Mesh] OR "Obstetric Labor Complications"[Mesh] OR "Labor Stage, Third"[Mesh] OR "Labor Stage, Second"[Mesh] OR "Labor Onset"[Mesh] OR "Labor Stage, First"[Mesh] OR "Labor Pain"[Mesh] OR "Trial of Labor"[Mesh] OR "Labor, Induced"[Mesh] OR "Labor Presentation"[Mesh] OR ("Parturition"[Mesh] OR "Uterine Monitoring"[Mesh] OR "Vaginal Birth after Cesarean"[Mesh] OR "Uterine Contraction"[Mesh] OR "Analgesia, Obstetrical"[Mesh] OR ("Oxytocics"[Mesh] OR "Natural Childbirth"[Mesh] OR "Postpartum Hemorrhage"[Mesh] OR "Dystocia"[Mesh] OR "Birth Injuries"[Mesh] OR "Term Birth"[Mesh] OR "Live Birth"[Mesh] OR "Midwifery"[Mesh]	* see below for limits	1003	370

*PubMed Limits Activated: Humans, Meta-Analysis, Randomized Controlled Trial, Review, Clinical Trial, Phase I, Clinical Trial, Phase II, Clinical Trial, Phase III, Clinical Trial, Phase IV, Comparative Study, Controlled Clinical Trial, Evaluation Studies, Government Publications, Interview, Journal Article, Multicenter Study, Research Support, American Recovery and Reinvestment Act, Research Support, N I H, Extramural, Research Support, N I H, Intramural, Research Support, Non U S Gov't, Research Support, U S Gov't, Non P H S, Research Support, U S Gov't, P H S, Validation Studies, English, Publication Date from 1995 to 2010/09/30

Table 2.2 Data Extraction Guide
Data Extraction: (citation)

Geographic location of study:

Dates of study:

Key words (stated in report):

Related reports:

Date of reading:

(my comments/words)

Research problem:

Research purposes & questions:

How was place defined and depicted: what import (role) did it have in study:

Study design/type:

Orientation toward the target phenomenon/theoretical orientation:

Sampling strategy and techniques:

Sample size and composition:

Data collection or generation techniques & sources:

Data management & analysis techniques:

Findings:

- Physical:
- Social:
- Symbolic:

Protection of human subjects:

Logic & form of findings:

Reviewer's abstract & summary appraisal:

Research purpose:

Theoretical framework:

Method:

Sample size & key characteristics:

Data collection techniques:

Data analysis techniques:

Primary topic of findings:

Secondary topics of findings:

Type of findings:

- No finding (exclude from study) _____
- Topical survey _____

- Thematic survey ____
- Conceptual/thematic descriptive _____
- Interpretive explanation _____
- Statistical/numerical ___

Extracted & edited findings:

Evaluation:

- Acceptable (Signal > noise) _____
- Questionable (noise > signal) _____

Table 3.1. Europe Study Details

	Citation Country	Purpose	Place	Design/method	Sample	Data collection, time period, year collected
1	Borquez & Wiegers (2006) Netherlands	Compare birth experiences of women who delivered at home with women who delivered in hospital (nothing about intent)	Home vs. hospital	Quantitative Descriptive Cross section survey	129 ♀ home del 64 ♀ hospital del	Postal questionnaire 1-6 months after birth 2003
	E1. Women wanted to deliver in a familiar birthplace where they could exert control over their environment. (.42) E2. Women considered aspects of safety when they chose their birthplace. (.37) E5. Women who labored and delivered at home perceived the care they received by their midwife to be confident, competent, supportive, intensive, personalized and satisfying (0.32). E9. Women wanted their birthplace to be cozy, comfortable, trustworthy, relaxed, calm quiet, warm, secure and have dimmable lights, soothing colors, and accessory equip (0.26). E10. Women who gave birth in hospital stated they did not receive necessary support and presence from their midwife; they felt alone, with nobody present who could help them (0.21). E11. Women wanted to have medical help available during labor and delivery. Some women chose to deliver in hospital because of the ready availability of medical help. Women who deliver at home make transportation plans in the event complications occur (0.21). E13. Women who labored and delivered at home (out of hospital) were more likely to wanted to deliver their next baby in the same place compared to women who delivered in the birth center(hospital) (0.16). E14. Women who labored and delivered at home were more satisfied with their birth setting than women who labored and delivered at a birth center (hospital) (0.16). E15. Women who labored and delivered at a birth center(hospital) perceived their birth place to be more strange and anxiety producing than women who delivered at home (0.16). E17. Women do not like having to travel and change environments during labor. They wish to avoid having to make decision about the right time to go to hospital, and travel home after delivery (0.16). E19. Women who labor/deliver in familiar surroundings (home, known birth center) report less pain and/or receive less pain medicine (epidural) or were more likely to use alternative pain relieving methods than women who were in unfamiliar birth places (hospitals, referred to unfamiliar birth center/hospital) (0.11). E22. Women who labored and delivered at home described their birth place to be more safe, intimate, comfortable and trust-worthy than women who delivered in a birth center(hospital) (0.11). E28. Women who delivered in a birthcenter (hospital) stated it was not comfortable (0.11). E48. Some women perceive birth centers (hospital) to be more convenient birthplaces (.05). E51. Some women who delivered at home did not like that there was no medical help immediately available (.05). E52. Some women who delivered at home stated their home was too small (.05).				
2	Carlsson et al (2009) Sweden	Describe latent labor experiences All plan hospital	Desire hospital, stuck at home	Qualitative descriptive Cross section	18 ♀ hospital del	Interview 2-4 wks after birth year not given
	E31. Women planning hospital birth have difficulty gaining access to hospital if they do not meet criteria for admission and were uncomfortable returning home when home is located far away from the hospital (0.11). E50. Women who plan to labor and deliver in hospital wish to be admitted when their contractions become painful. They experience a sense of safety and security in the hospital, appreciate the opportunity to hand over responsibility for their wellbeing and that of their baby to competent professionals. They do not like to be sent home, and attempt to exert control over the situation by being admitted early (.05).					
3	Chalmers & Jeckaite (2010) Lithuania	Compare birth experiences between two hospitals All plan hospital	2 hospitals	Observational descriptive Cross section	720 ♀ hospital delivery	Survey questionnaire 1 day post partum 2004
	E4. An ideal birth environment provides women with the opportunity to control pain (0.32). 33. Hospital exposed to WHO guidelines has higher epidural rate (but fewer women walked during labor) compared to traditional hospital in Lithuania (.05).					
4	Christiaens & Bracke (2009)	Compare home and hospital births in two countries	Home vs. hospital	Quantitative, comparative	580 ♀ home/hosp	"where would you like to

				descriptive		give birth" asked at 30 wk gestation Mackey Satisfaction with childbirth rating scale 2 wks after birth 2004-2005
	Belgium & Netherlands	Analyzed according to planned rather than actual place of birth	2 countries			
	E5. Women who labored and delivered at home perceived the care they received by their midwife to be confident, competent, supportive, intensive, personalized and satisfying (0.32). 14. Women who labored and delivered at home were more satisfied with their birth setting than women who labored and delivered at a birth center (hospital) (0.16).					
5	Johnson et al (2007) Netherlands	Describe home birth experiences in Netherlands	Home vs. hospital	Qualitative descriptive	14 ♀ home del	Interview (guide) w/in 1 yr of birth 2004-2005
	E1. Women wanted to deliver in a familiar birthplace where they could exert control over their environment. (.42) E2. Women considered aspects of safety when they chose their birthplace. (.37) E5. Women who labored and delivered at home perceived the care they received by their midwife to be confident, competent, supportive, intensive, personalized and satisfying (0.32). E7. Women wanted a birthplace that is natural with a peaceful, unhurried atmosphere, and no outside influences where they could relax (0.32). E9. Women wanted their birthplace to be cozy, comfortable, trustworthy, relaxed, calm quiet, warm, secure and have dimmable lights, soothing colors, and accessory equip (0.26). E12. Women wanted a birthplace that accommodates their support persons and permits an intense family experience (0.21). E16. Women wanted their birthplace to be privacy and intimate (0.16). E25. Women who deliver at home wanted a hospital nearby and available if necessary (0.11).					
6	Kukulu & Oncel (2007) Turkey	Reasons women deliver at home	Home vs. hospital	Quantitative Descriptive cross-section	392 ♀ delivered at least one baby at home All resided in shanty town	Structured interview Unspecified time since delivery 2003
	E2. Women considered aspects of safety when they chose their birthplace. (.37) E5. Women who labored and delivered at home perceived the care they received by their midwife to be confident, competent, supportive, intensive, personalized and satisfying (0.32). E8. Women wish to avoid hospitals for birth because of the poor behavior by hospital staff that they describe as rude, hostile strangers who speak as if woman not present, and were impersonal and not caring (0.32). E9. Women wanted their birthplace to be cozy, comfortable, trustworthy, relaxed, calm quiet, warm, secure and have dimmable lights, soothing colors, and accessory equip (0.26). E12. Women wanted a birthplace that accommodates their support persons and permits an intense family experience (0.21). E26. Women who delivered at home believe home is a better birthplace for baby (0.11). E29. Women wanted to avoid strange bacteria present in hospitals (0.11). E58. Women in Turkey delivered at home because they could not afford to deliver in hospital (.05). E59. Women in Turkey delivered at home because it was too difficult to reach hospital (.05). E60. Some women in Turkey delivered at home because their spouses or relatives decided (.05).					
7	Lindgren et al (2006) Sweden	Parents perception of risks involved in home birth	Home vs. hospital	Qualitative descriptive Cross section	5 couples home	Interview 1-5 yrs since last birth

E2. Women considered aspects of safety when they chose their birthplace. (.37)
E1. Women wanted to deliver in a familiar birthplace where they could exert control over their environment. (.37)
E8. Women wish to avoid hospitals for birth because of the poor behavior by hospital staff that they describe as rude, hostile strangers who speak as if woman not present, and were impersonal and not caring (0.32).
E11. Women wanted to have medical help available during labor and delivery. Some women chose to deliver in hospital because of the ready availability of medical help. Women who deliver at home make transportation plans in the event complications occur (0.21).
E15. Women who labored and delivered at a birth center(hospital) perceived their birth place to be more strange and anxiety producing than women who delivered at home (0.16).
E32. Women who plan to labor and deliver at home must prepare mentally by breathing, information gathering, and physically by arranging for caregiver, child care, and transportation in event of complication (0.11).
E63. Women who planned home birth faced reluctance by family at first (.05).

8	Lindgren et al (2010) Sweden	Women's risk appraisal of home birth and hospital birth	Home vs. hospital	Qualitative descriptive	727 ♀ responded about 1025 home births	Interview Timing not given 1992-2005

E1. Women wanted to deliver in a familiar birthplace where they could exert control over their environment. (.42)
E2. Women considered aspects of safety when they chose their birthplace. (.37)
E3. Women wanted to deliver in a birthplace where they could avoid unnecessary or routine interventions use of technology. (.37)
E6. Women wanted a birthplace where they could be involved in decision-making about their labor and birth (0.32).
E8. Women wish to avoid hospitals for birth because of the poor behavior by hospital staff that they describe as rude, hostile strangers who speak as if woman not present, and were impersonal and not caring (0.32).
E17. Women do not like having to travel and change environments during labor. They wish to avoid having to make decision about the right time to go to hospital, and travel home after delivery (0.16).
E30. Women who plan to deliver at home felt stigmatized by medical profession (0.11).
E32. Women who plan to labor and deliver at home must prepare mentally by breathing, information gathering, and physically by arranging for caregiver, child care, and transportation in event of complication (0.11).

9	Melender (2006) Finland	Describe women's perspectives of a good childbirth	Environmental aspects	Qualitative descriptive	24 pregnant ♀ (12 nulliparous)	Interview During pregnancy Year not given

E1. Women wanted to deliver in a familiar birthplace where they could exert control over their environment. (.42)
E3. Women wanted to deliver in a birthplace where they could avoid unnecessary or routine interventions use of technology.
E4. An ideal birth environment provides women with the opportunity to control pain (0.32).
E6. Women wanted a birthplace where they could be involved in decision-making about their labor and birth (0.32).
E7. Women wanted a birthplace that is natural with a peaceful, unhurried atmosphere, and no outside influences where they could relax (0.32).
E9. Women wanted their birthplace to be cozy, comfortable, trustworthy, relaxed, calm quiet, warm, secure and have dimmable lights, soothing colors, and accessory equip (0.26).
E16. Women wanted their birthplace to be privacy and intimate (0.16).
E20. Women wanted caring, attentive caregiver throughout labor, wherever they deliver (0.11).
E49. Women wanted a birthplace where they have freedom to move around (.05).

10	Neuhaus et al (2002) Germany	Describe reasons why women avoid hospital for birth	Hospital vs. out of hospital	Qualitative Longitudinal descriptive	132 ♀ who planned out of hospital birth	2 Postal questionnaires 30th week of pregnancy 1st month after birth 1995

E1. Women wanted to deliver in a familiar birthplace where they could exert control over their environment (.42)
E3. Women wanted to deliver in a birthplace where they could avoid unnecessary or routine interventions use of technology. (.37)
E4. An ideal birth environment provides women with the opportunity to control pain (0.32).
E5. Women who labored and delivered at home perceived the care they received by their midwife to be confident, competent, supportive, intensive, personalized and satisfying (0.32).

	E6. Women wanted a birthplace where they could be involved in decision-making about their labor and birth (0.32). E7. Women wanted a birthplace that is natural with a peaceful, unhurried atmosphere, and no outside influences where they could relax (0.32). E12. Women wanted a birthplace that accommodates their support persons and permits an intense family experience (0.21). E13. Women who labored and delivered at home (out of hospital) were more likely to wanted to deliver their next baby in the same place compared to women who delivered in the birth center(hospital) (0.16). E18. Uncontrolled labor/delivery pain leads to very negative /traumatic experience whether in or out of hospital (0.11). E26. Women who delivered at home believe home is a better birthplace for baby (0.11). E34. Women who planned out of hospital delivery, but delivered in hospital, wish next delivery to occur at home (.05). E56. Women avoid hospitals for birth because of the association with sickness (.05).					
11	Nilsson et al (2010) Sweden	Describe previous traumatic hospital birth experiences	Poor env of hospital	Qualitative descriptive	9 ♀ hospital	Interview During pregnancy with second child 2006-2007
	E3. Women wanted to deliver in a birthplace where they could avoid unnecessary or routine interventions use of technology. (.37) E4. An ideal birth environment provides women with the opportunity to control pain (0.32). E10. Women who gave birth in hospital stated they did not receive necessary support and presence from their midwife; they felt alone, with nobody present who could help them (0.21). E15. Women who labored and delivered at a birth center(hospital) perceived their birth place to be more strange and anxiety producing than women who delivered at home (0.16). E18. Uncontrolled labor/delivery pain leads to very negative /traumatic experience whether in or out of hospital (0.11). E20. Women wanted caring, attentive caregiver throughout labor, wherever they deliver (0.11). E24. Women who delivered in hospital stated that lack of control (in hospital) prevented them from feeling secure in hospital (0.11). E27. Women wanted to deliver in a birthplace where the caregiver provides information about labor progress (0.11). E28. Women who delivered in a birthcenter (hospital) stated it was not comfortable (0.11). E31. Women planning hospital birth have difficulty gaining access to hospital if they do not meet criteria for admission and were uncomfortable returning home when home is located far away from the hospital (0.11). E53. Lack of communication (information sharing) made women feel insecure about their place in hospital (.05). E64. Women who delivered in hospital stated their husbands mediated potentially bad relationship with midwife in hospital and performed support activities expected of midwife (.05).					
12	Pavlova et al (2009) Netherlands	Describe attributes women use to decide upon OB care	Home vs. hospital	Quantitative Descriptive Discrete choice	78 ♀ nulliparous	Discrete choice questionnaire During pregnancy 2004
	E4. An ideal birth environment provides women with the opportunity to control pain (0.32). E7. Women wanted a birthplace that is natural with a peaceful, unhurried atmosphere, and no outside influences where they could relax (0.32). E9. Women wanted their birthplace to be cozy, comfortable, trustworthy, relaxed, calm quiet, warm, secure and have dimmable lights, soothing colors, and accessory equip (0.26). E11. Women wanted to have medical help available during labor and delivery. Some women chose to deliver in hospital because of the ready availability of medical help. Women who deliver at home make transportation plans in the event complications occur (0.21). E61. Women with less money who live farther from hospital prefer hospital delivery (.05).					
13	Rijinders et al (2008) Netherlands	Compare women's long term perception of childbirth	Home vs. hospital	Quantitative survey	1310 ♀ home/ hospital	Postal questionnaire 3 yrs after birth 2004
	E4. An ideal birth environment provides women with the opportunity to control pain (0.32).					

E13. Women who labored and delivered at home (out of hospital) were more likely to wanted to deliver their next baby in the same place compared to women who delivered in the birth center(hospital) (0.16).
14. Women who labored and delivered at home were more satisfied with their birth setting than women who labored and delivered at a birth center (hospital) (0.16).

14	Rudman et al (2007) Sweden	Investigate women's satisfaction with intrapartum care (including birth environment)	Birth envir within hospital	Quantitative Longitudinal survey	2605 ♀ hospital	3 questionnaires Early pregnancy, 2 mos & 1 yr after birth 1999-2000

E21. Satisfaction with intrapartum care in Sweden is negatively affected by dissatisfaction with hospital birth environment (0.11).
E41. 9% of women who delivered in hospital in Sweden were very satisfied with birth environment (.05).

15	Sjoblom et al (2006) Sweden	Describe women's home birth experiences	Home vs. hospital	Qualitative descriptive	12 ♀ home	Interview w/in 10 yrs data collection yr not given

E1. Women wanted to deliver in a familiar birthplace where they could exert control over their environment. (.42)
E2. Women considered aspects of safety when they chose their birthplace. (.37)
E5. Women who labored and delivered at home perceived the care they received by their midwife to be confident, competent, supportive, intensive, personalized and satisfying (0.32).
E7. Women wanted a birthplace that is natural with a peaceful, unhurried atmosphere, and no outside influences where they could relax (0.32).
E12. Women wanted a birthplace that accommodates their support persons and permits an intense family experience (0.21).
E17. Women do not like having to travel and change environments during labor. They wish to avoid having to make decision about the right time to go to hospital, and travel home after delivery (0.16).
E27. Women wanted to deliver in a birthplace where the caregiver provides information about labor progress (0.11).

16	Van der Hulst et al (2004) Netherlands	Ascertain impact of intended birthplace on course of labor/delivery	Home vs. hospital	Quantitative descriptive Survey	608 ♀ 70% intended home 30% intended hospital	Questionnaire during pregnancy & medical records for outcomes analysis according to intent

E3. Women wanted to deliver in a birthplace where they could avoid unnecessary or routine interventions use of technology. (.37)
E22. Women who labored and delivered at home described their birth place to be more safe, intimate, comfortable and trust-worthy than women who delivered in a birth center(hospital) (0.11).
E36. Women who were accepting of technology tend to chose hospital birth (.05).
E37. Nulliparous women who planned hospital births were more likely to experience episiotomy, consultation, referral to secondary care, obstetrical interventions of labor induction, labor augmentation, pain relief, assisted delivery and cesarean section. They were less likely to experience midwife interventions of sweeping membranes and amniotomy (.05).
E38. Multiparous women who planned hospital births were more likely to experience episiotomy, labor augmentation but less likely to have their labors induced (.05).
E39. Multiparous women who planned hospital births were significantly more likely to experience consultation, referral to secondary care, obstetrical interventions, pain relief, assisted delivery and cesarean section (.05).

17	Viisainen (2000) Finland	Describe parent's perceptions of risks associated with home birth	Home vs. hospital	Qualitative descriptive	21 ♀ & 12 partners who planned home birth	Interview 2 wks to 3 yrs after birth 1995-1996

E2. Women considered aspects of safety when they chose their birthplace. (.37)
E3. Women wanted to deliver in a birthplace where they could avoid unnecessary or routine interventions use of

technology. (.37)
E6. Women wanted a birthplace where they could be involved in decision-making about their labor and birth (0.32).
E7. Women wanted a birthplace that is natural with a peaceful, unhurried atmosphere, and no outside influences where they could relax (0.32).
E16. Women wanted their birthplace to be privacy and intimate (0.16).
E24. Women who delivered in hospital stated that lack of control (in hospital) prevented them from feeling secure in hospital (0.11).
E30. Women who plan to deliver at home felt stigmatized by medical profession (0.11).
E40. Women state that the hospital staff takes over birth process and do not acknowledge women's knowledge (.05).
E43. Women perceive that hospitals take away their responsibility, identity and choice (.05).
E44. Women recognize that not all hospitals were equipped to handle all emergency situations, therefore some hospitals were no safer than home for birth (.05).
E45. Women who plan to deliver at home use prenatal medical screening technology for reassurance of safety (.05).
E46. Women who plan to deliver at home redefine possible risks within their personal contexts (performed own research to counter info given by medical professionals) in ways that minimize the meaning of risk. The result is an increase in the risk threshold allowing them to remain at home (.05).
E47. Women who plan home births assume responsibility for outcomes of birth, regardless of where they occur, as it is they who must deal with long and short term consequences of the harm (.05).
E54. Women wanted to avoid birthplaces that focus on technology (.05).
E55. Some women avoid hospitals for delivery because they believe errors /hazards could be covered up by institution (.05).
E57. Women who plan home delivery do not trust medical professionals to be honest about risk status (.05).
E62. Distance from home to hospital a safety factor taken into consideration by women planning home birth (.05).

18	Viisainen (2001) Finland	Describe women's reasons for planning home birth	Home vs. hospital	Qualitative descriptive	21 ♀ & 12 partners who planned home birth	Interview 2 wks to 3 yrs after birth 1995-1996

E3. Women wanted to deliver in a birthplace where they could avoid unnecessary or routine interventions use of technology. (.37)
E6. Women wanted a birthplace where they could be involved in decision-making about their labor and birth (0.32).
E7. Women wanted a birthplace that is natural with a peaceful, unhurried atmosphere, and no outside influences where they could relax (0.32).
E8. Women wish to avoid hospitals for birth because of the poor behavior by hospital staff that they describe as rude, hostile strangers who speak as if woman not present, and were impersonal and not caring (0.32).
E10. Women who gave birth in hospital stated they did not receive necessary support and presence from their midwife; they felt alone, with nobody present who could help them (0.21).
E11. Women wanted to have medical help available during labor and delivery. Some women chose to deliver in hospital because of the ready availability of medical help. Women who deliver at home make transportation plans in the event complications occur (0.21).
E16. Women wanted their birthplace to be privacy and intimate (0.16).
E25. Women who deliver at home wanted a hospital nearby and available if necessary (0.11).
E29. Women wanted to avoid strange bacteria present in hospitals (0.11).
E54. Women wanted to avoid birthplaces that focus on technology (.05).
E57. Women who plan home delivery do not trust medical professionals to be honest about risk status (.05).

19	Waldenstrom et al (2006) Sweden	Investigate women's satisfaction with intrapartum care	Factors of hospital	Quantitative descriptive longitudinal Survey	2686 ♀ hospital	Questionnaire Early pregnancy & 2 mos post partum

E6. Women wanted a birthplace where they could be involved in decision-making about their labor and birth (0.32).
E21. Satisfaction with intrapartum care in Sweden is negatively affected by dissatisfaction with hospital birth environment (0.11).
E42. Size of hospital in Sweden does not affect satisfaction with intrapartum care (.05).

20	Wiklund et al (2002) Sweden	Compare women's perceptions of care and labor outcomes following delivery in intended hospital vs. referral hospital (due to over crowding)	Intended place vs. actual place	Mixed methods Descriptive Cross section	266 ♀ ½ delivered in intended hospital ½ in referral hospital	Questionnaire 1 mos post partum

E1. Women wanted to deliver in a familiar birthplace where they could exert control over their environment. (.42)
E3. Women wanted to deliver in a birthplace where they could avoid unnecessary or routine interventions use of technology. (.37)
E6. Women wanted a birthplace where they could be involved in decision-making about their labor and birth (0.32).
E8. Women wish to avoid hospitals for birth because of the poor behavior by hospital staff that they describe as rude, hostile strangers who speak as if woman not present, and were impersonal and not caring (0.32).
E10. Women who gave birth in hospital stated they did not receive necessary support and presence from their midwife; they felt alone, with nobody present who could help them (0.21).
E19. Women who labor/deliver in familiar surroundings (home, known birth center) report less pain and/or receive less pain medicine (epidural) or were more likely to use alternative pain relieving methods than women who were in unfamiliar birth places (hospitals, referred to unfamiliar birth center/hospital) (0.11).
E35. Women who were referred to unfamiliar birth place reported greater importance of knowing where birth would take place than women who were not referred (0.05).

