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"It could not have been more different." Comparing experiences of hospital-based birth and homebirth in Ireland: A mixed-methods survey

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ABSTRACT

Problem: Internationally, little is known about the experiences of the minority who have birthed both in hospital and at home. This group are in a unique position to provide experiential evidence regarding perceptions of care under each approach.
Background: Obstetric care within the hospital setting is the hegemonic approach to birth in western cultures. Homebirth is at least as safe as hospital birth for those with low-risk pregnancies, yet access is strictly regulated.
Aim: To explore how those who have experienced both hospital and homebirth maternity care in Ireland perceived the care received, and experienced birth in each setting.
Methods: 141 participants who birthed both in hospital and at home between 2011 and 2021 completed an online survey.
Findings: Participants' overall experience scores were significantly higher for homebirth (9.7/10) than hospital birth (5.5/10). In hospital, midwifery-led care scored significantly higher (6.4/10) than consultant-led care (4.9/10). Qualitative data revealed four explanatory themes: 1) Regulation of birth; 2) Continuity of care and/or carer and establishing relationships; 3) Bodily integrity and informed consent; and 4) Lived experiences of labour and birth at home and in hospital.
Discussion: Homebirth was perceived far more positively than hospital birth experiences across all aspects of care surveyed. Findings suggest that those who have experienced both models of care have unique perspectives and aspirations about childbirth.
Conclusion: This study provides evidence regarding the need for genuine choices for maternity care and reveals the importance of care which is respectful and responsive to divergent ideologies about birth.

Statement of significance

Problem or issue

Little is known about how those who experienced both hospital-based and homebirth maternity care experienced and perceived the care they received in each setting.

What is Already Known

Worldwide, the medical model enjoys hegemonic status as the dominant model for birth. It has been argued that the medical model does not provide sufficient choice, or adequately facilitate different birthing approaches, despite woman (person)-centred care being a key strategy objective for global maternity policy.

What this Paper Adds

This paper provides evidence on the need for a variety of choices for maternity care and reveals the importance of care that is respectful and responsive to divergent ideologies about birth.

Introduction

Over the course of the last century there was a global shift in attitudes towards place of birth [1,2]. Homebirth declined in popularity, and hospital-based obstetric care become the dominant model for maternity care provision worldwide [3,4]. The current study took place in the Republic of Ireland (hereafter 'Ireland') where, consistent with the

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global trend, the percentage of homebirths has declined. In the 1950 s, one third of births took place in the home [1] compared to an average of 0.275% of total births per year between 2018 and 2020 [5]. Furthermore, 85% of total births occur under obstetric care in the hospital-setting [6,7]. Recent research suggests homebirth figures are gradually rising in Europe, although there exists a dearth of research to explain this trend [8].

The main critique of homebirth is that it is not as safe as hospital-based birth in relation to maternal and neonatal physical morbidity and mortality [9]. However, homebirth has been shown to be at least as safe as hospital for uncomplicated pregnancies [10,11]. Two systematic reviews and meta-analyses on birth outcomes in low-risk pregnancies in each setting found that maternal and infant mortality rates were comparable and that there were no greater adverse outcomes for women who intended to birth at home [10,11]. Additionally, medical interventions and untoward maternal outcomes were found to be, on average, fewer for those who intended to birth at home, even if they did not succeed [10]. Furthermore, homebirth has been associated with high rates of satisfaction due to feelings of comfort, security and heightened feelings of being in control from being at home [4,10]. Many who have had homebirths described it as a life-enriching experience, from which they gained feelings of strength and empowerment [12,13]. Previous Irish research also found that homebirth maternity care was perceived extremely positively by those who utilised it [7,14].

While women are the overwhelming majority to become pregnant and give birth, we acknowledge that not everyone who gets pregnant identifies as a woman. Additionally, while participants in this study were not asked about their gender/gender identity, the majority of participants used the term 'woman'. However, there were two participants who used 'pregnant person' to refer to themselves. On this basis, women and people will be used to remain in keeping with participants' language. Both worldwide and in the Irish context little is known about the experiences and perceptions of the minority of women and people who have chosen to give birth *both* in hospital and at home. Yet this group are in the unique position to compare their personal, subjective experiences of both models of care. Furthermore, woman and person-centred care (WPCC), which is respectful of and responsive to people's unique preferences, needs and values and ensures that all decisions are guided by the individual [15,16], is a key policy objective both in Ireland [6] and internationally [15]. Those who have experienced both hospital and homebirth can offer important experiential evidence regarding perceived choice and WPCC care across both models of care.