Table 3.2. Sub-Saharan Africa Study Details

	Citation Country	Purpose	Place	Design method	Sample	Data collection, time period, year collected
21	Adamu & Salihu (2002) Nigeria	Identify sociocultural and economic factors that act as barriers to women's use of antenatal care services and hospital delivery	Home vs. facility	Quantitative descriptive	107 ♀	Questionnaire Pregnancy 2000
	1. Women in Africa do not need to plan or prepare for delivery at home. Women in Africa who deliver at health facilities have to make elaborate preparations including the purchase of supplies, saving money for delivery expenses, transportation arrangements and childcare (.88). 2. Women in Africa avoid hospitals (.81). 3. Women in Africa must make preparations to deliver at hospital (.69). 4. Women in Africa prefer to deliver at home (.69). 5. Women in Africa were prevented from using health facilities for labor and delivery because of the costs of care (.69). 6. Women in Africa avoid hospital and clinics for childbirth because of the costs of one or more of the following: facility fees, professional fees, supplies, new clothes for the infant, food opportunity costs, and transportation (.56). 7. Women in Africa prefer to labor and deliver at home or at a traditional birth home because the pregnancy is normal (without complications), and delivering at home is the norm (typical, accepted) (.56). 8. Women in Africa who labor and deliver at home, or in traditional birth homes, typically experience one or more of the following: fast, easy labor, less painful labor, affectionate, confident, and skilled care by traditional birth attendants and relatives, choice of delivery position, husband or mother-in-law determines if and when to go to facility (.56). 10. Husbands, mothers-in-law, and other relatives were the decision makers about place of delivery (.50). 12. Women in Africa avoid hospitals and clinics for childbirth because of the high rate of interventions (.44). 12. Women in Africa avoid hospitals and clinics for childbirth because of poor quality of care or lack of confidence in the staff (.44). 14. Women in Africa prefer to labor and deliver at home or at a traditional birth home because of the high quality of care they receive from relatives and TBAs, and confidence in the TBA (.44). 16. Women in Africa were prevented from using health facilities for labor and delivery because their husbands or mothers-in-law forbid it (.44). 19. Women in Africa avoid hospitals and clinics for childbirth because there is no privacy (.31). 20. Women in Africa prefer to labor and deliver at home or at a traditional birth home because it is more affordable (.31). 21. Female relatives provide support to women laboring at home in Africa (.31). 22. Women in Africa prefer to labor and deliver in a health facility when there is a known complication (.25). 23. Women in Africa avoid hospitals and clinics for childbirth because of the high rate of routine interventions including one or more of the following: vaginal examination, episiotomies, repair of vaginal tears, requirement to bathe and wear hospital gown (.25). 24. Women in Africa prefer to labor and deliver at home or at a traditional birth home because they were closer and more convenient (.25). 25. Women in Africa prefer to labor and deliver at home or at a traditional birth home because they can choose their delivery position (.25). 26. Women in Africa were prevented from using health facilities for childbirth because they delivered too quickly (.25). 29. Women in Africa avoid hospital and clinics for childbirth because they were forced to lie in lithotomy position for delivery (.19). 37. Women in Africa avoid hospitals and clinics for childbirth because of the presence of male staff (.13). 39. Women in Africa avoid hospitals and clinics for childbirth because they believe in predestination or God's will (.13). 46. Women in Africa prefer to labor and deliver at home because their husbands prefer it (.06).					
22	Amooti-Kaguna & Nuwaha (2000) Uganda	Describe factors influencing choice of birthplace	Anti-home birth	Quantitative descriptive	243 ♀ 32 ♂	Interview using questionnaire (delivery w/in 1 yr) Focus group (♀&♂)

							1998

1. Women in Africa do not need to plan or prepare for delivery at home. Women in Africa who deliver at health facilities have to make elaborate preparations including the purchase of supplies, saving money for delivery expenses, transportation arrangements and childcare (.88).
2. Women in Africa avoid hospitals (.81).
3. Women in Africa must make preparations to deliver at hospital (.69).
4. Women in Africa prefer to deliver at home (.69).
5. Women in Africa were prevented from using health facilities for labor and delivery because of the costs of care (.69).
6. Women in Africa avoid hospital and clinics for childbirth because of the costs of one or more of the following: facility fees, professional fees, supplies, new clothes for the infant, food opportunity costs, and transportation (.56).
7. Women in Africa prefer to labor and deliver at home or at a traditional birth home because the pregnancy is normal (without complications), and delivering at home is the norm (typical, accepted) (.56).
8. Women in Africa who labor and deliver at home, or in traditional birth homes, typically experience one or more of the following: fast, easy labor, less painful labor, affectionate, confident, and skilled care by traditional birth attendants and relatives, choice of delivery position, husband or mother-in-law determines if and when to go to facility (.56).
9. Women in Africa avoid hospitals and clinics for childbirth because of the poor attitude displayed by health professionals (rude behavior of nurses/midwives) (.50).
10. Husbands, mothers-in-law, and other relatives were the decision makers about place of delivery (.50).
13. Women in Africa avoid hospitals and clinics for childbirth because of poor quality of care or lack of confidence in the staff (.44).
14. Women in Africa prefer to labor and deliver at home or at a traditional birth home because of the high quality of care they receive from relatives and TBAs, and confidence in the TBA (.44).
15. Women in Africa were prevented from using health facilities for labor and delivery because there is no transportation available (.44).
17. Women in Africa were prevented from using health facilities for childbirth because of the distance (.38).
20. Women in Africa prefer to labor and deliver at home or at a traditional birth home because it is more affordable (.31).
24. Women in Africa prefer to labor and deliver at home or at a traditional birth home because they were closer and more convenient (.25).
26. Women in Africa were prevented from using health facilities for childbirth because they delivered too quickly (.25).
27. Women in Africa prefer to deliver where they, or their family, delivered in the past (habit) (.25).
28. Women in Africa do not perceive risks associated with labor and birth when their pregnancies were labeled normal (without complication), and were therefore confident laboring and delivering at home (.25).
35. Women in Africa prefer to labor and deliver in a health facility because they perceive it is safer (.19).
36. Midwives were rude in health centers/affectionate in home or private maternity home (.19).

23	Bazzano et al (2008) Ghana	Examine social costs to women who receive skilled care at birth	Home vs. health center:	Ethnographic	87 ♀ ~ 91 focus grp particip 32 providers	Participant obs, interview, focus group Recent birth to distant birth 2003-2004

1. Women in Africa do not need to plan or prepare for delivery at home. Women in Africa who deliver at health facilities have to make elaborate preparations including the purchase of supplies, saving money for delivery expenses, transportation arrangements and childcare (.88).
2. Women in Africa avoid hospitals (.81).
3. Women in Africa must make preparations to deliver at hospital (.69).
4. Women in Africa prefer to deliver at home (.69).
5. Women in Africa were prevented from using health facilities for labor and delivery because of the costs of care (.69).
6. Women in Africa avoid hospital and clinics for childbirth because of the costs of one or more of the following: facility fees, professional fees, supplies, new clothes for the infant, food opportunity costs, and transportation (.56).
7. Women in Africa prefer to labor and deliver at home or at a traditional birth home because the pregnancy is normal (without complications), and delivering at home is the norm (typical, accepted) (.56).
8. Women in Africa who labor and deliver at home, or in traditional birth homes, typically experience one or more of the following: fast, easy labor, less painful labor, affectionate, confident, and skilled care by traditional birth attendants and relatives, choice of delivery position, husband or mother-in-law determines if and when to go to

facility (.56).
9. Women in Africa avoid hospitals and clinics for childbirth because of the poor attitude displayed by health professionals (rude behavior of nurses/midwives) (.50).
10. Husbands, mothers-in-law, and other relatives were the decision makers about place of delivery (.50).
11. Women in Africa perceive risks associated with childbirth in health facilities including one or more of the following: episiotomy, gossip, stigma, loss of status, loss of privacy, loss of secrecy, poor care, criticism, scolding, painful vaginal exams, care by male provider, witchcraft, medical operation, intervention, financial hardship (.44).
12. Women in Africa avoid hospitals and clinics for childbirth because of the high rate of interventions (.44).
13. Women in Africa avoid hospitals and clinics for childbirth because of poor quality of care or lack of confidence in the staff (.44).
16. Women in Africa were prevented from using health facilities for labor and delivery because their husbands or mothers-in-law forbid it (.44).
18. Women in Africa avoid hospital and clinics for childbirth because they were afraid of medical operations (.31).
20. Women in Africa prefer to labor and deliver at home or at a traditional birth home because it is more affordable (.31).
30. Women in Africa avoid hospitals and clinics for childbirth because they believe they were easier targets of witchcraft there (.19).
31. Women in Africa prefer to labor and deliver at home or at a traditional birth home because of the ability to keep labor a secret (.19).
34. Women in Africa were prevented from using facilities for childbirth because they have not collected supplies required by the facility for themselves or their babies (.19).
38. Women in Africa avoid hospitals and clinics for childbirth because of the stigma associated with hospital deliveries (.13).
42. Women in Africa prefer to labor and deliver at home because it increases their status (.13).
43. Prolonged labor is one reason women seek assistance at a health facility for childbirth in Africa. Dishonesty about paternity of the baby is a common explanation for prolonged labor in Africa (.13).
44. User fees charged at health facilities (which increase for complicated labor/delivery) amplify risk taking when complications arise at home; because families must weigh costs vs. likelihood of survival (.13).
45. Women in Africa prefer to labor and deliver at home or at a traditional birth home because they fear being turned away from health facilities (.06).
48. Women in Africa were prevented from using health facilities for childbirth if they do not have admittance cared obtained during prenatal care (.06).

24	Ekele et al (2007) Nigeria	Describe reasons why women do not deliver at hospital where they received prenatal care	Home vs. hospital	Quantitative descriptive Longitudinal	740 ♀ hospital 340 ♀ elsewhere	2-questionaires Pregnancy At delivery 2004

1. Women in Africa do not need to plan or prepare for delivery at home. Women in Africa who deliver at health facilities have to make elaborate preparations including the purchase of supplies, saving money for delivery expenses, transportation arrangements and childcare (.88).
2. Women in Africa avoid hospitals (.81).
3. Women in Africa must make preparations to deliver at hospital (.69).
5. Women in Africa were prevented from using health facilities for labor and delivery because of the costs of care (.69).
6. Women in Africa avoid hospital and clinics for childbirth because of the costs of one or more of the following: facility fees, professional fees, supplies, new clothes for the infant, food opportunity costs, and transportation (.56).
9. Women in Africa avoid hospitals and clinics for childbirth because of the poor attitude displayed by health professionals (rude behavior of nurses/midwives) (.50).
10. Husbands, mothers-in-law, and other relatives were the decision makers about place of delivery (.50).
15. Women in Africa were prevented from using health facilities for labor and delivery because there is no transportation available (.44).
16. Women in Africa were prevented from using health facilities for labor and delivery because their husbands or mothers-in-law forbid it (.44).
19. Women in Africa avoid hospitals and clinics for childbirth because there is no privacy (.31).
26. Women in Africa were prevented from using health facilities for childbirth because they delivered too quickly (.25).

25	Izugbara & Ukwayi (2004)	Describe essential services provided by traditional birth homes & reasons why women use	Home vs. hospital	Qualitative descriptive Cross section	149 ♀ 13 TBA	Interview (semi-struct) Time from

	Nigeria	them				birth not given 2001

1. Women in Africa do not need to plan or prepare for delivery at home. Women in Africa who deliver at health facilities have to make elaborate preparations including the purchase of supplies, saving money for delivery expenses, transportation arrangements and childcare (.88).
2. Women in Africa avoid hospitals (.81).
4. Women in Africa prefer to deliver at home (.69).
7. Women in Africa prefer to labor and deliver at home or at a traditional birth home because the pregnancy is normal (without complications), and delivering at home is the norm (typical, accepted) (.56).
12. Women in Africa avoid hospitals and clinics for childbirth because of the high rate of interventions (.44).
14. Women in Africa prefer to labor and deliver at home or at a traditional birth home because of the high quality of care they receive from relatives and TBAs, and confidence in the TBA (.44).
19. Women in Africa avoid hospitals and clinics for childbirth because there is no privacy (.31).
20. Women in Africa prefer to labor and deliver at home or at a traditional birth home because it is more affordable (.31).
23. Women in Africa avoid hospitals and clinics for childbirth because of the high rate of routine interventions including one or more of the following: vaginal examination, episiotomies, repair of vaginal tears, requirement to bathe and wear hospital gown (.25).
24. Women in Africa prefer to labor and deliver at home or at a traditional birth home because they were closer and more convenient (.25).
28. Women in Africa do not perceive risks associated with labor and birth when their pregnancies were labeled normal (without complication), and were therefore confident laboring and delivering at home (.25).
31. Women in Africa prefer to labor and deliver at home or at a traditional birth home because of the ability to keep labor a secret (.19).
47. Women in Africa prefer to labor and deliver at home because it is safer (.06).

26	Jansen (2006) Ghana	Describe why women do not deliver in modern hospitals	Out of hospital vs. hospital	Ethnographic	5 untrained TBA	Participant observation Interview 2000

1. Women in Africa do not need to plan or prepare for delivery at home. Women in Africa who deliver at health facilities have to make elaborate preparations including the purchase of supplies, saving money for delivery expenses, transportation arrangements and childcare (.88).
2. Women in Africa avoid hospitals (.81).
4. Women in Africa prefer to deliver at home (.69).
5. Women in Africa were prevented from using health facilities for labor and delivery because of the costs of care (.69).
7. Women in Africa prefer to labor and deliver at home or at a traditional birth home because the pregnancy is normal (without complications), and delivering at home is the norm (typical, accepted) (.56).
8. Women in Africa who labor and deliver at home, or in traditional birth homes, typically experience one or more of the following: fast, easy labor, less painful labor, affectionate, confident, and skilled care by traditional birth attendants and relatives, choice of delivery position, husband or mother-in-law determines if and when to go to facility (.56).
9. Women in Africa avoid hospitals and clinics for childbirth because of the poor attitude displayed by health professionals (rude behavior of nurses/midwives) (.50).
11. Women in Africa perceive risks associated with childbirth in health facilities including one or more of the following: episiotomy, gossip, stigma, loss of status, loss of privacy, loss of secrecy, poor care, criticism, scolding, painful vaginal exams, care by male provider, witchcraft, medical operation, intervention, financial hardship (.44).
14. Women in Africa prefer to labor and deliver at home or at a traditional birth home because of the high quality of care they receive from relatives and TBAs, and confidence in the TBA (.44).
15. Women in Africa were prevented from using health facilities for labor and delivery because there is no transportation available (.44).
21. Female relatives provide support to women laboring at home in Africa (.31).
22. Women in Africa prefer to labor and deliver in a health facility when there is a known complication (.25).
28. Women in Africa do not perceive risks associated with labor and birth when their pregnancies were labeled normal (without complication), and were therefore confident laboring and delivering at home (.25).
33. Women in Africa were prevented from using health facilities for childbirth because there were no facilities available, or the facilities were not staffed when they need them (.19).
41. Women in Africa prefer to labor and deliver at home or at a traditional birth home because they can care for the placenta (.13).
42. Women in Africa prefer to labor and deliver at home because it increases their status (.13).

27	Magnoma et al (2010) Tanzania	Describe factors influencing women's decisions on where to deliver	Home vs. hospital	Ethnographic	78 ♀ 18 providers 36 TBA 40 ♂	Focus group-15 groups Key informant interviews (12 ♀) Participant observation 2001-2008

1. Women in Africa do not need to plan or prepare for delivery at home. Women in Africa who deliver at health facilities have to make elaborate preparations including the purchase of supplies, saving money for delivery expenses, transportation arrangements and childcare (.88).
2. Women in Africa avoid hospitals (.81).
3. Women in Africa must make preparations to deliver at hospital (.69).
4. Women in Africa prefer to deliver at home (.69).
6. Women in Africa avoid hospital and clinics for childbirth because of the costs of one or more of the following: facility fees, professional fees, supplies, new clothes for the infant, food opportunity costs, and transportation (.56).
7. Women in Africa prefer to labor and deliver at home or at a traditional birth home because the pregnancy is normal (without complications), and delivering at home is the norm (typical, accepted) (.56).
8. Women in Africa who labor and deliver at home, or in traditional birth homes, typically experience one or more of the following: fast, easy labor, less painful labor, affectionate, confident, and skilled care by traditional birth attendants and relatives, choice of delivery position, husband or mother-in-law determines if and when to go to facility (.56).
10. Husbands, mothers-in-law, and other relatives were the decision makers about place of delivery (.50).
11. Women in Africa perceive risks associated with childbirth in health facilities including one or more of the following: episiotomy, gossip, stigma, loss of status, loss of privacy, loss of secrecy, poor care, criticism, scolding, painful vaginal exams, care by male provider, witchcraft, medical operation, intervention, financial hardship (.44).
12. Women in Africa avoid hospitals and clinics for childbirth because of the high rate of interventions (.44).
14. Women in Africa prefer to labor and deliver at home or at a traditional birth home because of the high quality of care they receive from relatives and TBAs, and confidence in the TBA (.44).
15. Women in Africa were prevented from using health facilities for labor and delivery because there is no transportation available (.44).
16. Women in Africa were prevented from using health facilities for labor and delivery because their husbands or mothers-in-law forbid it (.44).
17. Women in Africa were prevented from using health facilities for childbirth because of the distance (.38).
18. Women in Africa avoid hospital and clinics for childbirth because they were afraid of medical operations (.31).
21. Female relatives provide support to women laboring at home in Africa (.31).
22. Women in Africa prefer to labor and deliver in a health facility when there is a known complication (.25).
23. Women in Africa avoid hospitals and clinics for childbirth because of the high rate of routine interventions including one or more of the following: vaginal examination, episiotomies, repair of vaginal tears, requirement to bathe and wear hospital gown (.25).
25. Women in Africa prefer to labor and deliver at home or at a traditional birth home because they can choose their delivery position (.25).
27. Women in Africa prefer to deliver where they, or their family, delivered in the past (habit) (.25).
28. Women in Africa do not perceive risks associated with labor and birth when their pregnancies were labeled normal (without complication), and were therefore confident laboring and delivering at home (.25).
29. Women in Africa avoid hospital and clinics for childbirth because they were forced to lie in lithotomy position for delivery (.19).

28	Mathole et al (2005) Zimbabwe	Role of TBA in care of women during childbirth	Difficult to transfer	Qualitative descriptive	48 TBA -FG 6 TBA-interview	Focus group interview <2005

1. Women in Africa do not need to plan or prepare for delivery at home. Women in Africa who deliver at health facilities have to make elaborate preparations including the purchase of supplies, saving money for delivery expenses, transportation arrangements and childcare (.88).
2. Women in Africa avoid hospitals (.81).
3. Women in Africa must make preparations to deliver at hospital (.69).
4. Women in Africa prefer to deliver at home (.69).
5. Women in Africa were prevented from using health facilities for labor and delivery because of the costs of care

(.69).
11. Women in Africa perceive risks associated with childbirth in health facilities including one or more of the following: episiotomy, gossip, stigma, loss of status, loss of privacy, loss of secrecy, poor care, criticism, scolding, painful vaginal exams, care by male provider, witchcraft, medical operation, intervention, financial hardship (.44).
12. Women in Africa avoid hospitals and clinics for childbirth because of the high rate of interventions (.44).
14. Women in Africa prefer to labor and deliver at home or at a traditional birth home because of the high quality of care they receive from relatives and TBAs, and confidence in the TBA (.44).
15. Women in Africa were prevented from using health facilities for labor and delivery because there is no transportation available (.44).
18. Women in Africa avoid hospital and clinics for childbirth because they were afraid of medical operations (.31).
32. Women in Africa were prevented from using health facilities for childbirth because of the onerous referral process when complications occur during labor at home or at a peripheral health unit (.19).

29	Mrisho et al (2007) Tanzania	Describe gender roles and relations within home, influence on help-seeking behavior for delivery	Home vs. facility	Mixed methods	32 ♀ - interview ~112 ♀ - FG 9152 ♀- survey	Interview (recent pp) Focus group (pregnant or pp) Participant observation Survey (<3 yrs pp) 2004-2005

1. Women in Africa do not need to plan or prepare for delivery at home. Women in Africa who deliver at health facilities have to make elaborate preparations including the purchase of supplies, saving money for delivery expenses, transportation arrangements and childcare (.88).
2. Women in Africa avoid hospitals (.81).
3. Women in Africa must make preparations to deliver at hospital (.69).
4. Women in Africa prefer to deliver at home (.69).
5. Women in Africa were prevented from using health facilities for labor and delivery because of the costs of care (.69).
6. Women in Africa avoid hospital and clinics for childbirth because of the costs of one or more of the following: facility fees, professional fees, supplies, new clothes for the infant, food opportunity costs, and transportation (.56).
7. Women in Africa prefer to labor and deliver at home or at a traditional birth home because the pregnancy is normal (without complications), and delivering at home is the norm (typical, accepted) (.56).
8. Women in Africa who labor and deliver at home, or in traditional birth homes, typically experience one or more of the following: fast, easy labor, less painful labor, affectionate, confident, and skilled care by traditional birth attendants and relatives, choice of delivery position, husband or mother-in-law determines if and when to go to facility (.56).
9. Women in Africa avoid hospitals and clinics for childbirth because of the poor attitude displayed by health professionals (rude behavior of nurses/midwives) (.50).
10. Husbands, mothers-in-law, and other relatives were the decision makers about place of delivery (.50).
13. Women in Africa avoid hospitals and clinics for childbirth because of poor quality of care or lack of confidence in the staff (.44).
15. Women in Africa were prevented from using health facilities for labor and delivery because there is no transportation available (.44).
17. Women in Africa were prevented from using health facilities for childbirth because of the distance (.38).
19. Women in Africa avoid hospitals and clinics for childbirth because there is no privacy (.31).
26. Women in Africa were prevented from using health facilities for childbirth because they delivered too quickly (.25).
31. Women in Africa prefer to labor and deliver at home or at a traditional birth home because of the ability to keep labor a secret (.19).
34. Women in Africa were prevented from using facilities for childbirth because they have not collected supplies required by the facility for themselves or their babies (.19).
37. Women in Africa avoid hospitals and clinics for childbirth because of the presence of male staff (.13).
43. Prolonged labor is one reason women seek assistance at a health facility for childbirth in Africa. Dishonesty about paternity of the baby is a common explanation for prolonged labor in Africa (.13).

30	Osubor et al (2006) Nigeria	Describe health seeking behavior of women for delivery	Clinic vs. other place	Mixed methods Survey Focus group	225 ♀ - survey 4 FGs of	Survey Focus groups Timing not

					♀ 1 FGs of TBA 1FG of medical	given 1999

1. Women in Africa do not need to plan or prepare for delivery at home. Women in Africa who deliver at health facilities have to make elaborate preparations including the purchase of supplies, saving money for delivery expenses, transportation arrangements and childcare (.88).
2. Women in Africa avoid hospitals (.81).
3. Women in Africa must make preparations to deliver at hospital (.69).
4. Women in Africa prefer to deliver at home (.69).
5. Women in Africa were prevented from using health facilities for labor and delivery because of the costs of care (.69).
6. Women in Africa avoid hospital and clinics for childbirth because of the costs of one or more of the following: facility fees, professional fees, supplies, new clothes for the infant, food opportunity costs, and transportation (.56).
7. Women in Africa prefer to labor and deliver at home or at a traditional birth home because the pregnancy is normal (without complications), and delivering at home is the norm (typical, accepted) (.56).
8. Women in Africa who labor and deliver at home, or in traditional birth homes, typically experience one or more of the following: fast, easy labor, less painful labor, affectionate, confident, and skilled care by traditional birth attendants and relatives, choice of delivery position, husband or mother-in-law determines if and when to go to facility (.56).
11. Women in Africa perceive risks associated with childbirth in health facilities including one or more of the following: episiotomy, gossip, stigma, loss of status, loss of privacy, loss of secrecy, poor care, criticism, scolding, painful vaginal exams, care by male provider, witchcraft, medical operation, intervention, financial hardship (.44).
12. Women in Africa avoid hospitals and clinics for childbirth because of the high rate of interventions (.44).
13. Women in Africa avoid hospitals and clinics for childbirth because of poor quality of care or lack of confidence in the staff (.44).
14. Women in Africa prefer to labor and deliver at home or at a traditional birth home because of the high quality of care they receive from relatives and TBAs, and confidence in the TBA (.44).
18. Women in Africa avoid hospital and clinics for childbirth because they were afraid of medical operations (.31).
24. Women in Africa prefer to labor and deliver at home or at a traditional birth home because they were closer and more convenient (.25).
25. Women in Africa prefer to labor and deliver at home or at a traditional birth home because they can choose their delivery position (.25).
30. Women in Africa avoid hospitals and clinics for childbirth because they believe they were easier targets of witchcraft there (.19).
33. Women in Africa were prevented from using health facilities for childbirth because there were no facilities available, or the facilities were not staffed when they need them (.19).
36. Midwives were rude in health centers/affectionate in home or private maternity home (.19).

31	Pettersson et al (2004) Angola	Describe factors influencing women's decision about birthplace	Home vs. hospital	Qualitative descriptive	48 ♀	Focus groups Timing not given 2002

1. Women in Africa do not need to plan or prepare for delivery at home. Women in Africa who deliver at health facilities have to make elaborate preparations including the purchase of supplies, saving money for delivery expenses, transportation arrangements and childcare (.88).
2. Women in Africa avoid hospitals (.81).
3. Women in Africa must make preparations to deliver at hospital (.69).
4. Women in Africa prefer to deliver at home (.69).
5. Women in Africa were prevented from using health facilities for labor and delivery because of the costs of care (.69).
6. Women in Africa avoid hospital and clinics for childbirth because of the costs of one or more of the following: facility fees, professional fees, supplies, new clothes for the infant, food opportunity costs, and transportation (.56).
7. Women in Africa prefer to labor and deliver at home or at a traditional birth home because the pregnancy is normal (without complications), and delivering at home is the norm (typical, accepted) (.56).
8. Women in Africa who labor and deliver at home, or in traditional birth homes, typically experience one or more of the following: fast, easy labor, less painful labor, affectionate, confident, and skilled care by traditional birth attendants and relatives, choice of delivery position, husband or mother-in-law determines if and when to go to facility (.56).
9. Women in Africa avoid hospitals and clinics for childbirth because of the poor attitude displayed by health professionals (rude behavior of nurses/midwives) (.50).

11. Women in Africa perceive risks associated with childbirth in health facilities including one or more of the following: episiotomy, gossip, stigma, loss of status, loss of privacy, loss of secrecy, poor care, criticism, scolding, painful vaginal exams, care by male provider, witchcraft, medical operation, intervention, financial hardship (.44).
10. Husbands, mothers-in-law, and other relatives were the decision makers about place of delivery (.50).
12. Women in Africa avoid hospitals and clinics for childbirth because of the high rate of interventions (.44).
13. Women in Africa avoid hospitals and clinics for childbirth because of poor quality of care or lack of confidence in the staff (.44).
16. Women in Africa were prevented from using health facilities for labor and delivery because their husbands or mothers-in-law forbid it (.44).
18. Women in Africa avoid hospital and clinics for childbirth because they were afraid of medical operations (.31).
21. Female relatives provide support to women laboring at home in Africa (.31).
22. Women in Africa prefer to labor and deliver in a health facility when there is a known complication (.25).
23. Women in Africa avoid hospitals and clinics for childbirth because of the high rate of routine interventions including one or more of the following: vaginal examination, episiotomies, repair of vaginal tears, requirement to bathe and wear hospital gown (.25).
25. Women in Africa prefer to labor and deliver at home or at a traditional birth home because they can choose their delivery position (.25).
29. Women in Africa avoid hospital and clinics for childbirth because they were forced to lie in lithotomy position for delivery (.19).
32. Women in Africa were prevented from using health facilities for childbirth because of the onerous referral process when complications occur during labor at home or at a peripheral health unit (.19).
34. Women in Africa were prevented from using facilities for childbirth because they have not collected supplies required by the facility for themselves or their babies (.19).
35. Women in Africa prefer to labor and deliver in a health facility because they perceive it is safer (.19).
36. Midwives were rude in health centers/affectionate in home or private maternity home (.19).
39. Women in Africa avoid hospitals and clinics for childbirth because they believe in predestination or God's will (.13).
40. Women in Africa avoid hospitals and clinics for childbirth because they face discrimination based upon poverty or ethnicity (.13).
41. Women in Africa prefer to labor and deliver at home or at a traditional birth home because they can care for the placenta (.13).
44. User fees charged at health facilities (which increase for complicated labor/delivery) amplify risk taking when complications arise at home; because families must weigh costs vs. likelihood of survival (.13).

32	Spangler & Bloom (2010) Tanzania	Examine women's use of biomedical obstetric care	Home vs. hospital	Mixed methods	1150 ♀ -	Census Interview (42-60 days pp) In-depth interview (6 mos pp) 2007-2008

1. Women in Africa do not need to plan or prepare for delivery at home. Women in Africa who deliver at health facilities have to make elaborate preparations including the purchase of supplies, saving money for delivery expenses, transportation arrangements and childcare (.88).
2. Women in Africa avoid hospitals (.81).
3. Women in Africa must make preparations to deliver at hospital (.69).
4. Women in Africa prefer to deliver at home (.69).
5. Women in Africa were prevented from using health facilities for labor and delivery because of the costs of care (.69).
6. Women in Africa avoid hospital and clinics for childbirth because of the costs of one or more of the following: facility fees, professional fees, supplies, new clothes for the infant, food opportunity costs, and transportation (.56).
9. Women in Africa avoid hospitals and clinics for childbirth because of the poor attitude displayed by health professionals (rude behavior of nurses/midwives) (.50).
10. Husbands, mothers-in-law, and other relatives were the decision makers about place of delivery (.50).
11. Women in Africa perceive risks associated with childbirth in health facilities including one or more of the following: episiotomy, gossip, stigma, loss of status, loss of privacy, loss of secrecy, poor care, criticism, scolding, painful vaginal exams, care by male provider, witchcraft, medical operation, intervention, financial hardship (.44).
16. Women in Africa were prevented from using health facilities for labor and delivery because their husbands or mothers-in-law forbid it (.44).
16. Women in Africa were prevented from using health facilities for childbirth because of the distance (.38).
19. Women in Africa avoid hospitals and clinics for childbirth because there is no privacy (.31).
20. Women in Africa prefer to labor and deliver at home or at a traditional birth home because it is more affordable

(.31).
21. Female relatives provide support to women laboring at home in Africa (.31).
22. Women in Africa prefer to labor and deliver in a health facility when there is a known complication (.25).
30. Women in Africa avoid hospitals and clinics for childbirth because they believe they were easier targets of witchcraft there (.19).
33. Women in Africa were prevented from using health facilities for childbirth because there were no facilities available, or the facilities were not staffed when they need them (.19).
35. Women in Africa prefer to labor and deliver in a health facility because they perceive it is safer (.19).
38. Women in Africa avoid hospitals and clinics for childbirth because of the stigma associated with hospital deliveries (.13).
40. Women in Africa avoid hospitals and clinics for childbirth because they face discrimination based upon poverty or ethnicity (.13).
49. Women in Africa prefer to labor and deliver in a health facility because they want to appear modern (.06).

33	Stephenson et al (2006) Burkina Faso Ghana Ivory Coast Kenya Malawi Tanzania	Examine factors involved in decision making about birthplace	Home vs. hospital	Quantitative descriptive survey	17,169 ♀	Questionnaire Within 3 yrs pp 1998-2000

27. Women in Africa prefer to deliver where they, or their family, delivered in the past (habit) (.25).

34	Van den Boogaard et al (2008) Zambia	Describe factors used to decide between skilled and traditional birth attendants	Home vs. hospital	Quantitative descriptive	444 ♀ 429 ♂ - husbands 378 elderly ♀ 162 head-♂	Structured interviews Birth w/in 5 yrs for 444 ♀ < 2008

1. Women in Africa do not need to plan or prepare for delivery at home. Women in Africa who deliver at health facilities have to make elaborate preparations including the purchase of supplies, saving money for delivery expenses, transportation arrangements and childcare (.88).
17. Women in Africa were prevented from using health facilities for childbirth because of the distance (.38).
27. Women in Africa prefer to deliver where they, or their family, delivered in the past (habit) (.25).

35	Weeks et al (2005) Uganda	Socio-economic determinants of maternal mortality	Difficult getting emergent care	Qualitative observational	30 ♀ "near miss"	Semi-structured interview Immediate pp <2005

1. Women in Africa do not need to plan or prepare for delivery at home. Women in Africa who deliver at health facilities have to make elaborate preparations including the purchase of supplies, saving money for delivery expenses, transportation arrangements and childcare (.88).
2. Women in Africa avoid hospitals (.81).
3. Women in Africa must make preparations to deliver at hospital (.69).
5. Women in Africa were prevented from using health facilities for labor and delivery because of the costs of care (.69).
9. Women in Africa avoid hospitals and clinics for childbirth because of the poor attitude displayed by health professionals (rude behavior of nurses/midwives) (.50).
13. Women in Africa avoid hospitals and clinics for childbirth because of poor quality of care or lack of confidence in the staff (.44).
15. Women in Africa were prevented from using health facilities for labor and delivery because there is no transportation available (.44).
32. Women in Africa were prevented from using health facilities for childbirth because of the onerous referral process when complications occur during labor at home or at a peripheral health unit (.19).

36	Winani et al (2007) Tanzania	Determine effectiveness of clean delivery kit in different birthplaces	Home vs. hospital	Cross sectional Intervention	3262 ♀ and attendants	Questionnaire During delivery and

		postpartum 2000+
50. If clean delivery kits were used, women bathe before delivery, and attendants wash hands, then incidence of puerperal infection and cord infection in home deliveries equal those in health facilities (.06).		

Table 3.3. United Kingdom Study Details

	Citation Country	Purpose	Place	Design method	Sample	Data collection, time period, year collected
37	Andrews (2004) South Wales	Record experiences of women who delivered at home	Avoid medical paradigm by delivering at home	Observational Qualitative Descriptive Cross section	8 ♀ home delivery (7 had prior hospital birth)	Semi structured interviews w/in 6 mos date not given

8. Women who delivered at home or in free-standing birth center described a process that was permitted to progress naturally without imposed time restraints (0.16).
19. Women who delivered at home had greater freedom to walk around, eat, drink, have family present, and engage in helpful distractions (.08).
22. Women who delivered at home said it was easier to cope with the pain: it still hurt, but they were able to relax and engage in distracting activities, and therefore deal with it better (.08).
24. Women who delivered at home described themselves as having had more confidence, greater control over environment, more input into decisions, and their opinions and choices respected compared to earlier hospital birth experiences (.08).
25. Women who delivered at home described their homes as peaceful, relaxed, familiar, private, calm, and quiet (.08).
26. Women who delivered at home were connected to outside world by sounds that helped keep them oriented (.08).
27. Women who delivered at home experienced a postpartum period that was more relaxed and celebratory, and not interrupted by having to relocate from hospital to home (.08).
29. Women who delivered at home said they received more attention and nurturing care at home compared to earlier hospital birth experiences (.08).
30. Women who delivered at home appreciated the comfort of having a confident midwife in attendance who was attentive and available, but unobtrusive (.08).
33. Husbands of women who delivered at home stated they were more confident and involved in the process, and had greater knowledge of what was going on (.08).

38	Barnett et al (2008) Scotland	Describe factors that influence a woman's decision to go to the maternity unit; and impact of being sent home "not in labor"	Inhospitable environment of hospitals	Observational Qualitative Descriptive Cross section	6 ♀ hospital	Semi-structured diaries kept during labor and interview (1-4 mos pp) 2006

1. Women who planned to deliver in the hospital needed to have their experience of early labor validated by a health professional. They sought reassurance from a knowledgeable, confident person (.25).
2. Women who planned to labor and deliver in the hospital were accompanied at home during early labor by family members who were unfamiliar with labor, were uncomfortable seeing their loved ones in pain, were anxious about being at home. They lacked a knowledgeable and confident person to guide them through early labor (.25).
3. Partners and family members of women who plan to deliver in the hospital were uncomfortable with idea of being at home for labor and or delivery (.25).
4. Women who planned hospital deliveries relied upon the hospital for all of their care, reassurance, information, and coping strategies. They were unprepared to deal with any of it at home. They experienced a great deal of uncertainty and lack of confidence during their time at home (.25).
5. Women who planned hospital deliveries were greatly dissatisfied when they were sent home to continue laboring at home (.25).
6. Women who planned to deliver in the hospital found pain relief advice from hospital inadequate to cope with pain during prolonged latent labor. They were unable to relax, and experienced increased anxiety being at home (.25).
7. Women had to be in active labor in order to be admitted to the hospital for labor(.25) .
10. Women who planned hospital deliveries were unprepared to cope with exhaustion resulting from sleep deprivation caused by repeated nights of contractions (0.16).
13. Women who planned hospital deliveries were often unknowledgeable about what to expect in early labor (0.16).
34. Women who planned hospital deliveries wanted their partners to stay with them, so frequently chose to return home rather than stay in hospital alone (.08).

39	Burges et al (2007) UK	Describe medial professionals contribution to construction of therapeutic landscapes during labor	Physical spaces perceived differently	Descriptive Observational Thematic analysis	3 focus groups of mid-wives 1 focus group of phys.	Focus groups 2005

14. Professionals caring for women in labor in the UK view pain relief in labor as a 'ladder' to climb. Women start out at home with natural methods in early labor and continue climbing as their labor progresses and they transition to the hospital for pharmacologic methods. Pain legitimizes their admission to the hospital. Women seek permission to go to the hospital. Women were able to gain admittance to hospital by expressing high levels of pain (0.16).
17. Women in labor believed they needed to achieve a certain level of pain to be admitted to the hospital for labor (0.16).
47. Pain relief options in different Birthplaces were determined by professionals based upon their opinions of what options "belong" in different settings. Home is a "natural" setting, therefore no pharmacologic pain relief offered. Hospital is a clinical setting, therefore, only options with a proven "evidence-based" effect were offered (.08).
48. Therapeutic effects of being in the environment where they expect to deliver and/or specific environmental conditions (such as water, lighting, temperature) often remain unrecognized by professionals and may be attributed to women's choice and empowerment (.08).

40	Cheyne et al (2007) Scotland	Describe women's early labor experiences at home and decision making about when to go to hospital	Home for latent labor, hospital for active	Observational Qualitative Descriptive Cross section	21 ♀ hospital	Interviews Group & individual Timing not stated Dates not given

1. Women who planned to deliver in the hospital needed to have their experience of early labor validated by a health professional. They sought reassurance from a knowledgeable, confident person (.25).
2. Women who planned to labor and deliver in the hospital were accompanied at home during early labor by family members who were unfamiliar with labor, were uncomfortable seeing their loved ones in pain, were anxious about being at home. They lacked a knowledgeable and confident person to guide them through early labor (.25).
3. Partners and family members of women who plan to deliver in the hospital were uncomfortable with idea of being at home for labor and or delivery (.25).
4. Women who planned hospital deliveries relied upon the hospital for all of their care, reassurance, information, and coping strategies. They were unprepared to deal with any of it at home. They experienced a great deal of uncertainty and lack of confidence during their time at home (.25).
5. Women who planned hospital deliveries were greatly dissatisfied when they were sent home to continue laboring at home (.25).
6. Women who planned to deliver in the hospital found pain relief advice from hospital inadequate to cope with pain during prolonged latent labor. They were unable to relax, and experienced increased anxiety being at home (.25).
7. Women had to be in active labor in order to be admitted to the hospital for labor(.25) .
9. Women who planned to deliver in the hospital felt insecure and unsafe at home in early labor, not knowing how advanced their labor was. They attempted to use hospital-defined measures to gauge their progress at home. They were unable to differentiate latent labor from active labor. They had an underlying need for reassurance during early labor at home (0.16).
10. Women who planned hospital deliveries were unprepared to cope with exhaustion resulting from sleep deprivation caused by repeated nights of contractions (0.16).
13. Women who planned hospital deliveries were often unknowledgeable about what to expect in early labor (0.16).
15. Women who planned to deliver in the hospital were instructed to stay at home as long as they could, until they needed pain relief (0.16).
28. Some women who planned to deliver in the hospital appreciated the comfort of being home early in labor (.08).

41	Houghton et al (2008) London	Identify influences upon women's decision making regarding place of birth		Observational Qualitative Descriptive	30 ♀ hospital	Questionnaire (2 prenatal) & interviews (34 wks gestation & 28 days pp) 2006

3. Partners and family members of women who plan to deliver in the hospital were uncomfortable with idea of being at

home for labor and or delivery (.25).
11. Women who planned hospital deliveries did not feel they could be in control of or influence the birth process (0.16).
12. Women who planned hospital deliveries believed hospital birth was safer than home birth, and were reassured by the clinical environment of the hospital (0.16)
37. Women who planned hospital deliveries did not think the birth setting would alter their psychological or social journey into motherhood (.08).
38. Women who planned hospital deliveries view intervention as necessary and normal part of birth (.08).

42	Nicholls & Ayers (2007) England	Describe experience and impact of childbirth related PTSD	Trauma of hospital birth	Qualitative Descriptive Cross section	6 couples ♀♂	Semi-structured interviews conducted individually > 3 mos pp dates not given

23. Women who developed PTSD stated they were forcibly restrained or their movement was restricted (.08).
56. Women did not like being in a birthplace where she experienced the perception of not being in control, or not involved in decision making (.08).
57. Women did not like being in a birthplace where she was not informed of labor progress or imposed interventions (.08).
58. Women did not like being in a birthplace where the staff did not communicate well, had poor attitudes, and were there was open conflict with or between staff (.08).
61. Women did not like being in a birthplace environment that was unpleasant, lacked privacy, or was unhygienic (.08).
62. Women did not like being in a birthplace where the faces of professional caregivers were covered up by masks (.08).

43	Nolan & Smith (2010) England	Describe experience of early labor at home	Hospital is desired environment	Qualitative Descriptive Cross section	8 ♀ hospital	Semi-structured interviews 1 mos pp 2008

1. Women who planned to deliver in the hospital needed to have their experience of early labor validated by a health professional. They sought reassurance from a knowledgeable, confident person (.25).
2. Women who planned to labor and deliver in the hospital were accompanied at home during early labor by family members who were unfamiliar with labor, were uncomfortable seeing their loved ones in pain, were anxious about being at home. They lacked a knowledgeable and confident person to guide them through early labor (.25).
4. Women who planned hospital deliveries relied upon the hospital for all of their care, reassurance, information, and coping strategies. They were unprepared to deal with any of it at home. They experienced a great deal of uncertainty and lack of confidence during their time at home (.25).
5. Women who planned hospital deliveries were greatly dissatisfied when they were sent home to continue laboring at home (.25).
6. Women who planned to deliver in the hospital found pain relief advice from hospital inadequate to cope with pain during prolonged latent labor. They were unable to relax, and experienced increased anxiety being at home (.25).
7. Women had to be in active labor in order to be admitted to the hospital for labor(.25) .
9. Women who planned to deliver in the hospital felt insecure and unsafe at home in early labor, not knowing how advanced their labor was. They attempted to use hospital-defined measures to gauge their progress at home. They were unable to differentiate latent labor from active labor. They had an underlying need for reassurance during early labor at home (0.16).
14. Professionals caring for women in labor in the UK view pain relief in labor as a 'ladder' to climb. Women start out at home with natural methods in early labor and continue climbing as their labor progresses and they transition to the hospital for pharmacologic methods. Pain legitimizes their admission to the hospital. Women seek permission to go to the hospital. Women were able to gain admittance to hospital by expressing high levels of pain (0.16).
15. Women who planned to deliver in the hospital were instructed to stay at home as long as they could, until they needed pain relief (0.16).
17. Women in labor believed they needed to achieve a certain level of pain to be admitted to the hospital for labor (0.16).
31. Women who planned to deliver in the hospital felt the hospital staff had an agenda to keep them out of the hospital in early labor, and had little consideration for their distress when they were at home (.08).

44	Pitchforth et al (2009) Scotland	Describe women's choice of delivery place in rural Scotland	Rural Remote	Observational Qualitative Descriptive	71 ♀	Focus groups (12) Timing not

				Cross section		given Dates not given

11. Women who planned hospital deliveries did not feel they could be in control of or influence the birth process (0.16).
12. Women who planned hospital deliveries believed hospital birth was safer than home birth, and were reassured by the clinical environment of the hospital (0.16)
32. Women perceived greater quality of care in local midwife-led units (.08).
35. Local maternity units, led by midwives, were more accommodating to visitors and made child care arrangements easier (.08).
63. Physical distance and geographical barriers influence women's decision on whether to deliver at home or in the hospital. (influence both ways; some women choose hospital unit to avoid transfer during labor, some women worry they will not reach hospital in time, some women feel distance to travel to hospital makes home birth unsafe, some women mention that children at home makes distant hospital birth unattractive) (.08).
64. Women's decision about where to deliver is influenced by provider preference, often deters home birth (.08).
65. Financial restrictions limit women's choice about where to deliver (.08).

45	Symon et al (2007) England	Compare outcomes between two birthplaces for women who have similar, self-described risk status	Midwife-led vs. physician-led units	Observational Quantitative descriptive Cross section	432 ♀ 294-midwife 138-OB	Questionnaire 8 days after birth 2004-2005

41. Low risk women who intended to deliver on midwife-led units in England had significantly shorter labors than woman who intended to deliver on obstetric-led units (.08).
42. Low risk women who intended to deliver on midwife-led units in England had significantly fewer interventions than women who intended to deliver on obstetric-led units (.08).
43. Low risk women who intended to deliver on midwife-led units in England had significantly less analgesia than women who intended to deliver on obstetric-led units (.08).
44. Low risk women primiparous who intended to deliver on midwife-led units in England had fewer midwives caring for them than women who intended to deliver on obstetric-led units (.08).
45. Low risk women primiparous who intended to deliver on midwife-led units in England were significantly more likely to experience spontaneous vaginal delivery than women who intended to deliver on obstetric-led units (.08).
46. Low risk women who intended to deliver on midwife-led units in England had were significantly more likely to report they had been involved in making all or most decisions regarding their care than women who intended to deliver on obstetric-led units (.08).

46	Walker (2000) England	Describe women's experiences being transferred to unfamiliar place for labor due to complication	Familiar vs. unfamiliar	Observational Qualitative Descriptive	18 ♀	Interview Antenatal, on postpartum unit, OR at home <28 days pp Dates not given

16. Women prefer a birthplace that is familiar, relaxed, calm, friendly, homey, small, intimate, and where they felt comfortable arranging to suit needs (0.16).
36. Women who deliver in hospitals dislike being separated from their partner and family (.08).
40. Women planning to deliver in midwife-led units engaged in tactics to avoid transfer to consultant-led units when complications occurred. They continued to perceive themselves as low risk and did not agree condition warranted transfer (.08).
54. Women appreciated the birthplace that supports choice and control (.08).
55. Women did not like being transfered to unfamiliar birth place. They stated it was isolating and anxiety producing and resulted in lost opportunities for choice, loss of control, and feelings of helplessness (.08).
66. Complications at end of pregnancy or during labor prevented women from delivering in birthplace of their choice (.08).

47	Walsh (2006a) England	Explore the culture, beliefs, values, customs and practices around the birth process within an FSBC	Free-standing birth center	Ethnography Observational Qualitative Descriptive	30 ♀	Interviews: 3 mos pp Participant observation Dates not specified:1993-2006

16. Women prefer a birthplace that is familiar, relaxed, calm, friendly, homey, small, intimate, and where they felt comfortable arranging to suit needs (0.16).
18. Women preferred birth places that allowed family members to be present and addressed women's needs not related strictly to labor, such as child care and feeding birth partners (.08).
49. Women appreciated the welcoming attitude of birth center staff, which conveyed the sense they wanted to help (.08).
50. Women appreciated the comfort and protection and caring attitude provided by birth center staff (.08).
51. Women appreciated the emotional and nurturing needs cared for – as if MUM were there (.08).
52. Women appreciated the opportunity to stay at birth center for up to one week after delivery, have staff look after baby at night so woman could sleep (.08).
53. Women appreciated the baby-friendly environment (.08).
59. Women did not like being in a birthplace with a clinical environment where focus wass on what could go wrong, and there were exposed instruments and machines (.08).
60. Women did not like the fast pace and frenetic activity associated with hospital birth places (.08).
67. Birth center did not use space to construct identity or maintain power differential (.08).

48	Walsh (2006b) England	Explore the culture, beliefs, values, customs and practices around the birth process within an FSBC	Free-standing birth center	Ethnography Observational Qualitative Descriptive	30 ♀	Interviews: 3 mos pp Participant observation Dates not specified:1993-2006

8. Women who delivered at home or in free-standing birth center described a process that was permitted to progress naturally without imposed time restraints (0.16).
16. Women prefer a birthplace that is familiar, relaxed, calm, friendly, homey, small, intimate, and where they felt comfortable arranging to suit needs (0.16).
18. Women preferred birth places that allowed family members to be present and addressed women's needs not related strictly to labor, such as child care and feeding birth partners (.08).

49	Walsh (2007) England	Explore the culture, beliefs, values, customs and practices around the birth process within an FSBC	Free-standing birth center	Ethnography Observational Qualitative Descriptive	30 ♀	Interviews: 3 mos pp Participant observation Dates not specified:1993-2006

68. Midwives who practice at this birth center located in the midlands of England resist the biomedical model because they do not expect trouble (regarding women in labor/postpartum). While they assess, monitor, and care for complications as they arise, they keep the likelihood of it being something serious at the back of their minds, not at the forefront (.08).
69. Midwives who practice at this birth center located in the midlands of England were able to resist the 'vigil of care' because they were not constrained by clinical, organizational, and professional imperatives to ensure labor progresses at an acceptable pace, that women remain within acceptable hospital labor spaces, or that women comply with biomedically defined instructions and advice (.08).
70. Women who seek care at this birth center located in the midlands of England resist the 'vigil of care' by asserting their agency in clinical decision-making (.08).