Prior to the current study, there was no research in Ireland comparing hospital and homebirth experiences and no studies published on planned homebirth experiences in Ireland in over 25 years [17]. Internationally too, comparative experiences of home and hospital birth remains an under-studied topic. To the best of the authors' knowledge, there are only three papers comparing participants' experiences of hospital and homebirth. Two studies are from the United States, which specifically focused on homebirth after hospital birth(s) experience [12, 13]. The first US study [13] conducted semi-structured interviews with 11 participants while the subsequent study conducted five focus groups with a total of 20 participants [12]. Since it is widely understood that first births can be longer and more difficult, it could be argued that participants' accounts may have been biased in favour of homebirth, since all homebirth accounts were multiparous experiences. The third, an Australian study (n = 19), addressed this concern by focusing on first-time mothers' experiences of giving birth in a hospital-setting (n = 8), compared to first-time mothers' experiences of homebirth (n = 7) [18]. However, participants did not have experience of using both types of care.

While quantification is not possible due to the qualitative designs across the three studies, findings suggested participants' general experiences of homebirth were more positive than experiences of hospital birth [12, 13, 18]. The Australian study found positive birth experiences were mediated by 'preparation, choice and control, information, communication, and [care providers] support' in each setting, and that these factors were perceived as more abundant for homebirth. Further, homebirth midwives were perceived as unrestricted by hospital policies and time constraints, which contributed to more positive experiences [18]. In the US studies [12,13], compared to hospital birth, homebirth was perceived as enabling those giving birth to feel in control and empowered, with greater choice, respect and autonomy and greater trust in care providers, who were understood to be allies in the process. In contrast, the hospital birth experiences were described as featuring interruptions and interventions, coercion, disrespect, dismissal, loss of control and autonomy.

In Ireland, the maternity system has been characterised as being 'predominantly hospital-based and consultant-led' (p1) [19], and as such it has been described as highly medicalised [19,20]. A cross-sectional study using data from 2013 for 13 high-income countries reported that Ireland had the highest rate of induction of labour for first time mothers at 35.9% [21], in 2020 this figure rose to 43.6% [22]. In 2019, the proportion of first-time mothers who birthed spontaneously was 37.2%, 26.6% had an operative vaginal birth and 36.3% had a caesarean section [23]. The 2016 National Maternity Strategy [6] acknowledged several deficits in services, including lack of choice, inadequate focus on the wellbeing of those giving birth and the need for greater dignity and respect in care delivery. While 'the Strategy' established WPCC as a key objective,[6] homebirth services are not available nationwide [24–27]. Therefore, even those who are eligible for homebirth care may not be able to access it [25]. It has also been argued that Ireland uses overly strict criteria for assessing what is considered a 'low-risk' or 'normal' pregnancy for publicly-funded homebirths, when compared to other countries such as the UK [24,28]. Private homebirth services are currently provided by one company in Ireland, which provides homebirth services to those excluded from public homebirth services, for example, those who had a caesarean section or have gestational diabetes. Consequently, in some locations the only option is obstetric care.

This study sought to respond to national and international gaps in the literature surrounding comparative experiences of home and hospital birth and to inform emergent policy surrounding choice of maternity services and WPCC. Findings are reported from a mixed-methods survey of 141 individuals who experienced *both* homebirth and hospital birth in Ireland between 2011 and 2021. As the only mixed-methods study on this topic, the findings quantify the subjective comparative satisfaction of individuals' home and hospital births, while also providing in-depth qualitative data to explore participants' experiences.

Participants, ethics and methods

This mixed-methods study explored experiences of home and hospital maternity care for individuals who experienced *both* models of care. The study was guided by two research questions: [1] how do those who experienced both types of maternity care rate the antenatal and intrapartum care they received in each setting? and [2] how do these individuals perceive and describe their home and hospital birthing experiences? Participants were required to be 18 years or older and have experienced at least one homebirth and one hospital birth within the preceding ten years. Responses were screened to ensure participants met the criteria, and data from those who fell outside these parameters were excluded from the analysis.