50	Walsh (2009) England	Describe labor characteristics of women whose contractions decreased or increased upon admission to hospital	Effect of places on labor contractions	Mixed methods	87 ♀	Labor diaries and questionnaire (pp – handed out when diaries collected) 1997

20. Women reported frequent position changes during the last hour of labor at home before going to hospital (.08).
21. Women who delivered at home reported frequent position changes throughout labor and recorded increased contraction frequency every hour of labor until delivery (.08).
39. Women whose contraction pattern slowed after entering hospital had less average cervical dilation (compared to women whose contraction pattern increased in frequency), and were more likely to spend the first hour in hospital lying in bed. They were more likely to have longer first and second stage labor, AROM, Pitocin augmentation, request and receive pain relief, and have an assisted delivery (.08).

Table 3.4. North America Study Details

	Citation Country	Purpose	Place	Design method	Sample	Data collection, time period, year collected
51	Abenhaim et al. 2007 Canada	Determine whether obstetric outcomes differed between women whose babies were delivered by their own obstetrician and those by an on-call obstetrician	Different providers – same place	Descriptive Observational Retrospective Data-base	28322 medical records of ♀	Hospital data-base MR 1999-2001

NA1. Women in North America prefer a birthplace environment that supports their wish to avoid interventions (.75).
NA 7. A woman's labor and birth experience in a particular birthplace in North American is influenced by her relationship with the attendant (.58).

52	Beebe et al.2006 US	Explore the phenomenon of pre-hospitalization labor from perspective of nulliparous women	Home vs. hospital for those wanting hospital	Qualitative descriptive	23 ♀ hospital	Interview Shortly after birth Date not given

NA 1. Women in North America prefer a birthplace environment that supports their wish to avoid interventions (.75).
NA 2. Women in North America, regardless of where they plan to deliver, want support from knowledgeable, competent, and caring individuals throughout labor (.75).
NA 3. Women in North America prefer a birthplace environment that is one or more of the following: comfortable, familiar, private, peaceful, safe, secure, allows for freedom of movement (.75).
NA 4. Women in North America prefer a birthplace environment that accommodates support people (.75).
NA 5. Women in North America prefer to use multiple sources of knowledge, including their personal bodily experiences of labor, in addition to biomedical knowledge (.67).
NA 6. Women in North America prefer a birthplace environment where they can be in control, share in decision-making, and feel empowered (.58).
NA 13. Women in North America choose their birthplace in order to avoid risks associated with certain birthplaces (.50).
NA16. Women in North America who were laboring at home attempt to gauge labor progress according to biomedical guidelines (.33).
NA19. Women in North America experience discomfort/distress moving from home to hospital during labor (.25).
NA 22. Women who plan to deliver in hospital in North American do not have access to assessment and support by competent and caring professionals during early labor at home (.25).
NA 23. Women in North American who plan to deliver in hospital want to avoid getting to hospital too late to receive analgesia/anesthesia (.17).
NA 25. Women in North American who deliver in hospital would like to avoid unnecessary interventions, some of which include being stuck in bed, immobilized, hooked up to monitors, and receiving IV medication (.17).
NA 26. Women in North America who plan to deliver in hospital want to avoid being at home once contractions become painful (.17).
NA 27. Women in North America who plan to deliver in hospital want to be admitted when their contractions become painful (.17).
NA 30. Women in North America who plan to labor and deliver in the hospital must reach a specific cervical dilation before they will be admitted (.17).
NA 32. Women in North American who plan to deliver in hospital want to avoid having baby at home (.8).
NA 35. Women in North America who plan to deliver in hospital prefer the hospital because they believe it is safer (.8).

53	Boucher et al. 2009 US	Describe reasons why women choose home birth in US	Home vs. hospital	Qualitative descriptive	160 ♀ home	On-line survey Planned home birth (mean w/in past 3 yrs) 2007-2007

NA1. Women in North America prefer a birthplace environment that supports their wish to avoid interventions (.75).
NA 2. Women in North America, regardless of where they plan to deliver, want support from knowledgeable, competent, and caring individuals throughout labor (.75).
NA 3. Women in North America prefer a birthplace environment that is one or more of the following: comfortable, familiar, private, peaceful, safe, secure, allows for freedom of movement (.75).
4. Women in North America prefer a birthplace environment that accommodates support people (.75).

5. Women in North America prefer to use multiple sources of knowledge, including their personal bodily experiences of labor, in addition to biomedical knowledge (.67).
6. Women in North America prefer a birthplace environment where they can be in control, share in decision-making, and feel empowered (.58).
8. Women in North America prefer to have birth attendants who were familiar and support their wishes (.58).
9. Women in North America who plan a home birth believe birth is a natural process (not an illness), trust the birth process and want to be free to follow their intuition (.50).
NA10. Women in North America prefer a birthplace environment that encourages support people to take an active role in labor and birth process (.50).
NA11. Some women in North America prefer a birthplace environment that supports their desire to avoid pain medicine (.50).
NA13. Women in North America choose their birthplace in order to avoid risks associated with certain birthplaces (.50).
NA14. Women in North America who minimized or avoided relocation before or during labor had higher satisfaction scores (.42).
NA17. Many women in North America who deliver at home had negative prior experiences in the hospital (.33).
NA18. Women in North America who plan home deliveries want to avoid hospitals and physicians (.25).
NA19. Women in North America experience discomfort/distress moving from home to hospital during labor (.25).
NA 21. Women in North America prefer to deliver at home because someone in their family did, or it is the norm for their community (.25).
NA 24. Women in North America who plan home deliveries want to avoid intervention (.17).
NA 31. Women in North America wish to avoid time limits on their labor (.17).
NA 34. Women in North America plan to deliver at home to avoid cesarean section (.8).
NA 38. Women in North America prefer home birth say it is better for the baby (.8).
NA 39. Women in North America prefer home delivery because it costs less (.8).
NA 40. Women in North America prefer home delivery because they have a history of fast labors (.8).

54	Cheyney. 2008 US	Examine the processes and motivations involved when women in the United States reject the cultural norm of obstetrician-attended hospital birth and choose to deliver at home with a midwife	Home vs. hospital	ethnographic Qualitative descriptive	50 ♀ home began labor in own homes	Interview Participant observation Timing not specified 1998, 2000-2002

NA1. Women in North America prefer a birthplace environment that supports their wish to avoid interventions (.75).
NA 2. Women in North America, regardless of where they plan to deliver, want support from knowledgeable, competent, and caring individuals throughout labor (.75).
NA 3. Women in North America prefer a birthplace environment that is one or more of the following: comfortable, familiar, private, peaceful, safe, secure, allows for freedom of movement (.75).
NA 4. Women in North America prefer a birthplace environment that accommodates support people (.75).
NA 5. Women in North America prefer to use multiple sources of knowledge, including their personal bodily experiences of labor, in addition to biomedical knowledge (.67).
NA 7. A woman's labor and birth experience in a particular birthplace in North American is influenced by her relationship with the attendant (.58).
NA 8. Women in North America prefer to have birth attendants who were familiar and support their wishes (.58).
NA 9. Women in North America who plan a home birth believe birth is a natural process (not an illness), trust the birth process and want to be free to follow their intuition (.50).
NA10. Women in North America prefer a birthplace environment that encourages support people to take an active role in labor and birth process (.50).
NA11. Some women in North America prefer a birthplace environment that supports their desire to avoid pain medicine (.50).
NA12. Women in North America use non-medical sources of knowledge to guide them through labor (.50).
NA13. Women in North America choose their birthplace in order to avoid risks associated with certain birthplaces (.50).
NA16. Women in North America who were laboring at home attempt to gauge labor progress according to biomedical guidelines (.33).
NA17. Many women in North America who deliver at home had negative prior experiences in the hospital (.33).
NA18. Women in North America who plan home deliveries want to avoid hospitals and physicians (.25).
NA 20. Women in North America see physicians and technology as barriers to a meaningful birth experience in the hospital, and sometimes see midwives and physicians as barriers to meaningful birth experience at home (.25).
NA 29. Women in North America who plan a home delivery tend to express a strong trust in God's will (.17).
NA 31. Women in North America wish to avoid time limits on their labor (.17).
NA 36. Women in North America who plan a home birth experience negative reactions including accusations of selfish

irresponsibility and unnecessary risk taking from some friends, family and stranger (.8).

55	Hodnett et al.2009 Canada	Test feasibility of a randomized trial, and the acceptability of modified labor room to women and their care providers	Pt-centered vs. Provider centered env	Randomized controlled study	62 ♀ hospital	Questionnaire Before discharge from hospital 2007-2008

NA1. Women in North America prefer a birthplace environment that supports their wish to avoid interventions (.75).
NA 3. Women in North America prefer a birthplace environment that is one or more of the following: comfortable, familiar, private, peaceful, safe, secure, allows for freedom of movement (.75).
NA 4. Women in North America prefer a birthplace environment that accommodates support people (.75).
NA11. Some women in North America prefer a birthplace environment that supports their desire to avoid pain medicine (.50).
NA15. Physical place influenced professional's behavior in North American (.33).
NA 28. Women in North America prefer a birth environment where they can control features such as light and sound (.17).

56	Janssen et al.2000 Canada	Compare women's satisfaction with single room maternity care with that of clients cared for in traditional labor and delivery unit and postpartum unit	Pt-centered vs. Provider centered env	Descriptive Observational Quantitative Comparison groups	530 ♀ hospital	Questionnaire Before discharge from hospital > 1997

NA 3. Women in North America prefer a birthplace environment that is one or more of the following: comfortable, familiar, private, peaceful, safe, secure, allows for freedom of movement (.75).
NA 4. Women in North America prefer a birthplace environment that accommodates support people (.75).
NA14. Women in North America who minimized or avoided relocation before or during labor had higher satisfaction scores (.42).
NA15. Physical place influenced professional's behavior in North American (.33).

57	Janssen et al.2006 Canada	Compare satisfaction with planned place of delivery as distinct from satisfaction with choice of caregiver *same sample of women who delivered at home as janssen et al.2009	Home vs. hospital	Observational Descriptive Cross section Quantitative survey	550 ♀ home 108 ♀ hospital	Questionnaire w/in 6 wks pp 1998-1999

NA1. Women in North America prefer a birthplace environment that supports their wish to avoid interventions (.75).
NA 5. Women in North America prefer to use multiple sources of knowledge, including their personal bodily experiences of labor, in addition to biomedical knowledge (.67).
NA 6. Women in North America prefer a birthplace environment where they can be in control, share in decision-making, and feel empowered (.58).
NA 9. Women in North America who plan a home birth believe birth is a natural process (not an illness), trust the birth process and want to be free to follow their intuition (.50).
NA14. Women in North America who minimized or avoided relocation before or during labor had higher satisfaction scores (.42).
NA 22. Women who plan to deliver in hospital in North American do not have access to assessment and support by competent and caring professionals during early labor at home (.25).

58	Janssen et al.2009 Canada	What were the experiences of women who give birth at home and what were their reasons for choosing home birth	Home vs. hospital	Observational Descriptive Cross section survey	559 ♀ home	Open ended question on postal questionnaire w/in 6 wks pp 1998-1999

NA 1. Women in North America prefer a birthplace environment that supports their wish to avoid interventions (.75).
NA 2. Women in North America, regardless of where they plan to deliver, want support from knowledgeable, competent, and caring individuals throughout labor (.75).
NA 3. Women in North America prefer a birthplace environment that is one or more of the following: comfortable, familiar, private, peaceful, safe, secure, allows for freedom of movement (.75).
NA 4. Women in North America prefer a birthplace environment that accommodates support people (.75).

NA 5. Women in North America prefer to use multiple sources of knowledge, including their personal bodily experiences of labor, in addition to biomedical knowledge (.67).
NA 6. Women in North America prefer a birthplace environment where they can be in control, share in decision-making, and feel empowered (.58).
NA 7. A woman's labor and birth experience in a particular birthplace in North American is influenced by her relationship with the attendant (.58).
NA 8. Women in North America prefer to have birth attendants who were familiar and support their wishes (.58).
NA 9. Women in North America who plan a home birth believe birth is a natural process (not an illness), trust the birth process and want to be free to follow their intuition (.50).
NA 10. Women in North America prefer a birthplace environment that encourages support people to take an active role in labor and birth process (.50).
NA 12. Women in North America use non-medical sources of knowledge to guide them through labor (.50).
NA 13. Women in North America choose their birthplace in order to avoid risks associated with certain birthplaces (.50).
NA 15. Physical place influenced professional's behavior in North American (.33).
NA 17. Many women in North America who deliver at home had negative prior experiences in the hospital (.33).

59	Kornelsen. 2005 Canada	Examine the nature of technology itself and compare home-birthing women and hospital birthing women vis-à-vis their attitudes toward technology	Place and technology	Qualitative descriptive	25 ♀ home 25 ♀ hospital	Semi-structured interview 6 wks-18 mos pp Date not given

NA 1. Women in North America prefer a birthplace environment that supports their wish to avoid interventions (.75).
NA2. Women in North America, regardless of where they plan to deliver, want support from knowledgeable, competent, and caring individuals throughout labor (.75).
NA4. Women in North America prefer a birthplace environment that accommodates support people (.75).
NA 5. Women in North America prefer to use multiple sources of knowledge, including their personal bodily experiences of labor, in addition to biomedical knowledge (.67).
NA 6. Women in North America prefer a birthplace environment where they can be in control, share in decision-making, and feel empowered (.58).
NA 7. A woman's labor and birth experience in a particular birthplace in North American is influenced by her relationship with the attendant (.58).
NA 8. Women in North America prefer to have birth attendants who were familiar and support their wishes (.58).
NA 9. Women in North America who plan a home birth believe birth is a natural process (not an illness), trust the birth process and want to be free to follow their intuition (.50).
NA 10. Women in North America prefer a birthplace environment that encourages support people to take an active role in labor and birth process (.50).
NA 11. Some women in North America prefer a birthplace environment that supports their desire to avoid pain medicine (.50).
NA 12. Women in North America use non-medical sources of knowledge to guide them through labor (.50).
NA 13. Women in North America choose their birthplace in order to avoid risks associated with certain birthplaces (.50).
NA 14. Women in North America who minimized or avoided relocation before or during labor had higher satisfaction scores (.42).
NA 15. Physical place influenced professional's behavior in North American (.33).
NA 17. Many women in North America who deliver at home had negative prior experiences in the hospital (.33).
NA 20. Women in North America see physicians and technology as barriers to a meaningful birth experience in the hospital, and sometimes see midwives and physicians as barriers to meaningful birth experience at home (.25).
NA 24. Women in North America who plan home deliveries want to avoid intervention (.17).
NA 25. Women in North American who deliver in hospital would like to avoid unnecessary interventions, some of which include being stuck in bed, immobilized, hooked up to monitors, and receiving IV medication (.17).

60	Kornelsen et al. 2010 Canada	Considers implicatins of closure of a local maternity service from perspective of local first nation women	In or out of community	Qualitative case study Participatory research	20 ♀ home 35 ♀ hospital (out of community)	Written survey interview timing not specified 1996-2005

NA 1. Women in North America prefer a birthplace environment that supports their wish to avoid interventions (.75).
NA 2. Women in North America, regardless of where they plan to deliver, want support from knowledgeable, competent, and caring individuals throughout labor (.75).

NA 3. Women in North America prefer a birthplace environment that is one or more of the following: comfortable, familiar, private, peaceful, safe, secure, allows for freedom of movement (.75).
NA 4. Women in North America prefer a birthplace environment that accommodates support people (.75).
NA 5. Women in North America prefer to use multiple sources of knowledge, including their personal bodily experiences of labor, in addition to biomedical knowledge (.67).
NA 7. A woman's labor and birth experience in a particular birthplace in North American is influenced by her relationship with the attendant (.58).
NA 8. Women in North America prefer to have birth attendants who were familiar and support their wishes (.58).
NA 9. Women in North America who plan a home birth believe birth is a natural process (not an illness), trust the birth process and want to be free to follow their intuition (.50).
NA 10. Women in North America prefer a birthplace environment that encourages support people to take an active role in labor and birth process (.50).
NA 11. Some women in North America prefer a birthplace environment that supports their desire to avoid pain medicine (.50).
NA 12. Women in North America use non-medical sources of knowledge to guide them through labor (.50).
NA 13. Women in North America choose their birthplace in order to avoid risks associated with certain birthplaces (.50).
NA 14. Women in North America who minimized or avoided relocation before or during labor had higher satisfaction scores (.42).
NA 21. Women in North America prefer to deliver at home because someone in their family did, or it is the norm for their community (.25).
NA 37. Distance between home and hospital is a barrier to specialized obstetric care for women in remote areas of North America (.8).

61	Low & Moffatt. 2006 US	Investigate how women experience their transition to the delivery facility	Home vs. hospital for women who wanted hospital	Qualitative descriptive	26 ♀	Semi-structured interview Recent birth (recruited prenatally) Date not given

NA 2. Women in North America, regardless of where they plan to deliver, want support from knowledgeable, competent, and caring individuals throughout labor (.75).
NA 4. Women in North America prefer a birthplace environment that accommodates support people (.75).
NA 5. Women in North America prefer to use multiple sources of knowledge, including their personal bodily experiences of labor, in addition to biomedical knowledge (.67).
NA 6. Women in North America prefer a birthplace environment where they can be in control, share in decision-making, and feel empowered (.58).
NA 12. Women in North America use non-medical sources of knowledge to guide them through labor (.50).
NA 16. Women in North America who were laboring at home attempt to gauge labor progress according to biomedical guidelines (.33).
NA 22. Women who plan to deliver in hospital in North American do not have access to assessment and support by competent and caring professionals during early labor at home (.25).
NA 23. Women in North American who plan to deliver in hospital want to avoid getting to hospital too late to receive analgesia/anesthesia (.17).
NA 26. Women in North America who plan to deliver in hospital want to avoid being at home once contractions become painful (.17).
NA 27. Women in North America who plan to deliver in hospital want to be admitted when their contractions become painful (.17).
NA 30. Women in North America who plan to labor and deliver in the hospital must reach a specific cervical dilation before they will be admitted (.17).

62	Miller. 2009 US	Consider how and why women make decision to deliver at home without professional assistance	Control of space - who	Qualitative descriptive	133 ♀ home	Narratives collected from internet (127) In-depth interviews (6) Timing not specified Date not given

NA 1. Women in North America prefer a birthplace environment that supports their wish to avoid interventions (.75).
NA 2. Women in North America, regardless of where they plan to deliver, want support from knowledgeable, competent, and caring individuals throughout labor (.75).
NA 3. Women in North America prefer a birthplace environment that is one or more of the following: comfortable, familiar, private, peaceful, safe, secure, allows for freedom of movement (.75).
NA 4. Women in North America prefer a birthplace environment that accommodates support people (.75).
NA 5. Women in North America prefer to use multiple sources of knowledge, including their personal bodily experiences of labor, in addition to biomedical knowledge (.67).
NA 6. Women in North America prefer a birthplace environment where they can be in control, share in decision-making, and feel empowered (.58).
NA 7. A woman's labor and birth experience in a particular birthplace in North American is influenced by her relationship with the attendant (.58).
NA 8. Women in North America prefer to have birth attendants who were familiar and support their wishes (.58).
NA 9. Women in North America who plan a home birth believe birth is a natural process (not an illness), trust the birth process and want to be free to follow their intuition (.50).
NA 10. Women in North America prefer a birthplace environment that encourages support people to take an active role in labor and birth process (.50).
NA 12. Women in North America use non-medical sources of knowledge to guide them through labor (.50).
NA 16. Women in North America who were laboring at home attempt to gauge labor progress according to biomedical guidelines (.33).
NA 18. Women in North America who plan home deliveries want to avoid hospitals and physicians (.25).
NA 19. Women in North America experience discomfort/distress moving from home to hospital during labor (.25).
NA 20. Women in North America see physicians and technology as barriers to a meaningful birth experience in the hospital, and sometimes see midwives and physicians as barriers to meaningful birth experience at home (.25).
NA 21. Women in North America prefer to deliver at home because someone in their family did, or it is the norm for their community (.25).
NA 28. Women in North America prefer a birth environment where they can control features such as light and sound (.17).
NA 29. Women in North America who plan a home delivery tend to express a strong trust in God's will (.17).
NA 33. Some women in North America who plan home deliveries want to avoid all health professionals (.8).

63	Pewitt. 2008 US	Is it possible to reduce unnecessary intervention, improve outcomes, and possibly reduce lawsuits?	Birth center	Qualitative descriptive	7 ♀ birth center	Interview 7.5-14 mos pp 2005	

NA 2. Women in North America, regardless of where they plan to deliver, want support from knowledgeable, competent, and caring individuals throughout labor (.75).
NA 3. Women in North America prefer a birthplace environment that is one or more of the following: comfortable, familiar, private, peaceful, safe, secure, allows for freedom of movement (.75).
NA 6. Women in North America prefer a birthplace environment where they can be in control, share in decision-making, and feel empowered (.58).
NA 7. A woman's labor and birth experience in a particular birthplace in North American is influenced by her relationship with the attendant (.58).
NA 8. Women in North America prefer to have birth attendants who were familiar and support their wishes (.58).
NA 11. Some women in North America prefer a birthplace environment that supports their desire to avoid pain medicine (.50).

Table 3.5. Asia Study Details

	Citation Country	Purpose	Place	Design method	Sample	Data collection, time period, year collected
64	Adams et al. 2005 Tibet	What prevents rural Tibetan women from coming to clinics – What in other words did rural Tibetan women consider to be a "safe delivery"?	Home vs. hospital	Ethnography Observational Cross section	38 ♀	Interview Timing not given 2000

Asia 1. Women were unable to use hospitals for childbirth because of the cost, which has to be paid upfront (.71).
Asia 2. Women avoid hospitals for childbirth because the health workers there were rude, poor communicators, and possess questionable skills (.57).
Asia 3. Women were unable to use hospitals for childbirth because of the distance, requiring hours-days travel by foot (.57).
Asia 4. Women were unable to use hospitals for childbirth because of the expense of traveling to hospital – and difficulty finding transport (.43).
Asia 5. Women prefer a birthplace where they can labor and deliver alone; it protects family members from pollution, and self/baby from contamination by health workers (.29)
Asia 8. Women avoid hospitals for childbirth because they were associated with death, disease, zombies, ghosts, and demons (.29).
Asia 9. Women want to avoid having the pollution associated with childbirth (blood) enter their house (.29).
Asia 13. Women protect household from polluting effects of childbirth by delivering in animal shed (.29)
Asia 16. Women prefer a birthplace that is secret and private because it protects against jealousy and envy in others (.14).
Asia 18. Women avoid birthplaces with health workers. They believe they were contaminated with grib (.14).
Asia 20. Women avoid making preparations, such as collecting supplies needed to safely deliver at home, which can alert others of pregnancy/childbirth (.14).
Asia 21. Women avoid having birth helpers (husband) when they deliver at home because the helper might become polluted (.14).
Asia 25. Women were unable to use hospitals for childbirth because of the time away from family (.14).

65	Afsana & Rashid. 2001 Bangladesh	reasons why women do not make more use of facility services 15 postpartum mothers	Home vs. hospital	Qualitative descriptive	20 ♀ 5-home only 15 both	In depth interview Focus group Timing not given 1998-1999

Asia 1. Women were unable to use hospitals for childbirth because of the cost, which has to be paid upfront (.71).
Asia 2. Women avoid hospitals for childbirth because the health workers there were rude, poor communicators, and possess questionable skills (.57).
Asia 4. Women were unable to use hospitals for childbirth because of the expense of traveling to hospital – and difficulty finding transport (.43).
Asia 6. Women prefer a birthplace where they have a choice of position for delivery (.29).
Asia 8. Women avoid hospitals for childbirth because they were associated with death, disease, zombies, ghosts, and demons (.29).
Asia 10. Women avoid hospitals for childbirth because they want to avoid surgery and technology/interventions (.29).
Asia 11. Women avoid hospitals for childbirth because of the male doctors (.29).
Asia 12. Women were unable to use hospitals for childbirth because husbands/family decide where woman will deliver (.29).
Asia 14. Women state that childbirth a natural process, and therefore can be achieved at home (.29).
Asia 22. Women want to avoid the stigma of a defective body, associated with hospital delivery (.14).

66	Mutharayappa & Prabhuswamy 2003 India	understand factors influencing place of delivery in rural India	Home vs. facility	Quantitative descriptive observational	606 ♀	Interviews using structured questionnaires w/in 3 yrs of birth 2000

Asia 1. Women were unable to use hospitals for childbirth because of the cost, which has to be paid upfront (.71).
Asia 2. Women avoid hospitals for childbirth because the health workers there were rude, poor communicators, and possess questionable skills (.57).

Asia 3. Women were unable to use hospitals for childbirth because of the distance, requiring hours-days travel by foot (.57).
Asia 4. Women were unable to use hospitals for childbirth because of the expense of traveling to hospital – and difficulty finding transport (.43).
Asia 7. Women prefer a birthplace with a confident, familiar, caring, and local birth attendant (.29).
Asia 11. Women avoid hospitals for childbirth because of the male doctors (.29).
Asia 12. Women were unable to use hospitals for childbirth because husbands/family decide where woman will deliver (.29).
Asia 15. Women more likely to deliver in a health facility if they were more highly educated or employed in government or business (.29).
Asia 17. Women prefer to labor and deliver at home; the facilities and care at home were better than at a birth center (.14).
Asia 23. Women avoid hospitals for childbirth because of requirement to stay three days after delivery (.14).
Asia 26. Women were unable to use hospitals for childbirth because the facilities were not adequately staffed (.14).
Asia 27. Women were unable to use hospitals for childbirth because the healthcare workers of different caste (.14).
Asia 28. Delivering at home is perceived to be safer than hospital for childbirth (.14).
Asia 29. Women believe that pregnancies deemed healthy were safe to deliver at home (.14).
Asia 30. Women believe that traditional birth attendants provided protection from evil spirits in the birthplace (.14).
Asia 31. Women believe hospitals have ability to save women from death by performing c/s (.14).

67	Regmi & Madison 2009 Nepal	describe current context of birth in Nepal	Home vs. facility	Qualitative descriptive	23 ♀ 8 mothers-in-law	Interview and focus group "post partum" ?

Asia 1. Women were unable to use hospitals for childbirth because of the cost, which has to be paid upfront (.71).
Asia 2. Women avoid hospitals for childbirth because the health workers there were rude, poor communicators, and possess questionable skills (.57).
Asia 6. Women prefer a birthplace where they have a choice of position for delivery (.29).
Asia 10. Women avoid hospitals for childbirth because they want to avoid surgery and technology/interventions (.29).
Asia 19. Women avoid hospitals for childbirth because of the poor attitude of health workers (.14).
Asia 24. Women avoid hospitals for childbirth because experience that stripped woman of humanity (tied down like animal, reduced to feeling like object, staff with no compassion) (.14).

68	Sepehri et al. 2008 Vietnam	assess influence of individual, household and commune level characteristics on a woman's decision to seek prenatal care, number of visits, and choice of giving birth at a health facility or at home	Cross section Observational Quantitative survey	9400 ♀	Data generated by national survey w/in 5 yrs of birth 2001-02

Asia 1. Women were unable to use hospitals for childbirth because of the cost, which has to be paid upfront (.71).
Asia 3. Women were unable to use hospitals for childbirth because of the distance, requiring hours-days travel by foot (.57).
Asia 15. Women more likely to deliver in a health facility if they were more highly educated or employed in government or business (.29).
Asia 34. For women in Vietnam, the odds of delivering in a health facility increases with the number of prenatal visits (.14).
Asia 35. For women in Vietnam, the odds of delivering in a health facility increases with household income (.14).
Asia 36. For women in Vietnam, the odds of delivering in a health facility increases with the number of prenatal visits (.14).
Asia 37. For women in Vietnam, the odds of delivering in a health facility increases with living in an urban area – see distance to travel above (.14).
Asia 38. For women in Vietnam, the odds of delivering in a health facility increases with being a member of the ethnic majority (.14).

69	Thapa et al. 2000 Nepal	determine risk factors for neonatal/infant mortality	Preference for animal shed	Mixed methods Observational descriptive	772 ♀	Questionnaire Focus groups Interview Timing not given 1996

Asia 3. Women were unable to use hospitals for childbirth because of the distance, requiring hours-days travel by foot (.57).
Asia 5. Women prefer a birthplace where they can labor and deliver alone; it protects family members from pollution, and self/baby from contamination by health workers (.29)
Asia 9. Women want to avoid having the pollution associated with childbirth (blood) enter their house (.29).
Asia 13. Women protect household from polluting effects of childbirth by delivering in animal shed (.29)
Asia 14. Women state that childbirth a natural process, and therefore can be achieved at home (.29).
Asia 32. Women in rural Nepal who deliver in an animal shed prepare the area by cleaning up the cow dung, laying down clean dry grass and a plastic sheet or cloth (.14).
Asia 33. Women in rural Nepal who deliver in an animal shed place the baby on the rough floor with a thin cotton cloth, bath and warm the baby after completing their own care, and use an un-sterilized sickle to cut the cord (.14).
Asia 39. Women in rural Nepal who deliver in an animal shed experience higher rates of neonatal and infant mortality compared with women who deliver in houses (.14).
Asia 40. Women in rural Nepal who deliver in an animal shed without assistance experience the highest rates of neonatal and infant mortality (compared to delivering in home) (.14).
Asia 41. Women in rural Nepal delivering their first, second, or greater than seventh baby experience higher rates of neonatal and infant mortality (.14)
Asia 42. Women in rural Nepal who were illiterate, or whose husband is illiterate, experience higher rates of neonatal mortality (.14).

70	Saleem et al. 2007 Pakistan	Investigate acceptance of vaginal wipes among study population, delivering at home with TBA	increase safety of home delivery	Randomized controlled trial	203 pregnant ♀ 13 skilled TBA	Interview = TBA Focus group - ♀ Visual analogue - ♀ (assess tolerance) Physical exam (1/2 hr and 24 hrs) Follow-up checks (7, 14, & 28 days) 2005-06

Asia42. 40% of births to women living in a squatter camp in Karachi, Pakistan occurred at home (.14).
Asia43. 60% of home births occurring in a squatter camp in Karachi, Pakistan were attended by traditional birth attendants (.14).
Asia43. TBAs attending home births in squatter camp in Karachi, Pakistan were willing to receive training in vagina and neonatal washes as well as study protocols including consent and randomization
Asia44. TBAs attending home births in squatter camp in Karachi, Pakistan were able to obtain consent and randomly assign 95% of screened women (.14).
Asia45. Women living in squatter camps in Karachi, Pakistan were willing to participate in research, including randomization, and accept interventions as long as they were approved by TBA (.14).
Asia46. For women living in squatter camps in Karachi, Pakistan there is an indication of better outcomes for infants whose mothers were treated with Chlorhexidine during labor (.14).
Asia47. Women delivering at home in squatter camp in Karachi, Pakistan who received Chlorhexidine treatment were more likely to be referred for medical evaluation (.14).

Table 3.6. Latin America Study Details

	Citation Country	Purpose	Place	Design method	Sample	Data collection, time period, year collected
71	Berry. 2006 Guatemala	Reasons women delay seeking hospital treatment for labor/delivery complications	Home vs. hospital	ethnography	122 ♀	Semi-structured interviews Participant observation Timing not given 2000-2003

SA3. Women know and understand risks in birth. However, they interpret their knowledge of self in ways that effectively minimize risk status, allowing them to remain at home (.67).
SA4. Women avoid hospitals for birth because of the stigma associated with hospital delivery; a belief that spiritual deficiency causes birthing difficulty (.67).
SA5. Women avoid hospitals for birth because of the poor quality of care (.67).
SA9. Women were unable to go to hospitals for childbirth because of the costs, which must be prepaid for hospital, surgery, and blood (.67).
SA10. Women in Guatemala prefer to deliver at home with an Iyom (TBA) who is a birthing specialist; at home the emphasis is on social and spiritual factors affecting birth. Women believe that birth is normal process. Localized knowledge of what is effective obstetrical (birthing) knowledge, gained from personal experience of the Iyom (.33).
SA11. Women in Guatemala prefer to deliver at home where they receive individualized attention and the care is personalized to their situation. Social variables were prioritized – increases odds women will survive complication (.33).
SA 16. Women avoid hospitals for birth because they fear surgery(.33). .
SA17. Women avoid hospitals for birth because they believe c/s leads to future infertility (confused with tubal ligation) (.33).
SA26. Women believe that physical complications were symptoms of social problems (not treatable by biomedicine) best treated by Iyom at home (.33).
SA27. Women avoid hospitals because biomedical knowledge changes frequently, and is often contradictory (.33).

72	McCallum & Dos Res. 2008 Brazil	Describe effect of cultural practices on normal birth in hospital	Dehumanizing care in hospital	qualitative descriptive, cross section	26 ♀ 146 staff	Interview and participant observation "Women who recently gave birth" 2002-03

SA1. Women prefer birthplaces where they have the opportunity to move, change position (.67).
SA2. Women like hospital birthplaces because they were perceived as modern, safe, hygienic, and having clean air (.67).
SA6. Women avoid hospitals for birth because the hospital staff is rude and dismissive of the social aspects of birth (.67).
SA7. Women avoid hospitals for birth because the hospital birth experience is characterized by discomfort, fear, pain, and abandonment (.67).
SA8. Women avoid hospitals for birth because of the social divide between caregivers and women in labor (.67).
SA12. Women prefer hospitals for birth because they provide access to professionals' technical skill, birthing technology, high status OBs, warm showers, free meals, clean clothes (.33).
SA14. Physician's role in hospital births is to come as close to technical perfections as possible – aim is for a good outcome for mother and baby – no time for emotional support of women (.33).
SA15. Women receiving care in hospital for labor delivery undergo routine interventions including pubic shave, oxytocin augmentation, and episiotomy. Epidural anesthesia is not offered, even though covered by national health insurance system (.33).
SA21. Women were unable to go to hospitals for childbirth because of the unavailability of beds in hospitals (.33).

73	Otis & Brett. 2008 Bolivia	Explain reasons why women do not use free medical services in government run health facilities	Home vs. hospital	qualitative descriptive, cross section	44 ♀ 18 ♂	Participant observation, semi-structured interviews, open ended interviews

	Within 5 yrs 2005
SA1. Women prefer birthplaces where they have the opportunity to move, change position (.67). SA2. Women like hospital birthplaces because they were perceived as modern, safe, hygienic, and having clean air (.67). SA3. Women know and understand risks in birth. However, they interpret their knowledge of self in ways that effectively minimize risk status, allowing them to remain at home (.67). SA4. Women avoid hospitals for birth because of the stigma associated with hospital delivery; a belief that spiritual deficiency causes birthing difficulty (.67). SA5. Women avoid hospitals for birth because of the poor quality of care (.67). SA6. Women avoid hospitals for birth because the hospital staff is rude and dismissive of the social aspects of birth (.67). SA7. Women avoid hospitals for birth because the hospital birth experience is characterized by discomfort, fear, pain, and abandonment (.67). SA8. Women avoid hospitals for birth because of the social divide between caregivers and women in labor (.67). SA9. Women were unable to go to hospitals for childbirth because of the costs, which must be prepaid for hospital, surgery, and blood (.67). SA13. Women prefer birthplaces that allow family members in the room (.33). SA18. Women avoid hospitals for birth because hospitals were associated with death – including for pregnant women (.33). SA19. Women were unable to go to hospitals for childbirth because of the associated costs: travel, lodging, lost days of work, medicine, sheets, gas, laundry, food (.33). SA20. Women were unable to go to hospitals for childbirth because travel to hospital requires planning for transportation, childcare (.33). SA22. Women were unable to go to hospitals for childbirth because they must find someplace to stay during postpartum (.33). SA23. Women were unable to go to hospitals for childbirth because they must arrange childcare for other children (social) (.33). SA24. Women were unable to go to hospitals for childbirth because of the distance to hospital (.33). SA25. Women were unable to go to hospitals for childbirth because local hospitals not equipped to properly care for women in labor (.33).	

Table 3.7. Middle East Study Details

	Citation Country	Purpose	Place	Design method	Sample	Data collection, time period, year collected
74	El-Nemer et al. 2006 Egypt	Compare women's experiences of hospital and home birth	Home vs. hospital	Observational descriptive ethnography	21 ♀	Non-participant observation Interviews - During labor and immediate postpartum Reflective research diary 2000-2005

ME1. Women prefer a birthplace where they have freedom of movement (100).
ME2. Women wish to avoid birthplaces with routine interventions (100).
ME3. Women who labored and delivered in hospital experienced routine interventions including fetal heart rate monitor, IV w/ oxytocin, frequent vaginal exams, and deliver in lithotomy position (.50).
ME4. Women who labored and delivered in hospital perceived their environment as lacking privacy (.50).
ME5. Women who labored and delivered in hospital reported no skin-to-skin contact after birth (.50).
ME6. Women who labored and delivered in hospital described the nurses as being proximally close, but without providing emotional care (.50).
ME7. Women who labored and delivered in hospital reported that some nurses provided physical and emotional care (.50).
ME8. Women who labored and delivered in hospital described physical contact by professionals as a technical, medical touch – for procedures only; without care and objectifying (.50).
ME9. Women who labored and delivered in hospital reported rude and demeaning behavior by medical /nursing staff toward them (.50).
ME10. Women who labored and delivered in hospital reported poor communication by medical/nursing staff (.50).
ME11. Women who labored and delivered in hospital perceived their environment as isolating and lonely – even when nurses were present (.50).
ME12. Women who labored and delivered in hospital described their experiences as physical suffering (.50).
ME13. Women who labored and delivered in hospital perceived the absence of social support (.50).
ME14. Women who labored and delivered in hospital perceived safety from the presence of technology and skilled providers – yet believed this exposed low risk women to increased risk resulting from interventions (.50).
ME15. Women who labored and delivered at home perceived no time restraints on their labor (.50).
ME16. Women who labored and delivered at home described their experience as easy (.50).
ME17. Women who labored and delivered at home perceived compassionate, confident, continuous care by daya (TBA) at home (.50).
ME18. Women who labored and delivered at home reported they experienced freedom of movement, opportunities to eat, engagement in distracting activities, and sleep (.50).
ME19. Women who labored and delivered at home described their care as individualized, their daya was able to respond to unpredictable events (.50).
ME20. Women who labored and delivered at home reported their daya provided personalized advice about food, water, activity, to help labor, ease pain; embodied knowledge (.50).
ME21. Women who labored and delivered at home described care provided by daya as mothering (.50).

75	Pridel & Pirdel. 2009 Iran	Determine which environmental factors (in hospital) increase tension during labor	Hospital environment	Descriptive Comparative Cross section	600♀	Questionnaire (likert-type) Immediate postpartum (4th stage – in hospital) 2005-06

ME1. Women prefer a birthplace where they have freedom of movement (100).
ME2. Women wish to avoid birthplaces with routine interventions (100).
ME22. Women prefer a quiet birthplace (.50).
ME23. Women prefer a birthplace that provides privacy (.50).
ME24. Women prefer a birthplace where their family can provide support (.50).

ME25. Women prefer a birthplace that allows them to drink (.50).
ME26. For women who delivered in hospital, there was a significant positive correlation between pain and labor stress from environmental factors (.50).

Table 3.8. Australia/New Zealand Study Details

	Citation Country	Purpose	Place	Design method	Sample	Data collection, time period, year collected
76	Hauck et al. 2008 Australia	Describe women's experiences using Snoezelen room for labor	Alternative hospital environment	Qualitative Descriptive	16 ♀	Interview 6 wks postpartum 2005-06

ANZ1. Women report they were able to relax and give into birth forces when birthplace environments were quiet, private, painted in soothing colors, promote freedom of movement, contain comfortable furniture, distractions, pleasant smells, avoid prominent clinical features such as labor bed, and accommodate support persons, and have medical support available (.50).
ANZ2. Women prefer birthplaces with windows and view to outside (.50).

77	Maude & Foureur. 2007 New Zealand	Describe women's experiences of immersion in water during labor/deliver	Micro-environment of water	Qualitative Descriptive	5 ♀	Interview 4-21 days postpartum 2001

ANZ3. Women in New Zealand who were immersed in the warm water of a birthing pool were able to move around, change posture and achieve effective relaxation and comfort in the water because of the large size and depth of the tub (.50).
ANZ4. Women in New Zealand who were immersed in the warm water of a birthing pool situated within a hospital appreciated the pool was placed in a corner, and not as the focal point of the room, it helped them forget they were in a hospital (.50).
ANZ5. Women in New Zealand who were immersed in the warm water of a birthing pool described an all-encompassing warming effect engendered by being in the water that was relaxing, soothing, and comforting. Immersion in this environment altered their perception of pain, provided a barrier between themselves and their companions, afforded a sense of privacy, and gave women the ability to move away from people when she wanted (.50).
ANZ6. Women in New Zealand who were immersed in the warm water of a birthing pool were able to block out everything else in their environment, while maintaining awareness of everything that was going on (.50).

Table 3.9. Europe Effect Sizes

	Summary sentence and references	Effect size
E1.	1. Women wanted to deliver in a familiar birthplace where they could exert control over their environment. (.37) (Borquez & Wiegers, 2006) (Johnson, Callister, Freeborn, Beckstrand, & Huender, 2007) (H. Lindgren, Hildingsson, & Radestad, 2006) (H. E. Lindgren, Radestad, Christensson, Wally-Bystrom, & Hildingsson, 2010) (Melender, 2006) (Neuhaus, Piroth, Kiencke, Gohring, & Mallman, 2002) (Sjoblom, Nordstrom, & Edberg, 2006) (Wiklund, Matthiesen, Klang, & Ransjo-Arvidson, 2002)	0.42 8/19
E2.	2. Women considered aspects of safety when they chose their birthplace. (.37) (Borquez & Wiegers, 2006) (Johnson et al., 2007) (Kukulu & Oncel, 2009) (H. Lindgren et al., 2006) (H. E. Lindgren et al., 2010) (H. E. Lindgren et al., 2010) (Sjoblom et al., 2006) (K. Viisainen, 2000)	0.37 7/19
E3.	3. Women wanted to deliver in a birthplace where they could avoid unnecessary or routine interventions and use of technology. (.37) (H. E. Lindgren et al., 2010) (Melender, 2006) (Neuhaus et al., 2002) (Nilsson, Bondas, & Lundgren, 2010) (van Der Hulst, van Teijlingen, Bonsel, Eskes, & Bleker, 2004) (K. Viisainen, 2000) (K. Viisainen, 2001) (Wiklund et al., 2002)	0.37 7/19
E4.	4. An ideal birth environment provides women with the opportunity to control pain (0.32). (Chalmers & Jeckaite, 2010) (Melender, 2006) (Neuhaus et al., 2002) (Nilsson et al., 2010) (Pavlova, Hendrix, Nouwens, Nijhuis, & van Merode, 2009) (Rijnders et al., 2008)	0.32 6/19
E5.	5. Women who labored and delivered at home perceived the care they received by their midwife to be confident, competent, supportive, intensive, personalized and satisfying (0.32). (Borquez & Wiegers, 2006) (Christiaens & Bracke, 2009) (Johnson et al., 2007) (Kukulu & Oncel, 2009) (Neuhaus et al., 2002) (Sjoblom et al., 2006)	0.32 6/19
E6.	6. Women want a birthplace where they can be involved in decision-making about their labor and birth (0.32). (H. E. Lindgren et al., 2010) (Melender, 2006) (Neuhaus et al., 2002) (K. Viisainen, 2000) (K. Viisainen, 2001) (Waldenstrom, Rudman, & Hildingsson, 2006) (Wiklund et al., 2002)	0.32 6/19

E7.	7. Women want a birthplace that is natural with a peaceful, unhurried atmosphere, and no outside influences where they can relax (0.32). (Johnson et al., 2007) (Melender, 2006) (Neuhaus et al., 2002) (Pavlova et al., 2009) (Sjoblom et al., 2006) (K. Viisainen, 2000) (K. Viisainen, 2001)	0.32 6/19
E8.	8. Women wish to avoid hospitals for birth because of the poor behavior by hospital staff that they describe as rude, hostile strangers who speak as if woman not present, and were impersonal and not caring (0.32). (Kukulu & Oncel, 2009) (H. Lindgren et al., 2006) (H. E. Lindgren et al., 2010) (Nilsson et al., 2010) (K. Viisainen, 2001) (Wiklund et al., 2002)	0.32 6/19
E9.	9. Women want their birthplace to be cozy, comfortable, trustworthy, relaxed, calm quiet, warm, secure and have dimmable lights, soothing colors, and accessory equip (0.26). (Borquez & Wiegers, 2006) (Johnson et al., 2007) (Kukulu & Oncel, 2009) (Melender, 2006) (Pavlova et al., 2009)	0.26 5/19
E10.	10. Women want to have medical help available during labor and delivery. Some women choose to deliver in hospital because of the ready availability of medical help. Women who deliver at home make transportation plans in the event complications occur (0.21). (Borquez & Wiegers, 2006) (Johnson et al., 2007) (Pavlova et al., 2009) (H. Lindgren et al., 2006) (K. Viisainen, 2000) (K. Viisainen, 2001)	0.26 5/19
E11.	11. Women who gave birth in hospital stated they did not receive necessary support and presence from their midwife; they felt alone, with nobody present who could help them (0.21). (Borquez & Wiegers, 2006) (Nilsson et al., 2010) (K. Viisainen, 2001) (Wiklund et al., 2002)	0.21 4/19
E12.	12. Women want a birthplace that accommodates their support persons and permits an intense family experience (0.21). (Johnson et al., 2007) (Kukulu & Oncel, 2009) (Neuhaus et al., 2002) (Sjoblom et al., 2006)	0.21 4/19
E13.	13. Women who labored and delivered at home (out of hospital) were more likely to want to deliver their next baby in the same place compared to women who delivered in the birth center(hospital) (0.16). (Borquez & Wiegers, 2006) (Neuhaus et al., 2002) (Rijnders et al., 2008)	0.16 3/19
E14.	14. Women who labored and delivered at home were more satisfied with their birth setting than women who labored and delivered at a birth center (hospital) (0.16). (Borquez & Wiegers, 2006) (Christiaens & Bracke, 2009)	0.16 3/19

	(Rijnders et al., 2008)	
E15.	15. Women who labored and delivered at a birth center(hospital) perceived their birth place to be more strange and anxiety producing than women who delivered at home (0.16). (Borquez & Wiegers, 2006) (H. Lindgren et al., 2006) (Nilsson et al., 2010)	0.16 3/19
E16.	16. Women want their birthplace to be private and intimate (0.16). (Johnson et al., 2007) (Melender, 2006) (K. Viisainen, 2000) (K. Viisainen, 2001)	0.16 3/19
E17.	17. Women do not like having to travel and change environments during labor. They wish to avoid having to make decision about the right time to go to hospital, and travel home after delivery (0.16). (H. E. Lindgren et al., 2010) (Sjoblom et al., 2006) (Borquez & Wiegers, 2006)	0.16 3/19
E18.	18. Women want caring, attentive caregiver throughout labor, wherever they deliver (.16). (Carlsson, Hallberg, & Odberg Pettersson, 2009) (Nilsson et al., 2010) (Melender, 2006)	0.16 3/19
E19.	19. Uncontrolled labor/delivery pain leads to very negative /traumatic experience whether in or out of hospital (0.11). (Neuhaus et al., 2002) (Nilsson et al., 2010)	0.11 2/19
E20.	20. Women who labor/deliver in familiar surroundings (home, known birth center) report less pain and/or receive less pain medicine (epidural) or were more likely to use alternative pain relieving methods than women who were in unfamiliar birth places (hospitals, referred to unfamiliar birth center/hospital) (0.11). (Wiklund et al., 2002) (Borquez & Wiegers, 2006)	0.11 2/19
E21.	21. Satisfaction with intrapartum care in Sweden is negatively affected by dissatisfaction with hospital birth environment (0.11). (Waldenstrom et al., 2006) (Rudman, El-Khouri, & Waldenstrom, 2007)	0.11 2/19
E22.	22. Women who labored and delivered at home described their birth place to be more safe, intimate, comfortable and trust-worthy than women who delivered in a birth center(hospital) (0.11). (Borquez & Wiegers, 2006) (van Der Hulst et al., 2004)	0.11 2/19
E23.	23. Women like to labor and deliver at home so they can be in their own place with their own belongings (0.11). (Borquez & Wiegers, 2006) (Sjoblom et al., 2006)	0.11 2/19
E24.	24. Women who delivered in hospital stated that lack of control (in hospital) prevented them from feeling secure in hospital (0.11). (Nilsson et al., 2010) (K. Viisainen, 2000)	0.11 2/19
E25.	25. Women who delivered at home believe home is a better birthplace for baby (0.11). (Kukulu & Oncel, 2009) (Neuhaus et al., 2002)	0.11 2/19
E26.	26. Women want to deliver in a birthplace where the caregiver provides information about labor	0.11

	progress (0.11). (Nilsson et al., 2010) (Sjoblom et al., 2006)	2/19
E27.	27. Women who delivered in a birthcenter (hospital) stated it was not comfortable (0.11). (Borquez & Wiegers, 2006) (Nilsson et al., 2010)	0.11 2/19
E28.	28. Women who plan to deliver at home felt stigmatized by medical profession (0.11). (H. E. Lindgren et al., 2010) (K. Viisainen, 2000)	0.11 2/19
E29.	29. Women planning hospital birth have difficulty gaining access to hospital if they do not meet criteria for admission and were uncomfortable returning home when home is located far away from the hospital (0.11). (Carlsson et al., 2009) (Nilsson et al., 2010)	0.11 2/19
E30.	30. Women who plan to labor and deliver at home must prepare mentally by breathing, information gathering, and physically by arranging for caregiver, child care, and transportation in event of complication (0.11). (H. Lindgren et al., 2006) (H. E. Lindgren et al., 2010)	0.11 2/19
E31.	31. Hospital exposed to WHO guidelines has higher epidural rate (but fewer women walked during labor) compared to traditional hospital in Lithuania (0.05). (Chalmers & Jeckaite, 2010)	0.05 1/19
E32.	32. Women who planned out of hospital delivery, but delivered in hospital, wish next delivery to occur at home (0.05). (Neuhaus et al., 2002)	0.05 1/19
E33.	33. Women who were referred to unfamiliar birth place reported greater importance of knowing where birth would take place than women who were not referred (0.05). (Wiklund et al., 2002)	0.05 1/19
E34.	34. Women who were accepting of technology tend to chose hospital birth (0.05). (van Der Hulst et al., 2004)	0.05 1/19
E35.	35. Nulliparous women who planned hospital births were more likely to experience episiotomy, consultation, referral to secondary care, obstetrical interventions of labor induction, labor augmentation, pain relief, assisted delivery and cesarean section. They were less likely to experience midwife interventions of sweeping membranes and amniotomy (0.05). (van Der Hulst et al., 2004)	0.05 1/19
E36.	36. Multiparous women who planned hospital births were more likely to experience episiotomy, labor augmentation but less likely to have their labors induced (0.05). (van Der Hulst et al., 2004)	0.05 1/19
E37.	37. Multiparous women who planned hospital births were significantly more likely to experience consultation, referral to secondary care, obstetrical interventions, pain relief, assisted delivery and cesarean section (0.05). (van Der Hulst et al., 2004)	0.05 1/19
E38.	38. Women state that the hospital staff takes over birth process and do not acknowledge women's knowledge (0.05). (K. Viisainen, 2000)	0.05 1/19
E39.	39. 9% of women who delivered in hospital in Sweden were very satisfied with birth environment (0.05). (Rudman et al., 2007)	0.05 1/19