The size of the population of interest is not known as there are no data available on how many people have had both hospital births and homebirths. Convenience and snowball sampling was therefore used to access the target population using social media channels. Permission was granted to place a post with a link to the survey in a private Facebook group "Irish Homebirthers and Hopefuls" with over 1.9k members. A similar post was shared on Twitter with a link to the survey. Both posts requested it be 'shared' with contacts who met the criteria. Written informed consent was obtained via the survey instrument, which was

preceded by an information sheet and electronic consent form. All data collected were anonymised and any identifying personal details removed. The study was approved by the Research Ethics Committee in Trinity College Dublin.

A concurrent parallel mixed-methods survey design, comprising both quantitative and open-ended questions, was utilised to glean a more complete understanding of the research problem than either quantitative or qualitative alone could provide. The survey was prepared in Qualtrics™ and administered online during the three-week period between 4 and 29 July 2021. The survey included 31 items in total. There were 3 open-ended questions using free-text boxes, the remainder were multiple-choice closed questions, 7 of which included a free-text box for choices not offered by the multiple-choice selection. Permission was sought and received from Health Information and Quality Authority (HIQA) to use the wording and scoring system from five questions (Table 2) in the National Maternity Experience Survey (NMES) [7]. This enabled comparison between the survey data and national average scores.

Utilising the Mixed Methods Appraisal Tool (MMAT) guidelines [29], the data were analysed separately using their respective established analysis techniques. The data were then integrated to create a single narrative. Quantitative data were analysed descriptively using IBM SPSS Statistics Version 25 [30]. Where appropriate, inferential statistical testing was used by way of Independent samples t-tests, One sample t-tests and a Wilcoxon signed rank text. It was not possible to analyse the survey data for individual survey questions for hospital-based care compared to homebirth care with statistical tests because of the non-normal and asymmetrical distribution of the data. However, 'overall scores for experiences' in each setting were examined, and the assumption of symmetry was met, which allowed for non-parametric testing of these paired variables. Where significant differences were observed effect sizes were calculated using Eta^2 for parametric tests and r for non-parametric tests [31]. A 95% confidence interval (CI) was used with the exception of One-sample t-tests used to compare participants' average scores to national average scores, these utilised a 99% CI to facilitate comparison.

The qualitative data collected from free-text comments were analysed using Braun and Clarke's six-phases for conducting reflexive thematic analysis [32]. Qualitative data totalled approximately 15,000 words (n = 110). The process of generating codes, sorting and reviewing, continued until higher order themes which addressed the research questions were identified [32]. Microsoft Excel© and the qualitative coding software QDA Miner Lite v2.0.7© were used to code, sort and display themes as they emerged. Following each participant's quote(s), their identification number and chronological order of type of care/birth is presented in the bracketed text.

Table 1
Sample characteristics and birth information.

Age category	N	%
Under 25	1	0.7
25–29	3	2.2
30 – 34	22	16.2
35 – 39	61	44.9
40 and older	49	36.0
Most recent type of hospital-based birth care		
Midwifery-led hospital birth	60	42.5
Consultant-led hospital birth	81	57.5
No. hospital-based births in total		
1 birth	85	60.3
2 births	43	30.5
3 or more births	13	9.2
Most recent homebirth care		
Publicly funded homebirth	97	69.3
Privately funded homebirth	43	30.7
No. homebirths in total		
1 birth	110	78.0
2 births	29	20.6
3 or more births	2	1.4
Order in which births occurred		
Hospital-based birth before having a homebirth	134	95.7
Homebirth before having a hospital-based birth	6	4.3
Ethnic group		
White Irish	114	83.8
Any other white background	16	11.8
Any other black background	1	0.7
Indian / Pakistani / Bangladeshi	1	0.7
Mixed	3	2.2
Other	1	0.7

Table 2
Dimensions of hospital-based birth experience compared to homebirth experience questions.

NMES Survey Questions	Hospital-based birth			Homebirth		
	N	M	SD	N	M	SD
During your pregnancy, did you feel you were involved in the decisions about your care?	**140**	**5.0**	3.7	140	**9.8**	1.0
During your labour and birth, did you feel you were involved in the decisions about your care?	139	**3.9**	3.4	140	**9.8**	1.1
Before you had any tests, procedures and treatments, were the benefits and risks explained to you in a way you could understand?	134	**4.2**	3.6	140	**9.9**	0.8
Did you have confidence and trust in the healthcare professionals caring for you during your labour and birth?	139	**5.0**	3.4	140	**9.9**	0.7
Overall, how would you rate your experience of the care you and your baby received during pregnancy, labour and birth and after your baby was born?	140	**5.5**	2.4	140	**9.7**	0.6

Findings

Participant characteristics

Responses were received from 141 participants. The average age of participants was 37.9 years (SD 4.0) (Table 1). The vast majority indicated their ethnic group as 'white Irish' (83.8%, n = 114), and 60.3% (n = 85) had experienced just one hospital birth, and 78.0% (n = 110) had experienced one homebirth. Over half (57.5%, n = 81) availed of 'consultant-led care' for their most recent hospital birth which, for 51.4% (n = 72), was within the last 5 years. During their hospital birth, 27.7% (n = 39) of participants reported some type of induction of labour (IoL) procedure, while 21.3% (n = 30) indicated they had an instrumental vaginal birth. In relation to homebirth, 90.0% (n = 126) had their most recent homebirth within the last 5-years. For 39.3% (n = 55) this birth occurred within the last year.

Participants' comparative experiences

Participants' mean overall experience score for homebirth (9.7/10) was significantly higher ($z = -9.969$, $p < .001$, $r = 0.084$) than the average score for hospital-based birth (5.5/10) demonstrating a 'very large' effect size [31]. This difference is illustrated in Fig. 1 utilising the same rating categories utilised by National Maternity Experience Survey (NMES) [7].

Participants overwhelmingly perceived their experience of homebirth far more positively when compared to their experience of hospital-based birth across all aspects of care surveyed. As Table 2 presents, this pattern was observed across average ratings for: 1) Involvement in decisions during pregnancy (homebirth = 9.8/10, hospital birth = 5.0 /10); 2) Involvement in decisions in labour and birth (homebirth = 9.8/10, hospital birth = 3.9/10); 3) Explanation of benefits and risks of tests and procedures (homebirth = 9.9/10, hospital birth = 4.2/10, and 4)

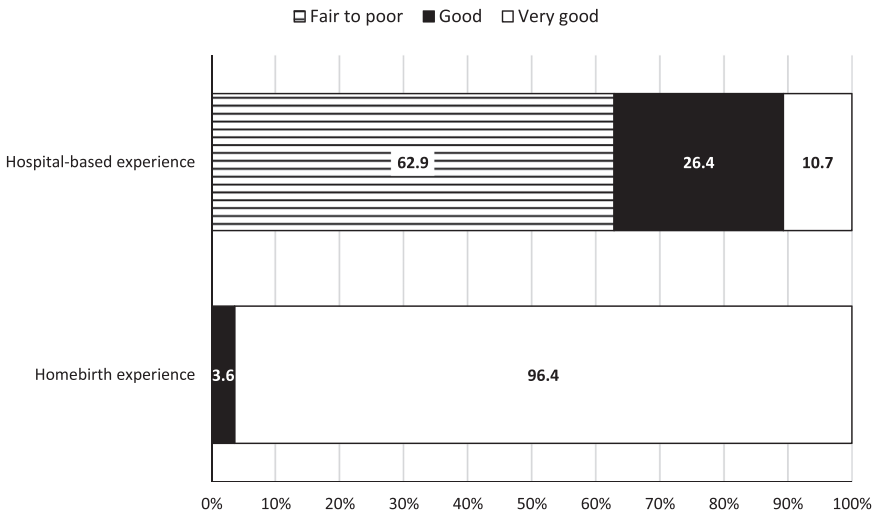

Fig. 1. Participants' overall ratings of recent hospital-based and homebirth experiences (n = 140).

Confidence and trust in health care professions providing care (homebirth = 9.7/10, hospital birth = 5.0/10). Although statistical testing was not possible owing to the non-normal and asymmetrical distribution of the data, there are discernible differences between these mean scores (Table 2).

Participants also awarded significantly lower average scores for their overall experience of hospital care (5.5/10) when compared to the national average scores for the same question (8.2/10) collected by NMES (P < .001 **) to a 'large effect size' [31]. Similar results were observed across all questions (Table 3).

Additionally, this study's findings highlight statistically significant differences between different types of hospital-based maternity care. Overall, participants rated midwifery-led care (n = 59) significantly higher (6.4/10) than consultant-led care (n = 77) (4.9/10). This pattern persisted across all care dimensions, with statistically significant differences identified across four dimensions (Table 4). Participants' narrative responses qualified that the same elements which made their homebirth experience positive (e.g., a physiological approach to birth, continuity of care and/or carer, establishing relationships, and respectful and responsive care) were present to a greater extent in midwifery-led care.