E40.	40. Size of hospital in Sweden does not affect satisfaction with intrapartum care (0.05). (Waldenstrom et al., 2006)	0.05 1/19
E41.	41. Women perceive that hospitals take away their responsibility, identity and choice (0.05). (K. Viisainen, 2000)	0.05 1/19
E42.	42. Women who plan to deliver at home use prenatal medical screening technology for reassurance of safety (0.05). (K. Viisainen, 2000)	0.05 1/19
E43.	43. Women who plan to deliver at home redefine possible risks within their personal contexts (performed own research to counter info given by medical professionals) in ways that minimize the meaning of risk. The result is an increase in the risk threshold allowing them to remain at home (0.05). (K. Viisainen, 2000)	0.05 1/19
E44.	44. Women who plan home births assume responsibility for outcomes of birth, regardless of where they occur, as it is they who must deal with long and short term consequences of the harm (0.05). (K. Viisainen, 2000)	0.05 1/19
E45.	45. Some women perceive birth centers (hospital) to be more convenient birthplaces (0.05). (Borquez & Wiegers, 2006)	0.05 1/19
E46.	46. Women want a birthplace where they have freedom to move around (0.05). (Melender, 2006)	0.05 1/19
E47.	47. Women who plan to labor and deliver in hospital wish to be admitted when their contractions become painful. They experience a sense of safety and security in the hospital, appreciate the opportunity to hand over responsibility for their wellbeing and that of their baby to competent professionals. They do not like to be sent home, and attempt to exert control over the situation by being admitted early (0.05). (Carlsson et al., 2009)	0.05 1/19
E48.	48. Some women who delivered at home stated their home was too small (0.05). (Borquez & Wiegers, 2006)	0.05 1/19
E49.	49. Lack of communication (information sharing) made women feel insecure about their place in hospital (0.05). (Nilsson et al., 2010)	0.05 1/19
E50.	50. Women want to avoid birthplaces that focus on technology (0.05). (K. Viisainen, 2000) (K. Viisainen, 2001)	0.05 1/19
E51.	51. Some women avoid hospitals for delivery because they believe errors /hazards can be covered up by institution (0.05). (K. Viisainen, 2000)	0.05 1/19
E52.	52. Women avoid hospitals for birth because of the association with sickness (0.05). (Neuhaus et al., 2002)	0.05 1/19
E53.	53. Women who plan home delivery do not trust medical professionals to be honest about risk status (0.05). (K. Viisainen, 2000) (K. Viisainen, 2001)	0.05 1/19
E54.	54. Women in Turkey delivered at home because they could not afford to deliver in hospital (0.05). (Kukulu & Oncel, 2009)	0.05 1/19
E55.	55. Women in Turkey delivered at home because it was too difficult to reach hospital (0.05). (Kukulu & Oncel, 2009)	0.05 1/19
E56.	56. Some women in Turkey delivered at home because their spouses or relatives decided (0.05).	0.05

	(Kukulu & Oncel, 2009)	1/19
E57.	57. Women with less money who live farther from hospital prefer hospital delivery (0.05). (Pavlova et al., 2009)	0.05 1/19
E58.	58. Women who planned home birth faced reluctance by family at first (0.05). (H. Lindgren et al., 2006)	0.05 1/19
E59.	59. Women who delivered in hospital stated their husbands mediated potentially bad relationship with midwife in hospital and performed support activities expected of midwife (0.05). (Nilsson et al., 2010)	0.05 1/19

Table 3.10. Sub-Saharan Africa Effect Sizes

Summary sentence and references	Effect size
SS1. Women in Africa do not need to plan or prepare for delivery at home. Women in Africa who deliver at health facilities have to make elaborate preparations including the purchase of supplies, saving money for delivery expenses, transportation arrangements, and childcare. (Adamu & Salihu, 2002) (Amooti-Kaguna & Nuwaha, 2000) (Bazzano, Kirkwood, Tawiah-Agyemang, Owusu-Agyei, & Adongo, 2008) (Ekele & Tunau, 2007) (Izugbara & Ukwayi, 2004) (Jansen, 2006) (Magoma, Requejo, Campbell, Cousens, & Filippi, 2010) (Mathole, Lindmark, & Ahlberg, 2005) (Mrisho et al., 2007) (Osubor, Fatusi, & Chiwuzie, 2006) (Pettersson, Christensson, de Freitas, & Johansson, 2004) (Spangler & Bloom, 2010) (van den Boogaard et al., 2008) (Weeks, Lavender, Nazziwa, & Mirembe, 2005)	0.88 14/16
SS2. Women in Africa avoid hospitals (Adamu & Salihu, 2002) (Amooti-Kaguna & Nuwaha, 2000) (Bazzano et al., 2008) (Ekele & Tunau, 2007) (Izugbara & Ukwayi, 2004) (Jansen, 2006) (Magoma et al., 2010) (Mathole et al., 2005) (Mrisho et al., 2007) (Osubor et al., 2006) (Pettersson et al., 2004) (Spangler & Bloom, 2010) (Weeks et al., 2005)	0.81 13/16
SS3. Women in Africa must make preparations to deliver at hospital (Adamu & Salihu, 2002) (Amooti-Kaguna & Nuwaha, 2000) (Bazzano et al., 2008) (Ekele & Tunau, 2007) (Magoma et al., 2010) (Mathole et al., 2005) (Mrisho et al., 2007) (Osubor et al., 2006) (Pettersson et al., 2004) (Spangler & Bloom, 2010) (Weeks et al., 2005)	0.69 11/16
SS4. Women in Africa prefer home (Adamu & Salihu, 2002) (Amooti-Kaguna & Nuwaha, 2000) (Bazzano et al., 2008) (Izugbara & Ukwayi, 2004) (Jansen, 2006) (Magoma et al., 2010) (Mathole et al., 2005) (Mrisho et al., 2007) (Osubor et al., 2006) (Spangler & Bloom, 2010) (Pettersson et al., 2004)	.69 11/16

SS5. Women in Africa were prevented from using health facilities for labor and delivery because of the costs of care. (Adamu & Salihu, 2002) (Amooti-Kaguna & Nuwaha, 2000) (Bazzano et al., 2008) (Ekele & Tunau, 2007) (Jansen, 2006) (Mathole et al., 2005) (Mrisho et al., 2007) (Osubor et al., 2006) (Pettersson et al., 2004) (Spangler & Bloom, 2010) (Weeks et al., 2005)	0.69 11/16
SS6. Women in Africa avoid hospital and clinics for childbirth because of the costs of one or more of the following: facility fees, professional fees, supplies, new clothes for infant, food, opportunity costs, and transportation. (Adamu & Salihu, 2002) (Amooti-Kaguna & Nuwaha, 2000) (Bazzano et al., 2008) (Ekele & Tunau, 2007) (Magoma et al., 2010) (Mrisho et al., 2007) (Osubor et al., 2006) (Pettersson et al., 2004) (Spangler & Bloom, 2010)	0.56 9/16
SS7. Women in Africa prefer to labor and deliver at home or at a traditional birth home because the pregnancy is normal (without complications), and delivering at home is the norm (typical, accepted). (Adamu & Salihu, 2002) (Amooti-Kaguna & Nuwaha, 2000) (Bazzano et al., 2008) (Izugbara & Ukwayi, 2004) (Jansen, 2006) (Magoma et al., 2010) (Mrisho et al., 2007) (Osubor et al., 2006) (Pettersson et al., 2004)	0.56 9/16
SS8. Women in Africa who labor and deliver at home, or in traditional birth homes, typically experience one or more of the following: fast, easy labor, less painful labor, affectionate, confident, and skilled care by traditional birth attendants and relatives, choice of delivery position, husband or mother-in-law determines if and when to go to facility (Adamu & Salihu, 2002) (Amooti-Kaguna & Nuwaha, 2000) (Bazzano et al., 2008) (Jansen, 2006) (Magoma et al., 2010) (Mrisho et al., 2007) (Osubor et al., 2006) (Pettersson et al., 2004)	0.56 9/16
SS9. Women in Africa avoid hospital and clinics for childbirth because of the poor attitude displayed by health professionals (rude behavior of nurses/midwifes) (Amooti-Kaguna & Nuwaha, 2000) (Bazzano et al., 2008) (Ekele & Tunau, 2007) (Jansen, 2006) (Mrisho et al., 2007) (Pettersson et al., 2004) (Spangler & Bloom, 2010) (Weeks et al., 2005)	0.50 8/16

SS10. Husbands, mothers-in-law, and other relatives were decision makers about place of delivery. (Adamu & Salihu, 2002) (Amooti-Kaguna & Nuwaha, 2000) (Bazzano et al., 2008) (Ekele & Tunau, 2007) (Magoma et al., 2010) (Mrisho et al., 2007) (Pettersson et al., 2004) (Spangler & Bloom, 2010)	0.50 8/16
SS11. Women in Africa perceive risks associated with labor and birth in health facilities, including one or more of the following: episiotomy, gossip, stigma, loss of status, loss of privacy, loss of secrecy, poor care, criticism, scolding, painful vaginal exams, care by male provider, witchcraft, medical operation, intervention, financial hardship, (Bazzano et al., 2008) (Jansen, 2006) (Magoma et al., 2010) (Mathole et al., 2005) (Osubor et al., 2006) (Pettersson et al., 2004) (Spangler & Bloom, 2010)	0.44 7/16
SS12. Women in Africa avoid hospital and clinics for childbirth because of the high rate of interventions (Adamu & Salihu, 2002) (Bazzano et al., 2008) (Izugbara & Ukwayi, 2004) (Magoma et al., 2010) (Mathole et al., 2005) (Osubor et al., 2006) (Pettersson et al., 2004)	0.44 7/16
SS13. Women in Africa avoid hospital and clinics for childbirth because of poor quality of care or lack of confidence in the staff. (Adamu & Salihu, 2002) (Amooti-Kaguna & Nuwaha, 2000) (Bazzano et al., 2008) (Mrisho et al., 2007) (Osubor et al., 2006) (Pettersson et al., 2004) (Weeks et al., 2005)	0.44 7/16
SS14. Women in Africa prefer to labor and deliver at home or at a traditional birth home because of the high quality of care they receive from relatives and TBAs, and confidence in the TBA. (Adamu & Salihu, 2002) (Amooti-Kaguna & Nuwaha, 2000) (Izugbara & Ukwayi, 2004) (Jansen, 2006) (Magoma et al., 2010) (Mathole et al., 2005) (Osubor et al., 2006)	0.44 7/16
SS15. Women in Africa were prevented from using health facilities for labor and delivery because there is no transportation available. (Amooti-Kaguna & Nuwaha, 2000) (Ekele & Tunau, 2007) (Jansen, 2006) (Magoma et al., 2010) (Mathole et al., 2005) (Mrisho et al., 2007) (Weeks et al., 2005) –	0.44 7/16

SS16. Women in Africa were prevented from using health facilities for labor and delivery because their husbands or mothers-in-law forbid it. (Adamu & Salihu, 2002) (Amooti-Kaguna & Nuwaha, 2000) (Bazzano et al., 2008) (Ekele & Tunau, 2007) (Magoma et al., 2010) (Pettersson et al., 2004) (Spangler & Bloom, 2010)	0.44 7/16
SS17. Women in Africa were prevented from using health facilities for labor and delivery because of the distance. (Amooti-Kaguna & Nuwaha, 2000) (Magoma et al., 2010) (Mrisho et al., 2007) (Spangler & Bloom, 2010) (van den Boogaard et al., 2008)	0.38 6/16
SS18. Women in Africa avoid hospital and clinics for childbirth because they were afraid of medical operations. (Bazzano et al., 2008) (Magoma et al., 2010) (Mathole et al., 2005) (Osubor et al., 2006) (Pettersson et al., 2004)	0.31 5/16
SS19. Women in Africa avoid hospitals and clinics for childbirth because there is no privacy. (Adamu & Salihu, 2002) (Ekele & Tunau, 2007) (Izugbara & Ukwayi, 2004) (Mrisho et al., 2007) (Spangler & Bloom, 2010) Privacy – opportunity to be physically shielded from others.	0.31 5/16
SS20. Women in Africa prefer to labor and deliver at home or at a traditional birth home because it is more affordable (Adamu & Salihu, 2002) (Amooti-Kaguna & Nuwaha, 2000) (Bazzano et al., 2008) (Izugbara & Ukwayi, 2004) (Spangler & Bloom, 2010)	0.31 5/16
SS21. Female relatives provide support to women laboring at home in Africa. (Adamu & Salihu, 2002) (Jansen, 2006) (Magoma et al., 2010) (Pettersson et al., 2004) (Spangler & Bloom, 2010)	0.31 5/16
SS22. Women in Africa prefer to labor and deliver in a health facility when there is a known complication. (Amooti-Kaguna & Nuwaha, 2000) (Jansen, 2006) (Magoma et al., 2010) (Pettersson et al., 2004) (Spangler & Bloom, 2010)	0.31 5/16
SS23. Women in Africa avoid hospital and clinics for childbirth because of the high rate of routine interventions including one or more of the following: vaginal examination, episiotomies, repair of vaginal tears, requirement to bathe and wear hospital gown. (Adamu & Salihu, 2002) (Izugbara & Ukwayi, 2004) (Magoma et al., 2010) (Pettersson et al., 2004)	0.25 4/16

SS24. Women in Africa prefer to labor and deliver at home or at a traditional birth home because they were closer and more convenient	0.25
(Adamu & Salihu, 2002) (Amooti-Kaguna & Nuwaha, 2000) (Izugbara & Ukwayi, 2004) (Osubor et al., 2006)	4/16
SS25. Women in Africa prefer to labor and deliver at home or at a traditional birth home because they can choose their delivery position	0.25
(Adamu & Salihu, 2002) (Magoma et al., 2010) (Osubor et al., 2006) (Pettersson et al., 2004)	4/16
SS26. Women in Africa were prevented from using health facilities for labor and delivery because they delivered too quickly.	0.25
(Adamu & Salihu, 2002) (Amooti-Kaguna & Nuwaha, 2000) (Ekele & Tunau, 2007) (Mrisho et al., 2007)	4/16
SS27. Women in Africa prefer to deliver where they, or their family, delivered in the past (habit).	0.25
(Amooti-Kaguna & Nuwaha, 2000) (Magoma et al., 2010) (Stephenson, Baschieri, Clements, Hennink, & Madise, 2006) (van den Boogaard et al., 2008)	4/16
SS28. Women in Africa do not perceive risks associated with labor and birth when their pregnancies were labeled normal (without complication), and were therefore confident laboring and delivering at home.	0.25
(Amooti-Kaguna & Nuwaha, 2000) (Izugbara & Ukwayi, 2004) (Jansen, 2006) (Magoma et al., 2010)	4/16
SS29. Women in Africa avoid hospital and clinics for childbirth because they were forced to lie in lithotomy position for delivery.	0.19
(Adamu & Salihu, 2002) (Magoma et al., 2010) (Pettersson et al., 2004)	3/16
SS30. Women in Africa avoid hospitals and clinics for childbirth because they believe they were easier targets of witchcraft there.	0.19
(Bazzano et al., 2008) (Osubor et al., 2006) (Spangler & Bloom, 2010)	3/16
SS31. Women in Africa prefer to labor and deliver at home or at a traditional birth home because of the ability to keep labor a secret. Secrecy – keep personal information confidential.	0.19
(Bazzano et al., 2008) (Izugbara & Ukwayi, 2004) (Mrisho et al., 2007)	3/16
SS32. Women in Africa were prevented from using health facilities for labor and delivery because of the onerous referral process when complications occur during labor at home or at a peripheral health unit.	0.19
(Mathole et al., 2005) (Pettersson et al., 2004) (Weeks et al., 2005)	3/16

SS33. Women in Africa were prevented from using health facilities for labor and delivery because there were no facilities available, or the facilities were not staffed when they need them. (Jansen, 2006) (Osubor et al., 2006) (Spangler & Bloom, 2010)	0.19 3/16
SS34. Women in Africa were prevented from using health facilities for labor and delivery because they have not collected supplies required by the facility for themselves or their babies. (Bazzano et al., 2008) (Mrisho et al., 2007) (Pettersson et al., 2004)	0.19 3/16
SS35. Women in Africa prefer to labor and deliver in a health facility because it is safer. (Amooti-Kaguna & Nuwaha, 2000) (Pettersson et al., 2004) (Spangler & Bloom, 2010)	0.19 3/16
SS36. Midwives were rude in health centers/affectionate in home or private maternity home (Amooti-Kaguna & Nuwaha, 2000) (Osubor et al., 2006) (Pettersson et al., 2004)	0.19 3/16
SS37. Women in Africa avoid hospital and clinics for childbirth because of the presence of male staff. (Adamu & Salihu, 2002) (Mrisho et al., 2007)	0.13 2/16
SS38. Women in Africa avoid hospital and clinics for childbirth because of the stigma associated with hospital deliveries (Bazzano et al., 2008) (Spangler & Bloom, 2010)	0.13 2/16
SS39. Women in Africa avoid hospital and clinics for childbirth because they believe in predestination or God's will (Adamu & Salihu, 2002) (Pettersson et al., 2004)	0.13 2/16
SS40. Women in Africa avoid hospitals and clinics for childbirth because they face discrimination based on poverty and or ethnicity (Spangler & Bloom, 2010) (Pettersson et al., 2004)	0.13 2/16
SS41. Women in Africa prefer to labor and deliver at home or at a traditional birth home because they can care for the placenta (Jansen, 2006) (Pettersson et al., 2004)	0.13 2/16
SS42. Women in Africa prefer to labor and deliver at home because it increases their status. (Bazzano et al., 2008) (Jansen, 2006)	0.13 2/16
SS43. Prolonged labor is one reason women seek assistance at a health facility for delivery in Africa. Dishonesty about the paternity of the baby is a common explanation for prolonged labor in Africa. (Bazzano et al., 2008) (Mrisho et al., 2007)	0.13 2/16
SS44. User fees charged at health facilities (which increase for complicated labor/delivery) amplify risk taking when complications arise at home; because families must weigh costs vs. likelihood of survival. (Bazzano et al., 2008) (Pettersson et al., 2004)	0.13 2/16

SS45. Women in Africa prefer to labor and deliver at home or at a traditional birth home because they fear being turned away from health facilities. (Bazzano et al., 2008)	0.6 1/16
SS46. Women in Africa prefer to labor and deliver at home because their husbands prefer it. (Adamu & Salihu, 2002)	0.6 1/16
SS47. Women in Africa prefer to labor and deliver at home because it is safer. (Izugbara & Ukwayi, 2004)	0.6 1/16
SS48. Women in Africa were prevented from using health facilities for labor and delivery if they do not have admittance card obtained during prenatal care. (Bazzano et al., 2008)	0.6 1/16
SS49. Women in Africa prefer to labor and deliver in a health facility because they want to appear modern (Spangler & Bloom, 2010)	0.6 1/16
SS50. If clean delivery kits were used, women bathe before delivery, and attendants wash hands, then incidence of puerperal infection and cord infection in home deliveries equal those in health facilities. (Winani et al., 2007)	0.6 1/16

Table 3.11. United Kingdom Effect Sizes

	Summary sentence and references	Effect size
UK1.	UK1 Women who planned to labor and deliver in the hospital were accompanied at home during early labor by family members who were unfamiliar with labor, were uncomfortable seeing their loved ones in pain, were anxious about being at home. They lacked a knowledgeable and confident person to guide them through early labor. (Barnett, Hundley, Cheyne, & Kane, 2008) (Cheyne et al., 2007) (Houghton, Bedwell, Forsey, Baker, & Lavender, 2008) (Nolan & Smith, 2010)	0.33 4/12
UK2.	UK2 Women who planned to deliver in the hospital needed to have their experience of early labor validated by a health professional. They sought reassurance from a knowledgeable, confident person. They relied upon the hospital for all of their care, reassurance, information, and coping strategies. They were unprepared to deal with any of it at home. They experienced a great deal of uncertainty and lack of confidence during their time at home. (Barnett et al., 2008) (Cheyne et al., 2007) (Nolan & Smith, 2010)	0.25 3/12
UK3.	UK3 Women who planned hospital deliveries were greatly dissatisfied when they were sent home to continue laboring at home. (Barnett et al., 2008) (Cheyne et al., 2007) (Nolan & Smith, 2010)	0.25 3/12
UK4.	UK4 Women who planned to deliver in the hospital found pain relief advice from hospital inadequate to cope with pain during prolonged latent labor. They were unable to relax, and experienced increased anxiety being at home (Barnett et al., 2008) (Cheyne et al., 2007) (Nolan & Smith, 2010)	0.25 3/12
UK5.	UK5 Women had to be in active labor in order to be admitted to the hospital for labor. (Barnett et al., 2008) (Cheyne et al., 2007) (Nolan & Smith, 2010)	0.25 3/12
UK6.	UK6 Women who delivered at home or in freestanding birth center described a process that was permitted to progress naturally without imposed time restraints. (Andrews, 2004) (Walsh, 2006b)	0.16 2/12
UK7.	UK7 Women who planned to deliver in the hospital felt insecure and unsafe at home in early labor, not knowing how advanced their labor was. They attempted to use hospital-defined measures to gauge their progress at home. They were unable to differentiate latent labor from active labor. They had an underlying need for reassurance during early labor at home. (Cheyne et al., 2007) (Nolan & Smith, 2010)	0.16 2/12
UK8.	UK8 Women who planned hospital deliveries were unprepared to cope with exhaustion resulting from sleep deprivation caused by repeated nights of contractions. (Barnett et al., 2008) (Cheyne et al., 2007)	0.16 2/12
UK9.	UK9 Women who planned hospital deliveries did not feel they could be in control of or influence the birth process. (Houghton et al., 2008) (Pitchforth et al., 2009)	0.16 2/12
UK10.	UK10 Women who planned hospital deliveries believed hospital birth was safer than home birth, and were reassured by the clinical environment of the hospital	0.16

	(Houghton et al., 2008) (Pitchforth et al., 2009)	2/12
UK11.	UK11 Women who planned hospital deliveries were often unknowledgeable about what to expect in early labor. (Barnett et al., 2008) (Cheyne et al., 2007)	0.16 2/12
UK12.	UK12 Professionals caring for women in labor in the UK view pain relief in labor as a 'ladder' to climb. Women start out at home with natural methods in early labor and continue climbing as their labor progresses and they transition to the hospital for pharmacologic methods. Pain legitimizes their admission to the hospital. Women seek permission to go to the hospital. Women were able to gain admittance to hospital by expressing high levels of pain. (Burges Watson, Murtagh, Lally, Thomson, & McPhail, 2007) (Nolan & Smith, 2010)	0.16 2/12
UK13.	UK13 Women who planned to deliver in the hospital were instructed to stay at home as long as they could, until they needed pain relief. (Cheyne et al., 2007) (Nolan & Smith, 2010)	0.16 2/12
UK14.	UK14 Women prefer a birthplace that is familiar, relaxed, calm, friendly, homey, small, intimate, and where they felt comfortable arranging to suit needs. (Walker, 2000) (Walsh, 2006a) (Walsh, 2006b)	0.16 2/12
UK15.	UK15 Women in labor believed they needed to achieve a certain level of pain to be admitted to the hospital for labor. (Burges Watson et al., 2007) (Nolan & Smith, 2010)	0.16 2/12
UK16.	UK16 Women preferred birth places that allowed family members to be present and addressed women's needs not related strictly to labor, such as child care and feeding birth partners. (Walsh, 2006a) (Walsh, 2006b)	0.08 1/12
UK17.	UK17 Women who delivered at home had greater freedom to walk around, eat, drink, have family present, and engage in helpful distractions. (Andrews, 2004)	0.08 1/12
UK18.	UK18 Women reported frequent position changes during the last hour of labor at home before going to hospital. (Walsh, 2009)	0.08 1/12
UK19.	UK19 Women who delivered at home reported frequent position changes throughout labor and recorded increased contraction frequency every hour of labor until delivery. (Walsh, 2009)	0.08 1/12
UK20.	UK20 Women who delivered at home said it was easier to cope with the pain: it still hurt, but they were able to relax and engage in distracting activities, and therefore deal with it better. (Andrews, 2004)	0.08 1/12
UK21.	UK21 Women who developed PTSD stated they were forcibly restrained or their movement was restricted. (Nicholls & Ayers, 2007)	0.08 1/12
UK22.	UK22 Women who delivered at home described themselves as having had more confidence, greater control over environment, more input into decisions, and their opinions and choices respected compared to earlier hospital birth experiences. (Andrews, 2004)	0.08 1/12

UK23.	UK23 Women who delivered at home described their homes as peaceful, relaxed, familiar, private, calm, and quiet. (Andrews, 2004)	0.08 1/12
UK24.	UK24 Women who delivered at home were connected to outside world by sounds that helped keep them oriented. (Andrews, 2004)	0.08 1/12
UK25.	UK25 Women who delivered at home experienced a postpartum period that was more relaxed and celebratory, and not interrupted by having to relocate from hospital to home. (Andrews, 2004)	0.08 1/12
UK26.	UK26 Some women who planned to deliver in the hospital appreciated the comfort of being home early in labor (Cheyne et al., 2007)	0.08 1/12
UK27.	UK 27 Women who delivered at home said they received more attention and nurturing care at home compared to earlier hospital birth experiences. (Andrews, 2004)	0.08 1/12
UK28.	UK 28 Women who delivered at home appreciated the comfort of having a confident midwife in attendance who was attentive and available, but unobtrusive. (Andrews, 2004)	0.08 1/12
UK29.	UK29 Women who planned to deliver in the hospital felt the hospital staff had an agenda to keep them out of the hospital in early labor, and had little consideration for their distress when they were at home. (Nolan & Smith, 2010)	0.08 1/12
UK30.	UK 30 Women perceived greater quality of care in local midwife-led units (Pitchforth et al., 2009)	0.08 1/12
UK31.	UK31 Husbands of women who delivered at home stated they were more confident and involved in the process, and had greater knowledge of what was going on. (Andrews, 2004)	0.08 1/12
UK32.	UK32 Women who planned hospital deliveries wanted their partners to stay with them, so frequently chose to return home rather than stay in hospital alone. (Barnett et al., 2008)	0.08 1/12
UK33.	UK33 Local maternity units, led by midwives, were more accommodating to visitors and made child care arrangements easier (Pitchforth et al., 2009)	0.08 1/12
UK34.	UK34 Women who deliver in hospitals dislike being separated from their partner and family. (Walker, 2000)	0.08 1/12
UK35.	UK35 Women who planned hospital deliveries did not think the birth setting would alter their psychological or social journey into motherhood. (Houghton et al., 2008)	0.08 1/12
UK36.	UK36 Women who planned hospital deliveries view intervention as necessary and normal part of birth. (Houghton et al., 2008)	0.08 1/12
UK37.	UK37 Women whose contraction pattern slowed after entering hospital had less average cervical dilation (compared to women whose contraction pattern increased in frequency), and were more likely to spend the first hour in hospital lying in bed. They were more likely to have had longer first and second stage labor, AROM, Pitocin augmentation, requested and received pain relief, and had an assisted delivery. (Walsh, 2009)	0.08 1/12

UK38.	UK38 Women planning to deliver in midwife-led units engaged in tactics to avoid transfer to consultant-led units when complications occurred. They continued to perceive themselves as low risk and did not agree condition warranted transfer. (Walker, 2000)	0.08 1/12
UK39.	UK39 Low risk women who intended to deliver on midwife-led units in England had significantly shorter labors than woman who intended to deliver on obstetric-led units. (Symon, Paul, Butchart, Carr, & Dugard, 2007)	0.08 1/12
UK40.	UK40 Low risk women who intended to deliver on midwife-led units in England had significantly fewer interventions than women who intended to deliver on obstetric-led units. (Symon et al., 2007)	0.08 1/12
UK41.	UK41 Low risk women who intended to deliver on midwife-led units in England had significantly less analgesia than women who intended to deliver on obstetric-led units. (Symon et al., 2007)	0.08 1/12
UK42.	UK42 Low risk women primiparous who intended to deliver on midwife-led units in England had fewer midwives caring for them than women who intended to deliver on obstetric-led units. (Symon et al., 2007)	0.08 1/12
UK43.	UK43 Low risk women primiparous who intended to deliver on midwife-led units in England were significantly more likely to experience spontaneous vaginal delivery than women who intended to deliver on obstetric-led units. (Symon et al., 2007)	0.08 1/12
UK44.	UK44 Low risk women who intended to deliver on midwife-led units in England had were significantly more likely to report they had been involved in making all or most decisions regarding their care than women who intended to deliver on obstetric-led units. (Symon et al., 2007)	0.08 1/12
UK45.	UK45 Pain relief options in different Birthplaces were determined by professionals based upon their opinions of what options "belong" in different settings. Home is a "natural" setting, therefore no pharmacologic pain relief offered. Hospital is a clinical setting, therefore, only options with a proven "evidence-based" effect were offered. (Burges Watson et al., 2007)	0.08 1/12
UK46.	UK46 Therapeutic effects of being in the environment where they expect to deliver and/or specific environmental conditions (such as water, lighting, temperature) often remain unrecognized by professionals and might be attributed to women's choice and empowerment. (Burges Watson et al., 2007)	0.08 1/12
UK47.	UK47 Women appreciated the welcoming attitude of birth center staff, which conveyed the sense they wanted to help. (Walsh, 2006a)	0.08 1/12
UK48.	UK48 Women appreciated the comfort and protection and caring attitude provided by birth center staff. (Walsh, 2006a)	0.08 1/12
UK49.	UK49 Women appreciated the emotional and nurturing needs cared for – as if MUM were there. (Walsh, 2006a)	0.08 1/12
UK50.	UK50 Women appreciated the opportunity to stay at birth center for up to one week after delivery, have staff look after baby at night so woman could sleep. (Walsh, 2006a)	0.08 1/12
UK51.	UK51 Women appreciated the baby-friendly environment (Walsh, 2006a)	0.08 1/12
UK52.	UK52 Women appreciated the birthplace that supports choice and control (Walker, 2000)	0.08 1/12

UK53.	UK53 Women did not like being transferred to unfamiliar birthplace. They stated it was isolating and anxiety producing and resulted in lost opportunities for choice, loss of control, and feelings of helplessness. (Walker, 2000)	0.08 1/12
UK54.	UK54 Women did not like being in a birthplace where she experienced the perception of not being in control, or not involved in decision making (Nicholls & Ayers, 2007)	0.08 1/12
UK55.	UK 55 Women did not like being in a birthplace where she was not informed of labor progress or imposed interventions (Nicholls & Ayers, 2007)	0.08 1/12
UK56.	UK56Women did not like being in a birthplace where the staff did not communicate well, had poor attitudes, and were there was open conflict with or between staff (Nicholls & Ayers, 2007)	0.08 1/12
UK57.	UK57 Women did not like being in a birthplace with a clinical environment where focus was on what could go wrong, and there were exposed instruments and machines. (Walsh, 2006a)	0.08 1/12
UK58.	UK58 Women did not like the fast pace and frenetic activity associated with hospital birth places (Walsh, 2006a)	0.08 1/12
UK59.	UK59 Women did not like being in a birthplace environment that was unpleasant, lacked privacy, or was unhygienic. (Nicholls & Ayers, 2007)	0.08 1/12
UK60.	UK 60 Women did not like being in a birthplace where the faces of professional caregivers were covered up by masks (Nicholls & Ayers, 2007	0.08 1/12
UK61.	UK61 Physical distance and geographical barriers influence women's decision on whether to deliver at home or in the hospital. (influence both ways; some women choose hospital unit to avoid transfer during labor, some women worry they will not reach hospital in time, some women feel distance to travel to hospital makes home birth unsafe, some women mention that children at home makes distant hospital birth unattractive). (Pitchforth et al., 2009)	0.08 1/12
UK62.	UK62 Women's decision about where to deliver is influenced by provider preference, often deters home birth (Pitchforth et al., 2009)	0.08 1/12
UK63.	UK63 Financial restrictions limit women's choice about where to deliver. (Pitchforth et al., 2009)	0.08 1/12
UK64.	UK64 Complications at end of pregnancy or during labor prevented women from delivering in birthplace of their choice. (Walker, 2000)	0.08 1/12
UK65.	UK65 Birth center did not use space to construct identity or maintain power differential. (Walsh, 2006a)	0.08 1/12
UK66.	UK66 Midwives who practice at this birth center located in the midlands of England resist the biomedical model because they do not expect trouble (regarding women in labor/postpartum). While they assess, monitor, and care for complications as they arise, they keep the likelihood of it being something serious at the back of their minds, not at the forefront. (Walsh, 2007)	0.08 1/12
UK67.	UK67 Midwives who practice at this birth center located in the midlands of England were able to resist the 'vigil of care' because they were not constrained by clinical, organizational, and professional	0.08 1/12

	imperatives to ensure labor progresses at an acceptable pace, that women remain within acceptable hospital labor spaces, or that women comply with biomedically defined instructions and advice. (Walsh, 2007)	
UK68.	UK68 Women who seek care at this birth center located in the midlands of England resist the 'vigil of care' by asserting their agency in clinical decision-making. (Walsh, 2007)	0.08 1/12

Table 3.12. North America Effect Sizes

	Summary sentence and references	Effect size
NA1.	NA1 Women in North America, regardless of where they plan to deliver, want support from knowledgeable, competent, and caring individuals throughout labor. (Beebe & Humphreys, 2006) (Boucher, Bennett, McFarlin, & Freeze, 2009) (Cheyney, 2008) (P. A. Janssen, Henderson, & Vedam, 2009) (Kornelsen, 2005) (Kornelsen, Kotaska, Waterfall, Willie, & Wilson, 2010) (Low & Moffat, 2006) (Miller, 2009) (Pewitt, 2008)	0.75 9/12
NA2.	NA2 Women in North America prefer a birth place environment that supports their wish to avoid interventions. (Abenhaim, Benjamin, Koby, Kinch, & Kramer, 2007) (Beebe & Humphreys, 2006) (Boucher et al., 2009) (Cheyney, 2008) (Hodnett, Stremler, Weston, & McKeever, 2009) (P. A. Janssen, Carty, & Reime, 2006) (P. A. Janssen et al., 2009) (Kornelsen, 2005) (Kornelsen et al., 2010) (Miller, 2009)	0.75 9/12
NA3.	NA3 Women in North America prefer a birthplace environment that is one or more of the following: comfortable, familiar, private, peaceful, safe, secure, allows for freedom of movement, (Beebe & Humphreys, 2006) (Boucher et al., 2009) (Cheyney, 2008) (Hodnett et al., 2009) (P. A. Janssen, Klein, Harris, Soolsma, & Seymour, 2000) (P. A. Janssen et al., 2009) 5 (Kornelsen et al., 2010) (Miller, 2009) (Pewitt, 2008)	0.75 9/12
NA4.	NA4 Women in North America prefer a birthplace environment that accommodates support people. (Beebe & Humphreys, 2006) (Boucher et al., 2009) (Cheyney, 2008) (Hodnett et al., 2009) (P. A. Janssen et al., 2000) (P. A. Janssen et al., 2009) (Kornelsen, 2005) (Kornelsen et al., 2010) (Miller, 2009)	0.75 9/12

NA5.	NA5 Women in North America prefer to use multiple sources of knowledge, including their personal bodily experiences of labor, in addition to biomedical knowledge. (Beebe & Humphreys, 2006) (Boucher et al., 2009) (Cheyney, 2008) (P. A. Janssen et al., 2006) (P. A. Janssen et al., 2009) (Kornelsen, 2005) (Kornelsen et al., 2010) (Low & Moffat, 2006) (Miller, 2009)	0.67 8/12
NA6.	NA6 Women in North America prefer a birthplace environment where they can be in control, share in decision-making, feel empowered. (Beebe & Humphreys, 2006) (Boucher et al., 2009) (P. A. Janssen et al., 2006) (P. A. Janssen et al., 2009) (Kornelsen, 2005) 25 women at home in BC (Low & Moffat, 2006) (Miller, 2009) (Pewitt, 2008)	0.58 7/12
NA7.	NA7 A woman's labor and birth experience in a particular birthplace in North American is influenced by her relationship with the attendant. (Abenhaim et al., 2007) (Cheyney, 2008) (P. A. Janssen et al., 2009) (Kornelsen, 2005) (Kornelsen et al., 2010) (Miller, 2009) (Pewitt, 2008)	0.58 7/12
NA8.	NA8 Women in North America prefer to have birth attendants who were familiar and support their wishes. (Boucher et al., 2009) (Cheyney, 2008) (P. A. Janssen et al., 2009) (Kornelsen, 2005) (Kornelsen et al., 2010) (Miller, 2009) (Pewitt, 2008)	0.58 7/12
NA9.	NA9. Women in North America who plan a home birth believe birth is a natural process (not an illness), trust the birth process and want to be free to follow their intuition. (Boucher et al., 2009) (Cheyney, 2008) (P. A. Janssen et al., 2006) (P. A. Janssen et al., 2009) (Kornelsen, 2005) (Kornelsen et al., 2010) (Miller, 2009)	0.50 6/12
NA10.	NA10. Women in North America prefer a birthplace environment that encourages support people to take an active role in labor and birth process. (Boucher et al., 2009) (Cheyney, 2008) (P. A. Janssen et al., 2009) (Kornelsen, 2005) (Kornelsen et al., 2010) (Miller, 2009)	0.50 6/12

NA11.	NA11. Some women in North America prefer a birthplace environment that supports their desire to avoid pain medicine. (Boucher et al., 2009) (Cheyney, 2008) (Hodnett et al., 2009) (Kornelsen, 2005) (Kornelsen et al., 2010) (Pewitt, 2008)	0.50 6/12
NA12.	NA12 Women in North America use non-medical sources of knowledge to guide them through labor. (Cheyney, 2008) (P. A. Janssen et al., 2009) (Kornelsen, 2005) (Kornelsen et al., 2010) (Low & Moffat, 2006) (Miller, 2009)	0.50 6/12
NA13.	NA13 Women in North America choose their birthplace in order to avoid risks associated with certain birthplaces. (Beebe & Humphreys, 2006) (Boucher et al., 2009) (Cheyney, 2008) 5 (P. A. Janssen et al., 2009) (Kornelsen, 2005) (Kornelsen et al., 2010)	0.50 6/12
NA14.	NA14 Women in North America who minimized or avoided relocation before or during labor had higher satisfaction scores. (Boucher et al., 2009) (P. A. Janssen et al., 2000) (P. A. Janssen et al., 2006) (Kornelsen, 2005) (Kornelsen et al., 2010)	0.42 5/12
NA15.	NA15 Physical place influenced professional's behavior in North American. (Hodnett et al., 2009) (P. A. Janssen et al., 2000) (P. A. Janssen et al., 2009) (Kornelsen, 2005)	0.33 4/12
NA16.	NA16 Women in North America who were laboring at home attempt to gauge labor progress according to biomedical guidelines (Beebe & Humphreys, 2006) (Low & Moffat, 2006) (Miller, 2009) opposite is true – women resist biomedical knowledge (Cheyney, 2008)	0.33 4/12
NA17.	NA17 Many women in North America who deliver at home had negative prior experiences in the hospital. (Boucher et al., 2009) (Cheyney, 2008) (P. A. Janssen et al., 2009) (Kornelsen, 2005)	0.33 4/12
NA18.	NA18 Women in North America who plan home deliveries want to avoid hospitals and physicians. (Boucher et al., 2009) (Cheyney, 2008) (Miller, 2009)	0.25 3/12

NA19.	NA19 Women in North America experience discomfort/distress moving from home to hospital during labor (Beebe & Humphreys, 2006) (Boucher et al., 2009) (Low & Moffat, 2006)	0.25 3/12
NA20.	NA20 Women in North America see physicians and technology as barriers to a meaningful birth experience in the hospital, and sometimes see midwives and physicians as barriers to meaningful birth experience at home. (Cheyney, 2008) (Kornelsen, 2005) (Miller, 2009)	0.25 3/12
NA21.	NA21. Women in North America prefer to deliver at home because someone in their family did, or it is the norm for their community. (Boucher et al., 2009) (Kornelsen et al., 2010) (Miller, 2009)	0.25 3/12
NA22.	NA22 Women who plan to deliver in hospital in North American do not have access to assessment and support by competent and caring professionals during early labor at home. (Beebe & Humphreys, 2006) (Low & Moffat, 2006) exception: (P. A. Janssen et al., 2006)	0.25 3/12
NA23.	NA23 Women in North American who plan to deliver in hospital want to avoid getting to hospital too late to receive analgesia/anesthesia. (Beebe & Humphreys, 2006) (Low & Moffat, 2006)	0.17 2/12
NA24.	NA24 Women in North America who plan home deliveries want to avoid intervention. (Boucher et al., 2009) (Kornelsen, 2005)	0.17 2/12
NA25.	NA25 Women in North American who deliver in hospital would like to avoid unnecessary interventions, some of which include being stuck in bed, immobilized, hooked up to monitors, and receiving IV medication. (Beebe & Humphreys, 2006) (Kornelsen, 2005)	0.17 2/12
NA26.	NA26 Women in North America who plan to deliver in hospital want to avoid being at home once contractions become painful. (Beebe & Humphreys, 2006) (Low & Moffat, 2006)	0.17 2/12
NA27.	NA27 Women in North America who plan to deliver in hospital want to be admitted when their contractions become painful. (Beebe & Humphreys, 2006) (Low & Moffat, 2006)	0.17 2/12
NA28.	NA28 Women in North America prefer a birth environment where they can control features such as light and sound. (Hodnett et al., 2009) (Miller, 2009)	0.17 2/12
NA29.	NA29 Women in North America who plan a home delivery tend to express a strong trust in God's will. (Cheyney, 2008) (Miller, 2009)	0.17 2/12

NA30.	NA30 Women in North America who plan to labor and deliver in the hospital must reach a specific cervical dilation before they will be admitted. (Beebe & Humphreys, 2006) (Low & Moffat, 2006)	0.17 2/12
NA31.	NA31.Women in North America wish to avoid time limits on their labor. (Boucher et al., 2009) (Cheyney, 2008)	0.17 2/12
NA32.	NA32 Women in North American who plan to deliver in hospital want to avoid having baby at home. (Beebe & Humphreys, 2006)	0.08 1/12
NA33.	NA33 Some women in North America who plan home deliveries want to avoid all health professionals. (Miller, 2009)	0.08 1/12
NA34.	NA34 Women in North America plan to deliver at home to avoid cesarean section (Boucher et al., 2009)	0.08 1/12
NA35.	NA35 Women in North America who plan to deliver in hospital prefer the hospital because they believe it is safer. (Beebe & Humphreys, 2006)	0.08 1/12
NA36.	NA36 Women in North America who plan a home birth experience negative reactions including accusations of selfish irresponsibility and unnecessary risk taking from some friends, family and strangers. (Cheyney, 2008)	0.08 1/12
NA37.	NA37 Distance between home and hospital is a barrier to specialized obstetric care for women in remote areas of North America (Kornelsen et al., 2010)	0.08 1/12
NA38.	NA38 Women in North America prefer home birth say it is better for the baby. (Boucher et al., 2009)	0.08 1/12
NA39.	NA39. Women in North America prefer home delivery because it costs less (Boucher et al., 2009)	0.08 1/12
NA40.	NA40. Women in North America prefer home delivery because they have a history of fast labors (Boucher et al., 2009)	0.08 1/12

Table 3.13. Asia Effect Sizes

	Summary sentence and references	Effect size
Asia 1.	Asia 1. Women were unable to use hospitals for childbirth because of the cost, which has to be paid upfront (Adams et al., 2005) (Afsana & Rashid, 2001) (Mutharayappa & Prabhuswamy, 2003) (Regmi & Madison, 2009) (Sepehri, Sarma, Simpson, & Moshiri, 2008)	0.71 5/7
Asia 2.	Asia 2. Women avoid hospitals for childbirth because the health workers there were rude, poor communicators, and possess questionable skills (Adams et al., 2005) (Afsana & Rashid, 2001) (Mutharayappa & Prabhuswamy, 2003) (Regmi & Madison, 2009)	0.57 4/7
Asia 3.	Asia 3. Women were unable to use hospitals for childbirth because of the distance, requiring hours-days travel by foot (Adams et al., 2005) (Mutharayappa & Prabhuswamy, 2003) (Sepehri et al., 2008) (Thapa, Chongsuvivatwong, Geater, Ulstein, & Bechtel, 2000)	0.57 4/7
Asia 4.	Asia 4. Women were unable to use hospitals for childbirth because of the expense of traveling to hospital – and difficulty finding transport (Adams et al., 2005) (Afsana & Rashid, 2001) (Mutharayappa & Prabhuswamy, 2003)	0.43 3/7
Asia 5.	Asia 5. Women prefer a birthplace where they can labor and deliver alone; it protects family members from pollution, and self/baby from contamination by health workers (Adams et al., 2005) (Thapa et al., 2000)	0.29 2/7
Asia 6.	Asia 6. Women prefer a birthplace where they have a choice of position for delivery (Afsana & Rashid, 2001) (Regmi & Madison, 2009)	0.29 2/7
Asia 7.	Asia 7. Women prefer a birthplace with a confident, familiar, caring, and local birth attendant (.29). (Mutharayappa & Prabhuswamy, 2003) (Regmi & Madison, 2009)	0.29 2/7
Asia 8.	Asia 8. Women avoid hospitals for childbirth because they were associated with death, disease, zombies, ghosts, and demons (.29). (Adams et al., 2005) (Afsana & Rashid, 2001)	0.29 2/7
Asia 9.	Asia 9. Women want to avoid having the pollution associated with childbirth (blood) enter their house (.29). (Adams et al., 2005) (Thapa et al., 2000)	0.29 2/7
Asia 10.	Asia 10. Women avoid hospitals for childbirth because they want to avoid surgery and technology/interventions (.29). (Afsana & Rashid, 2001) (Regmi & Madison, 2009)	0.29 2/7

Asia 11.	Asia 11. Women avoid hospitals for childbirth because of the male doctors (.29). (Afsana & Rashid, 2001) (Mutharayappa & Prabhuswamy, 2003)	0.29 2/7
Asia 12.	Asia 12. Women were unable to use hospitals for childbirth because husbands/family decide where woman will deliver (.29). (Afsana & Rashid, 2001) (Mutharayappa & Prabhuswamy, 2003)	0.29 2/7
Asia 13.	Asia 13. Women protect household from polluting effects of childbirth by delivering in animal shed (.29) (Adams et al., 2005) (Thapa et al., 2000)	0.29 2/7
Asia 14.	Asia 14. Women state that childbirth a natural process, and therefore can be achieved at home (.29). (Afsana & Rashid, 2001) (Thapa et al., 2000)	0.29 2/7
Asia 15.	Asia 15. Women more likely to deliver in a health facility if they were more highly educated or employed in government or business (.29). (Mutharayappa & Prabhuswamy, 2003) (Sepehri et al., 2008)	0.29 2/7
Asia 16.	Asia 16. Women prefer a birthplace that is secret and private because it protects against jealousy and envy in others (.14). (Adams et al., 2005)	0.14 1/7
Asia 17.	Asia 17. Women prefer to labor and deliver at home; the facilities and care at home were better than at a birth center (.14). (Mutharayappa & Prabhuswamy, 2003)	0.14 1/7
Asia 18.	Asia 18. Women avoid birthplaces with health workers. They believe they were contaminated with grib (.14). (Adams et al., 2005)	0.14 1/7
Asia 19.	Asia 19. Women avoid hospitals for childbirth because of the poor attitude of health workers (.14). (Regmi & Madison, 2009)	0.14 1/7
Asia 20.	Asia 20. Women avoid making preparations, such as collecting supplies needed to safely deliver at home, which can alert others of pregnancy/childbirth (.14). (Adams et al., 2005)	0.14 1/7
Asia 21.	Asia 21. Women avoid having birth helpers (husband) when they deliver at home because the helper might become polluted (.14). (Adams et al., 2005)	0.14 1/7
Asia 22.	Asia 22. Women want to avoid the stigma of a defective body, associated with hospital delivery (.14). (Afsana & Rashid, 2001)	0.14 1/7
Asia 23.	Asia 23. Women avoid hospitals for childbirth because of requirement to stay three days after delivery (.14). (Mutharayappa & Prabhuswamy, 2003)	0.14 1/7
Asia 24.	Asia 24. Women avoid hospitals for childbirth because experience that stripped woman of humanity (tied down like animal, reduced to feeling like object, staff with no compassion) (.14). (Regmi & Madison, 2009)	0.14 1/7
Asia 25.	Asia 25. Women were unable to use hospitals for childbirth because of the time away from family (.14). (Adams et al., 2005)	0.14 1/7
Asia 26.	Asia 26. Women were unable to use hospitals for childbirth because the facilities were not adequately staffed (.14). (Mutharayappa & Prabhuswamy, 2003)	0.14 1/7