Explanatory factors in contrasting home and hospital birth experiences

Convergence of the data, using quantitative ratings combined with thematic analysis, revealed four key explanatory factors in participants' contrasting experiences of hospital and homebirth: 1) Continuity of care and/or carer (CoC) and establishing relationships; 2) Bodily integrity and informed consent; 3) Regulation of birth in the hospital-setting, and

Table 3
One sample t-test results for dimensions of hospital-based care experience compared to the National average scores from the National Maternity Experience Survey (NMES) 2020.

Questions on hospital-based care experience	Current study Mean score (SD)	NMES Mean Score (SD)	p-value	Eta^2
Q. 10 - pregnancy decisions	**5.0 (3.7)**	**7.6**	P < .001 **	0.33
Q. 11 – labour & birth decisions	**3.9 (3.4)**	**7.7**	P < .001 **	0.55
Q. 12 – tests & procedures	**4.2 (3.6)**	**8.5**	P < .001 **	0.59
Q. 13 – trust in professional	**5.0 (3.4)**	**9.0**	P < .001 **	0.58
Q. 14 – Overall rating	**5.5 (2.4)**	**8.2**	P < .001 **	0.55

Table 4
Hospital-based birth experience scores: Independent samples t-test for subgroups.

Spontaneous vs instrumental vaginal birth	Spontaneous vaginal birth Mean (SD)	Instrumental vaginal birth Mean (SD)	p-value
Q. 10 - pregnancy decisions	5.4 (3.8)	3.8 (3.6)	P = .048 *
Q. 11 – labour & birth decisions	4.4 (3.5)	2.3 (2.9)	P = .004 *
Q. 12 – tests & procedures	4.6 (3.7)	3.0 (2.8)	P = .041 *
Q. 13 – trust in professionals	5.5 (3.5)	3.3 (2.7)	P = .002 *
Q. 14 – Overall rating	6.0 (2.3)	4.0 (2.0)	P < .001 **
Not induced vs induced	Not induced Mean (SD)	Induced Mean (SD)	p-value
Q. 10 - pregnancy decisions	5.3 (3.7)	4.2 (3.9)	P = .132
Q. 11 – labour & birth decisions	4.5 (3.4)	2.4 (3.2)	P = .001 *
Q. 12 – tests & procedures	4.8 (3.5)	2.6 (3.3)	P = 002 *
Q. 13 – trust in professionals	5.1 (3.4)	4.7 (3.5)	P = .578
Q. 14 – Overall rating	5.9 (2.3)	4.5 (2.6)	P = .003 *
Midwifery-led vs Consultant-led	Midwifery-led Mean (SD)	Consultant-led Mean (SD)	p-value
Q. 10 - pregnancy decisions	6.0 (3.7)	4.2 (3.5)	P = .005 *
Q. 11 – labour & birth decisions	5.2 (3.5)	3.1 (3.1)	P < .001 **
Q. 12 – tests & procedures	4.7 (3.6)	3.9 (3.5)	P = .162
Q. 13 – trust in professionals	6.4 (3.1)	3.9 (3.2)	P < .001 **
Q. 14 – Overall rating	6.4 (2.3)	4.9 (2.3)	P < .001 **

Abbreviations:
SD = standard deviation
* statistical significance = p < .05
** statistical significance = p < .001

4) Lived experiences of labour and birth at home and in hospital environments.

Theme 1: CoC and establishing relationships

Participants were asked to rate their confidence and trust in their care providers during their labour and birth in each setting; the average rating was 5.0/10 in the hospital-setting compared to 9.9/10 for homebirth. Trust and respect were reported as fundamental to participants' positive birth experiences, and this was understood to have been achieved through CoC delivered by homebirth midwives. For example:

> *"The most striking thing was the continuity of care. The same midwife for all my antenatal and labour care. This meant we bonded and had a huge amount of trust. I felt listened to and heard. I felt in control and secure /safe."* (P133: Consultant-led hospital, then private homebirth)

As a direct consequence of establishing a relationship with their homebirth midwife, participants reported that when they birthed at home they felt 'seen', 'heard' and 'respected' during their pregnancy and birth.

In contrast, several participants perceived that establishing a relationship was not a priority or not possible in the hospital-setting. Several participants reported that impersonal care left them feeling anxious or isolated. Some recounted care providers in the hospital-setting who were disinterested, or even condescending, during labour and birth. Furthermore, they felt that care provided in a standardised manner left little room for responding to individual birth aspirations. Participants' perceptions of CoC from within the hospital-setting were mixed, with less positive perceptions, as illustrated by this participant's quote:

> *"Zero continuity of care during pregnancy and same for birth. Midwives finishing and starting a shift even though my labour was only 1 hr 10 min in the hospital.*" (P94: Midwifery-led hospital, then public homebirth)

Many participants expressed the view that a lack of CoC played a direct role in their less positive experiences in the hospital.

Theme 2: bodily integrity and informed consent

Participants were asked to rate whether benefits and risks of any tests, procedures and treatments were explained to them adequately, and clearly, in each setting. On average this question received a score of 4.2/10 in the hospital-setting compared to 9.9/10 at home (Table 2).

Echoing these results, narrative responses from 27 participants revealed that interventions in the hospital-setting were performed without seeking explicit consent, without providing sufficient explanation about these procedures or the risks involved, or without being offered alternatives. No participant reported this about their homebirths.

> *"It was like it was happening to me rather than I was an active and involved part of the decision-making process."* (P121: Consultant-led hospital, then public homebirth)

By contrast, participants reported that homebirth midwives explicitly sought consent before any physical contact or procedure:

> *"She also asked my permission every time she put her hands on my body, including every time she did the standard palpation antenatally."* (P89: Midwifery-led hospital, then private homebirth)

As Table 4 presents, participants were asked if they perceived tests and procedures were explained to them clearly. Those who had an IoL on average rated the question significantly lower (2.6/10) than those who did not have IoL (4.8/10). Similarly, those who had an instrumental vaginal birth (3.0/10) gave a significantly lower rating compared to the average score for those who had a spontaneous vaginal birth (4.6/10). These results suggest that, on average, participants did not feel adequately informed about the benefits and risks of interventions used when compared to those who did not experience interventions.

Several participants perceived care providers' decisions in the hospital were driven by policies, which were often believed to be outdated:

> *"It's either [health authority] or the hospital's policy. They treat everyone like they can't be trusted to make decisions. It's very insulting and it has big consequences."* (P2: Midwifery-led hospital, then private homebirth)

Conversely, participants perceived that their homebirth midwives used up-to-date, evidenced-based research. Furthermore, participants asserted their homebirth midwives respected and supported them in their choices throughout:

> *"Very good experience. Everything explained and answered. Always involved in decisions. Everything evidenced based and advised to look up research myself. Empowering."* (P41: Midwifery-led hospital, then public homebirth)

Additionally, several participants reported gathering knowledge to challenge unwanted procedures in the hospital. Conversely, they described being imparted with knowledge from their homebirth midwives, which empowered them and prepared them for birth.

Theme 3: regulation of birth in the hospital-setting

Participants were asked to rate how involved they were in decisions about their care during their pregnancy, and during labour and birth, in each setting. On average participants using hospital-based care rated their involvement in decisions during pregnancy as 5.0/10, and during labour in birth as 3.9/10. This compares to average homebirth scores of 9.8/10 for pregnancy, and 9.8/10 for during labour and birth, at home.

Participants frequently perceived their experience was influenced by luck over which professionals they encountered on their reproductive journey. Those who had experience of consultant-led care, in particular, perceived that they had to be prepared, and informed, to resist hospital policies which may alter the physiological course of birth, or to avoid interventions, which were perceived by many participants to be unnecessary. These participants perceived that healthcare professionals in the hospital-setting assumed all people attending the hospital would want a medicalised birth, possibly featuring some type of IoL and/or pain management. Several participants described that their ability to self-advocate enabled them to assert their choices, or to challenge hospital policies.

Some participants believed hospital policies forced them into having unwanted and unwarranted interventions. For instance, those who were deemed to have 'high-risk' pregnancies described feeling as if interventions were urged on them. In these participants' accounts there was often a sentiment of having been mistreated or even violated. Several participants reported they consequently experienced trauma related symptoms or anxiety arising from their experiences. For example:

> *"I was treated horrendously by the gestational diabetes team in [hospital name]. I ended up with a 3rd degree [tear] as a result of poor and unwanted coached pushing and other interventions. I still have anxiety thinking about how I was treated there". (*P118: Midwifery-led hospital, then private homebirth)

Theme 4: lived experiences of labour and birth at home and in hospital

Participants reported that their experience of labour and birth at home brought about feelings of being '*safe* 'and *'secure', 'relaxed'* or '*comfort'* (from being at home). Expressions of *'joy'* were conveyed, with pleasure over having family near or involved in the birth, and the way in which midwives entered the family's space with sensitivity and respect. These experiences were explicitly conveyed, as illustrated by this participant's quote:

"… the trust and the respect. For me as the pregnant person, but also for our family. Home birth is such an inclusive, slotting-into-your-life experience for the whole family." (P92: Consultant-led hospital, then public homebirth)

However, there was one participant who found having her family around for labour and birth at home somewhat distracting:

" The one challenge was that I had two younger children and with my mother here to care for them I found it a bit distracting rather than being gone straight to the hospital." (P18: Midwifery-led hospital, then public homebirth)

For those who disclosed negative experiences within the hospital-setting, terms like *'disgraceful'*, *'impersonal'*, *'not respected'* or *'traumatic'* were articulated. Participants who described positive experiences under consultant-led care in the hospital used phrases like *'fine'*, *'good standard'* or '*met expectations*'. Descriptions of midwifery-led care in hospital were mixed. Some described it with words such as '*fabulous'* and '*wonderful'* while others used expressions like *'stressful'*, *'busy'* or *'not respectful'*.

Some participants indicated the physical environment of the hospital and the approach to birth switched the power dynamic between the care provider and the individual which was divergent from homebirth experiences:

"I felt the care I received was good but totally felt like a vessel and the cargo was somebody else's property. I felt I was told what was going to happen and my wellbeing (other than physical health) and voice were unimportant." (P28: Midwifery-led hospital, then public homebirth)

Several participants perceived the institutional and organisational needs of the hospital superseded their needs and aspirations for their birth. Administration procedures, staff rotas or time constraints were reported as contributing to negative hospital experiences:

"More concern for clock watching, shift ending, how long pushing than person-centred care…" (P60: Consultant-led hospital, then private homebirth)

Several participants described 'bad' encounters, which ended when staff shifts changed and a perceived offending care provider was replaced by a different, more amenable care provider, and subsequently a more positive experience was reported.

The overwhelming majority of comments relating to participants' experiences of birthing at home were extremely positive and were reported to have had a life-affirming effect in many instances. Most comments referred to being autonomous in their decisions and feeling unconditionally supported, as articulated in the next quote:

"It could not have been more different. The midwives constantly reminded me that it was my birth and my choice and that they were there to give me support and information so that my baby and I were safe. The care, attention, support I received was incredible" (P84: Midwifery-led hospital, then public homebirth)

Two participants reported less-positive perceptions of homebirth experiences, both related to the imposing of regulations, which attenuated decision-making power:

"Even with my homebirth, there were decisions made for me, i.e. *you cannot birth in your own pool, you must come in for induction next week if you are still pregnant, you cannot birth at home if you go over by 14+ days etc."* (P64: Consultant-led hospital, then public homebirth)

Of the 137 participants who answered the question on choice for a future birth, all except one (P18) indicated they would choose a homebirth. This was the participant who felt the family's presence (in the home) was distracting during labour and birth. Indeed, many participants enjoyed their homebirth experience so much they wished that others might experience it for themselves: *"I wish everyone could experience homebirth."* (P37: Midwifery-led hospital, then public homebirth). Not one participant wished the same for hospital birth.

Discussion

This topic is important as positive birth experiences can create feelings of accomplishment and empowerment. Negative experiences can lead to feelings of vulnerability with life-long consequences [33,34]. Studying the experiences of those who have experienced care in both systems is relatively unique. These individuals' perceptions are important, as they provide fresh insights into women and people's experiences of receiving maternity care in each setting. As WPCC is a principal objective of both Irish and international policy [6,15], it is essential to understand how care provided is perceived from the multiple, and potentially divergent, perspectives of those receiving this care, particularly if choice is restricted. Additionally, it has been suggested that women and people, midwives and doctors may hold divergent perspectives on what constitutes WPCC [35,36].

On average, participants perceived their homebirth experiences far more positively when compared to their experiences of hospital-based birth across all aspects of care investigated. Furthermore, participants rated their experience of hospital-based care significantly less positively than the national average score obtained via NMES [7]. This could indicate that individuals who choose and experience both hospital and homebirth may be a distinct group, with different perceptions of care compared to the average birthing woman or person. These data cannot demonstrate whether their preferences are informed by their relatively unusual experience of having both a home and hospital birth, or if they preceded these experiences. Regardless, the data indicate a cohort of individuals with experience of both forms of care for whom, on average, hospital-based maternity care did not fulfil their needs and aspirations to the same extent as homebirth maternity care. Lack of choice, or negative hospital experiences, have led some individuals to choose to 'freebirth' an intentional homebirth with no registered care provider [37,38]. Others move to a different country with less restrictive homebirth criteria [39].