Asia 27.	Asia 27. Women were unable to use hospitals for childbirth because the health care workers of different caste (.14). (Mutharayappa & Prabhuswamy, 2003)	0.14 1/7
Asia 28.	Asia 28. Delivering at home is perceived to be safer than hospital for childbirth (.14). (Mutharayappa & Prabhuswamy, 2003)	0.14 1/7
Asia 29.	Asia 29. Women believe that pregnancies deemed healthy were safe to deliver at home (.14). (Mutharayappa & Prabhuswamy, 2003)	0.14 1/7
Asia 30.	Asia 30. Women believe that traditional birth attendants provide protection from evil spirits in the birthplace (.14). (Mutharayappa & Prabhuswamy, 2003)	0.14 1/7
Asia 31.	Asia 31. Women believe hospitals have ability to save women from death by performing c/s (.14). (Mutharayappa & Prabhuswamy, 2003)	0.14 1/7
Asia 32.	Asia 32. Women in rural Nepal who deliver in an animal shed prepare the area by cleaning up the cow dung, laying down clean dry grass and a plastic sheet or cloth (.14). (Thapa et al., 2000)	0.14 1/7
Asia 33.	Asia 33. Women in rural Nepal who deliver in an animal shed place the baby on the rough floor with a thin cotton cloth, bath and warm the baby after completing their own care, and use an un-sterilized sickle to cut the cord (.14). (Thapa et al., 2000)	0.14 1/7
Asia 34.	Asia 34. For women in Vietnam, the odds of delivering in a health facility increases with the number of prenatal visits (.14). (Sepehri et al., 2008)	0.14 1/7
Asia 35.	Asia 35. For women in Vietnam, the odds of delivering in a health facility increases with household income (.14). (Sepehri et al., 2008)	0.14 1/7
Asia 36.	Asia 36. For women in Vietnam, the odds of delivering in a health facility increases with living in an urban area – see distance to travel above (.14). (Sepehri et al., 2008)	0.14 1/7
Asia 37.	Asia 37. For women in Vietnam, the odds of delivering in a health facility increases with being a member of the ethnic majority (.14). (Sepehri et al., 2008)	0.14 1/7
Asia 38.	Asia 38. Women in rural Nepal who deliver in an animal shed experience higher rates of neonatal and infant mortality compared with women who deliver in houses (.14). (Thapa et al., 2000)	0.14 1/7
Asia 39.	Asia 39. Women in rural Nepal who deliver in an animal shed without assistance experience the highest rates of neonatal and infant mortality (compared to delivering in home) (.14). (Thapa et al., 2000)	0.14 1/7
Asia 40.	Asia 40. Women in rural Nepal delivering their first, second, or greater than seventh baby experience higher rates of neonatal and infant mortality (.14) (Thapa et al., 2000)	0.14 1/7
Asia 41.	Asia 41. Women in rural Nepal who were illiterate, or whose husband is illiterate, experience higher rates of neonatal mortality (.14). (Thapa et al., 2000)	0.14 1/7
Asia 42.	Asia42. 40% of births to women living in a squatter camp in Karachi, Pakistan occurred at home (.14). (Saleem et al., 2010)	0.14 1/7

Asia 43.	Asia43. 60% of home births occurring in a squatter camp in Karachi, Pakistan were attended by Traditional Birth Attendants (.14). (Saleem et al., 2010)	0.14 1/7
Asia 44.	Asia43. TBAs attending home births in squatter camp in Karachi, Pakistan were willing to receive training in vagina and neonatal washes as well as study protocols including consent and randomization (Saleem et al., 2010)	0.14 1/7
Asia 45.	Asia44. TBAs attending home births in squatter camp in Karachi, Pakistan were able to obtain consent and randomly assign 95% of screened women (.14). (Saleem et al., 2010)	0.14 1/7
Asia 46.	Asia45. Women living in squatter camps in Karachi, Pakistan were willing to participate in research, including randomization, and accept interventions as long as they were approved by TBA (.14). (Saleem et al., 2010)	0.14 1/7
Asia 47.	Asia46. For women living in squatter camps in Karachi, Pakistan there is an indication of better outcomes for infants whose mothers were treated with Chlorhexidine during labor (.14). (Saleem et al., 2010)	0.14 1/7
Asia 48.	Asia47. Women delivering at home in squatter camp in Karachi, Pakistan who received Chlorhexidine treatment were more likely to be referred for medical evaluation (.14). (Saleem et al., 2010)	0.14 1/7

Table 3.14. Latin America Effect Sizes

	Summary sentence and references	Effect size
LA 1.	LA1. Women know and understand risks in birth. However, they interpret their knowledge of self in ways that effectively minimize risk status, allowing them to remain at home (0.67). (Berry, 2006) (Otis & Brett, 2008))	0.67 2/3
LA 2.	LA2. Women avoid hospitals for birth because of the stigma associated with hospital delivery; a belief that spiritual deficiency causes birthing difficulty (0.67). (Berry, 2006) (Otis & Brett, 2008)	0.67 2/3
LA 3.	LA3. Women avoid hospitals for birth because of the poor quality of care (0.67). (Berry, 2006) – (Otis & Brett, 2008)	0.67 2/3
LA 4.	LA4. Women avoid hospitals for birth because the hospital staff is rude and dismissive of the social aspects of birth (0.67). (McCallum & Dos Reis, 2008) (Otis & Brett, 2008)	0.67 2/3
LA 5.	LA5. Women avoid hospitals for birth because the hospital birth experience is characterized by discomfort, fear, pain, and abandonment (0.67). (McCallum & Dos Reis, 2008) (Otis & Brett, 2008)	0.67 2/3
LA 6.	LA6. Women avoid hospitals for birth because of the social divide between caregivers and women in labor (0.67). (McCallum & Dos Reis, 2008) (Otis & Brett, 2008)	0.67 2/3
LA 7.	LA7. Women prefer birthplaces where they have the opportunity to move, change position (0.67). (McCallum & Dos Reis, 2008) (Otis & Brett, 2008)	0.67 2/3
LA 8.	LA8. Women like hospital birthplaces because they were perceived as modern, safe, hygienic, and having clean air (0.67). (McCallum & Dos Reis, 2008) (Otis & Brett, 2008)	0.67 2/3
LA 9.	LA9. Women were unable to go to hospitals for childbirth because of the costs, which must be prepaid for hospital, surgery, and blood (0.67). (Berry, 2006) (Otis & Brett, 2008)	0.67 2/3
LA 10.	LA10. Women in Guatemala prefer to deliver at home with an Iyom (TBA) who is a birthing specialist; at home the emphasis is on social and spiritual factors affecting birth. Women believe that birth is normal process. Localized knowledge of what is effective obstetrical (birthing) knowledge, gained from personal experience of the Iyom (0.33). (Berry, 2006)	0.33 1/3
LA 11.	LA11. Women in Guatemala prefer to deliver at home where they receive individualized attention and the care is personalized to their situation. Social variables were prioritized – increases odds women will survive complication (0.33). (Berry, 2006)	0.33 1/3

LA 12.	LA12. Women prefer hospitals for birth because they provide access to professionals' technical skill, birthing technology, high status OBs, warm showers, free meals, clean clothes (0.33). (McCallum & Dos Reis, 2008)	0.33 1/3
LA 13.	LA13. Women prefer birthplaces that allow family members in the room (0.33). (Otis & Brett, 2008)	0.33 1/3
LA 14.	LA14. Physician's role in hospital births is to come as close to technical perfections as possible – aim is for a good outcome for mother and baby – no time for emotional support of women (0.33). (McCallum & Dos Reis, 2008)	0.33 1/3
LA 15.	LA15. Women receiving care in hospital for labor delivery undergo routine interventions including pubic shave, oxytocin augmentation, and episiotomy. Epidural anesthesia is not offered, even though covered by national health insurance system (0.33). (McCallum & Dos Reis, 2008)	0.33 1/3
LA 16.	LA 16. Women avoid hospitals for birth because they fear surgery(0.33). . (Berry, 2006)	0.33 1/3
LA 17.	LA17. Women avoid hospitals for birth because they believe c/s leads to future infertility (confused with tubal ligation) (0.33). (Berry, 2006)	0.33 1/3
LA 18.	LA18. Women avoid hospitals for birth because hospitals were associated with death – including for pregnant women (0.33). (Otis & Brett, 2008)	0.33 1/3
LA 19.	LA19. Women were unable to go to hospitals for childbirth because of the associated costs: travel, lodging, lost days of work, medicine, sheets, gas, laundry, food (0.33). (Otis & Brett, 2008)	0.33 1/3
LA 20.	LA20. Women were unable to go to hospitals for childbirth because travel to hospital requires planning for transportation, childcare (0.33). (Otis & Brett, 2008)	0.33 1/3
LA 21.	LA21. Women were unable to go to hospitals for childbirth because of the unavailability of beds in hospitals (0.33). (McCallum & Dos Reis, 2008)	0.33 1/3
LA 22.	LA22. Women were unable to go to hospitals for childbirth because they must find someplace to stay during postpartum (0.33). (Otis & Brett, 2008)	0.33 1/3
LA 23.	LA23. Women were unable to go to hospitals for childbirth because they must arrange childcare for other children (social) (0.33). (Otis & Brett, 2008)	0.33 1/3
LA 24.	LA24. Women were unable to go to hospitals for childbirth because of the distance to hospital (0.33). (Otis & Brett, 2008)	0.33 1/3
LA 25.	LA25. Women were unable to go to hospitals for childbirth because local hospitals not equipped to properly care for women in labor (0.33). (Otis & Brett, 2008)	0.33 1/3
LA 26.	LA26. Women believe that physical complications were symptoms of social problems (not treatable by biomedicine) best treated by Iyom at home (0.33). (Berry, 2006)	0.33 1/3
LA 27.	LA27. Women avoid hospitals because biomedical knowledge changes frequently, and is often contradictory (0.33). (Berry, 2006)	0.33 1/3

LA 28.	Validity of knowledge based on standpoint (0.33). (Berry, 2006)	0.33 1/3

Table 3.15. Middle East Effect Sizes

	Summary sentence and references	Effect size
ME1.	ME1. Women wish to avoid birthplaces with routine interventions (100). (El-Nemer, Downe, & Small, 2006) (Pirdel & Pirdel, 2009)	100 2/2
ME2.	ME2. Women prefer a birthplace where they have freedom of movement (100). (El-Nemer et al., 2006) (Pirdel & Pirdel, 2009)	100 2/2
ME3.	ME3. Women who labored and delivered in hospital experienced routine interventions including fetal heart rate monitor, IV w/ oxytocin, frequent vaginal exams, and deliver in lithotomy position (0.50). (El-Nemer et al., 2006)	0.50 1/2
ME4.	ME4. Women who labored and delivered in hospital described the nurses as being proximally close, but without providing emotional care (0.50). (El-Nemer et al., 2006)	0.50 1/2
ME5.	ME5. Women who labored and delivered in hospital reported no skin-to-skin contact after birth (0.50). (El-Nemer et al., 2006)	0.50 1/2
ME6.	ME6. Women who labored and delivered in hospital perceived their environment as lacking privacy (0.50). (El-Nemer et al., 2006)	0.50 1/2
ME7.	ME7. Women who labored and delivered in hospital reported that some nurses provided physical and emotional care (0.50). (El-Nemer et al., 2006)	0.50 1/2
ME8.	ME8. Women who labored and delivered in hospital described physical contact by professionals as a technical, medical touch – for procedures only; without care and objectifying (0.50). (El-Nemer et al., 2006)	0.50 1/2
ME9.	ME9. Women who labored and delivered in hospital reported rude and demeaning behavior by medical /nursing staff toward them (0.50). (El-Nemer et al., 2006)	0.50 1/2
ME10.	ME10. Women who labored and delivered in hospital reported poor communication by medical/nursing staff (0.50). (El-Nemer et al., 2006)	0.50 1/2
ME11.	ME11. Women who labored and delivered in hospital perceived their environment as isolating and lonely – even when nurses were present (0.50). (El-Nemer et al., 2006)	0.50 1/2
ME12.	ME12. Women who labored and delivered in hospital described their experiences as physical suffering (0.50). (El-Nemer et al., 2006)	0.50 1/2
ME13.	ME13. Women who labored and delivered in hospital perceived the absence of social support (0.50). (El-Nemer et al., 2006)	0.50 1/2
ME14.	ME14. Women who labored and delivered in hospital perceived safety from the presence of technology and skilled providers – yet believed this exposed low risk women to increased risk resulting from interventions (0.50). (El-Nemer et al., 2006)	0.50 1/2
ME15.	ME15. Women who labored and delivered at home perceived no time restraints on their labor (0.50). (El-Nemer et al., 2006)	0.50 1/2
ME16.	ME16. Women who labored and delivered at home described their experience as easy (0.50).	0.50

	(El-Nemer et al., 2006)	1/2
ME17.	ME17. Women who labored and delivered at home perceived compassionate, confident, continuous care by daya (TBA) at home (0.50). (El-Nemer et al., 2006)	0.50 1/2
ME18.	ME18. Women who labored and delivered at home reported they experienced freedom of movement, opportunities to eat, engagement in distracting activities, and sleep (0.50). (El-Nemer et al., 2006)	0.50 1/2
ME19.	ME19. Women who labored and delivered at home described their care as individualized; their daya was able to respond to unpredictable events (0.50). (El-Nemer et al., 2006)	0.50 1/2
ME20.	ME20. Women who labored and delivered at home reported their daya provided personalized advice about food, water, activity, to help labor, ease pain; embodied knowledge (0.50). (El-Nemer et al., 2006)	0.50 1/2
ME21.	ME21. Women who labored and delivered at home described care provided by daya as mothering (0.50). (El-Nemer et al., 2006)	0.50 1/2
ME22.	ME22. Women prefer a quiet birthplace (0.50). (Pirdel & Pirdel, 2009)	0.50 1/2
ME23.	ME23. Women prefer a birthplace that provides privacy (0.50). (Pirdel & Pirdel, 2009)	0.50 1/2
ME24.	ME24. Women prefer a birthplace where their family can provide support (0.50). (Pirdel & Pirdel, 2009)	0.50 1/2
ME25.	ME25. Women prefer a birthplace that allows them to drink (0.50). (Pirdel & Pirdel, 2009)	0.50 1/2
ME26.	ME26. For women who delivered in hospital, there was a significant positive correlation between pain and labor stress from environmental factors (0.50). (Pirdel & Pirdel, 2009)	0.50 1/2

Table 3.16. Australia/New Zealand Effect Sizes

	Summary sentence and references	Effect size
ANZ1.	Women report they were able to relax and give into birth forces when birthplace environments were quiet, private, painted in soothing colors, promote freedom of movement, contain comfortable furniture, distractions, pleasant smells, avoid prominent clinical features such as labor bed, accommodate support persons, and have medical support available (0.50). (Hauck, Rivers, & Doherty, 2008)	0.50
ANZ2	Women prefer birthplaces with windows and view to outside (0.50). (Hauck et al., 2008)	0.50
ANZ3.	Women in New Zealand who were immersed in the warm water of a birthing pool were able to move around, change posture and achieve effective relaxation and comfort in the water because of the large size and depth of the tub (0.50). (Maude & Foureur, 2007)	0.50
ANZ4.	Women in New Zealand who were immersed in the warm water of a birthing pool situated within a hospital appreciated the pool was placed in a corner, and not as the focal point of the room, it helped them forget they were in a hospital (0.50). (Maude & Foureur, 2007)	0.50
ANZ5.	Women in New Zealand who were immersed in the warm water of a birthing pool described an all-encompassing warming effect engendered by being in the water that was relaxing, soothing, and comforting. Immersion in this environment altered their perception of pain, provided a barrier between themselves and their companions, afforded a sense of privacy, and gave women the ability to move away from people when she wanted (0.50). (Maude & Foureur, 2007)	0.50
ANZ6.	Women in New Zealand who were immersed in the warm water of a birthing pool were able to block out everything else in their environment, while maintaining awareness of everything that was going on (0.50). (Maude & Foureur, 2007)	0.50

Table 4.1. Topics Women Considered Important in Choosing or Evaluating Birthplaces

	Physical environment	Familiarity	Safety	Intervention	Pain management	Caregiver behavior	Decision making	Support people	Barriers	Avoidance/preference	Relocation	Position/ movement	Knowledge
Europe 20 reports 19 unique pops 10417 participants	1 16/20 13/59	2 9/20 5/59	3 15/20 11/59	4 9/20 7/59	5 8/20 4/59	6 13/20 7/59	7 11/20 6/59	8 6/20 4/59	9 10/20 8/59				
Africa 16 reports 33,278 women 1167 others + FGs	7 5/16 1/50		4 11/16 11/50	5 7/16 2/50		3 13/16 6/50		6 9/16 2/50	1 14/16 16/50	2 15/16 18/50			
United Kingdom 14 reports 12 unique pops 717 women 470 others	6 9/14 23/68		7 6/14 3/68	10 3/14 4/68	4 6/14 6/68	2 8/14 11/68	8 7/14 6/68	1 8/14 6/68	5 5/14 8/68		3 6/14 4/68	9 2/14 4/68	
North America 13 reports 12 unique pops 30085 participants	3 10/13 5/40		7 7/13 4/40	2 10/13 3/40	6 8/13 3/40	1 13/13 5/40	5 8/13 1/40		10 5/13 4/40	9 6/13 7/40	8 7/13 3/40		4 9/13 4/40
Asia 7 reports 7 unique pops 11083 participants	4 4/7 5/47		3 6/7 20/47			2 6/7 7/47			1 6/7 13/47				
Latin America 3 reports 192 women 164 others	4 2/3 4/27		1 3/3 8/27			3 3/3 9/27			2 3/3 8/27				
Middle East 2 reports 621 women	2 2/2 10/26		5 1/2 1/26	1 2/2 2/26	4 2/2 2/26	3 1/2 9/26							
Australia 2 reports 21 women	1 2/2 6/6												

Top number is order of prevalence of finding within the region
Next is number of reports that addressed this finding/total reports for that region
Bottom is number of synthesized findings that addressed that c

Table 4.2. Physical Environment of Birthplace

	Privacy	Family present	Freedom of movement	Manage environment	Quiet	Familiar	Warm	Peaceful, relaxed	Comfortable	Intimate	No time constraints	No men	
Europe	X	X		X	X	X	X	X	X	X			9
Africa	X	X	X									X	4
United Kingdom	X	X	X	X	X	X		X		X	X		9
North America	X	X	X	X		X		X	X				7
Asia	X		X									X	3
South America		X	X				X						3
Middle East	X	X	X	X	X						X		6
Australia/New Zealand	X	X	X	X	X		X		X				7
	7	7	7	5	4	3	3	3	3	2	2	2	

Table 4.3. Caregiver Behavior

	Caring, attentive, supportive, affectionate	Knowledgeable, competent	Throughout labor	Confident	Familiar	Intense	Personalized	Satisfying	Not avail in home in early labor	Plan home to avoid professionals	Hospital caregivers			Health worker contaminated
											Rude	Hostile	Uncaring	
Europe	X	X	X	X		X	X	X		X	X	X	X	
Africa	X	X		X						X	X			
United Kingdom	X	X	X	X					X					
North America	X	X	X		X		X			X	X			
Asia	X				X					X	X			X
South America		X									X	X	X	
Middle East	X	X		X			X				X		X	
Australia/New Zealand														

Table 4.4. Safety

	Hospital – safe – able to save	Hospital– unsafe - intervention	Proximal hospital safety net	Women planning home use medical technology	Hospital personnel behavior can make women feel unsafe	Women planning hospital birth feel unsafe at home	Hospitals=sickness	Women resist elevated risk status if it means not delivering where they want	Witchcraft, spiritual problems in hospital	Hygiene interventions increase safety	Need for secrecy	Family needs protection from childbirth pollution
Europe	X	X	X	X	X	X	X	X				
Africa	X	X							X	X	X	
United Kingdom	X					X		X				
North America	X	X				X						
Asia	X	X					X		X	X	X	X
South America	X	X			X		X	X	X			
Middle East	X	X										
Australia/New Zealand												

Table 4.5. Barriers to Accessing Therapeutic Birthplace Landscape

	Distance-disrupts	Distance-too far	Hospital too far to provide safety net for home birth	Professionals did not support home birth plans	Family, society did not support home birth plans	Cost	Family not permit (husband, mother in law) hospital birth	Too early in labor	Lack of transport	Facility unavailable or understaffed	Need to prepare, gather supplies	Admittance card, prenatal attendance, referral	Fear of being turned away	Risk status
Europe	X		X	X	X	X	X	X						
Africa		X				X	X	X	X	X	X	X	X	
United Kingdom		X		X	X	X		X						X
North America		X				X		X		X				
Asia		X				X	X		X	X				
South America		X				X			X	X	X			
Middle East														
Australia/New Zealand														

Table 4.6. Intervention

	Avoid unnecessary or routine intervention	Avoid use of technology	Women who planned to deliver at home, experienced fewer interventions when they delivered in hospitals	Avoid hospital to avoid intervention	Hospitals = greater intervention
Europe	X	X	X		X
Africa	X			X	
United Kingdom	X				X
North America	X			X	
Asia	X			X	
South America					
Middle East					
Australia/New Zealand					

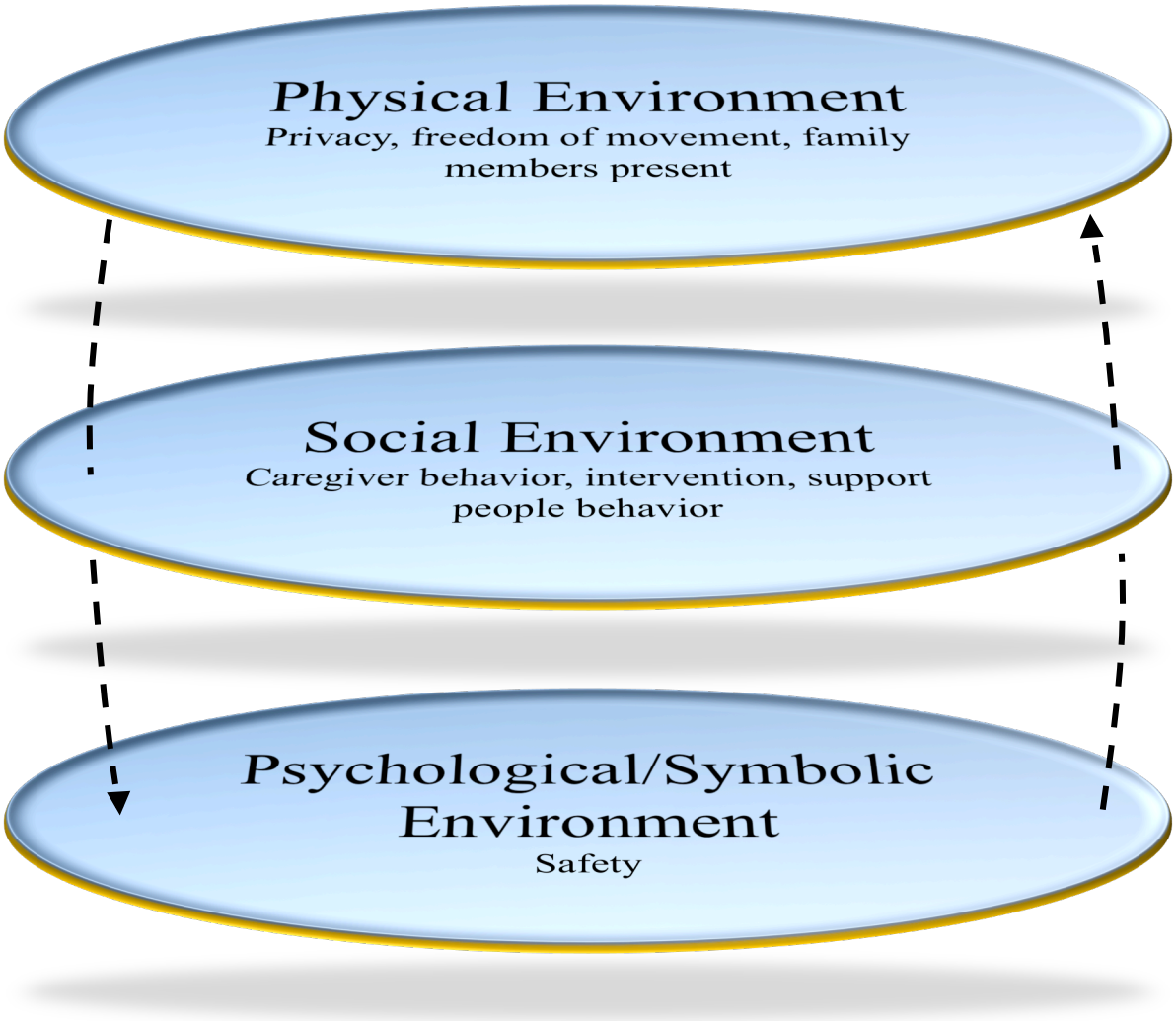
Therapeutic Landscapes for Birth
Physical Environment
Privacy, freedom of movement, family members present
Social Environment
Caregiver behavior, intervention, support people behavior
Psychological/Symbolic Environment
Safety

Figure 1

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