The findings of this study strongly echo the findings of the two US qualitative studies [12,13]. These studies presented participants' experiences of hospital birth compared to homebirth as being in binary opposition. In both these studies, their less positive hospital birth experience was a motivating factor for pursuing a homebirth. Similarly, the vast majority of this study's sample experienced a hospital birth and subsequently a homebirth, which may have influenced participants' experiences in each setting. Future research could seek out the perspectives of those who experienced a homebirth followed by a hospital birth, as their perspectives may provide disparate understandings. Nonetheless, the insights from all these studies converge in relation to the oppositional themes emergent from experiences of birthing in each setting. However, it is possible that for participants in these studies, the act of comparing their hospital births to their 'extremely positive' homebirths, might have caused them to 'downgrade' their hospital experience.

Typically midwifery-led care is categorised as a 'social model' of birth, with homebirth located at this far end of the spectrum [40]. The social model understands birth as natural, generally safe, physiological event that, for most people, will not require any medical intervention [9]. By contrast, the 'medical model' understands birth as pathological and full of potential risk, requiring a hospital-setting, with access to the full suite of medical equipment, under the supervision of an obstetrician [40]. Participants' perspectives about pregnancy and birth in this study align strongly with the social approach, and encounters with the medical approach were not generally understood or experienced as positively. Indeed, using the analogy of a spectrum, the further away care moved from the social model, the less positive participants' perceptions became to varying degrees.

The World Health Organization (WHO) [41], informed by a

systematic review [42], advocates that a positive birth experience must 'fulfil or exceed prior personal and socio-cultural beliefs and expectations' (p12). Most women and people 'want a physiological labour and birth, and to have a sense of personal achievement and control through involvement in decision-making, even when medical interventions are needed or wanted' (p12) [41]. Both 'choice and control' were also found to be mediating factors for first-time mothers' birth experiences [18]. All participants in this study perceived their lack of involvement in decisions about their care as undesirable, and not conducive to positive experiences. Indeed, a significant number of participants in this study perceived that interventions were performed without adequate information or (explicit) consent, contravening the Montgomery ruling regarding informed consent [43]. This is particularly important considering the high-rates of IoL and operative births reported in Irish hospitals [21–23]. It also reveals the key role of informed decision-making in birth experiences, and how it can act as a mechanism of empowerment.

A key issue that is emerging from all of the recent literature is the relational aspect of care [12, 13, 18, 41, 42, 44–47]. Continuity of care (r) facilitates this by allowing a relationship to develop between the individual and care provider(s), which is based on mutual trust and respect, over the course of the pregnancy [47]. Previous research found that the absence of connections with care providers left some individuals with a sense of isolation or fear during labour and birth in a hospital-setting [18, 44, 46], and this study's findings concur. Participants clearly identified that CoC and mutually respectful relationships were essential elements for positive birth experiences, these were most abundant during homebirth care, and were frequently reported to be comparatively lacking during hospital-based care.

It has been argued the power imbalance between the institution and the individual can define the birth experience in a hospital-setting [48]. Similarly, a Cochrane review of midwifery-led care concluded hospital policies, and government strategies, can affect how midwives are 'allowed' to practice [49,50]. Certainly, narratives from this study's participants convey many examples of this. The birth experiences shared depict situations where individuals perceived the institutional needs of the hospital, policies and procedures, were placed above individuals' needs and aspirations in the hospital-setting. The perceived restriction of participants' autonomy during childbirth or over-regulation of care practices were not understood positively in any setting. Conversely, there were very few instances of this discussed in the homebirth setting. Maternity care provided within the hospital setting was primarily perceived by participants as strongly medicalised and interventionist. This raises questions about whether the full spectrum of choices for non-medicalised care are available within hospitals, and (in)consistency in approaches to care provision, especially considering that some participants in this study felt there was an element of 'luck' over which professionals they encountered on their labour and birth journey.

Nonetheless, it has been surmised that elements of both models are required to provide quality and 'fit-for-purpose' maternity care (p495) [9]. It is further argued marrying these elements to circumvent a 'one-size-fits-all' approach to providing care, will better meet the needs of women and people, communities and those providing their care [9].

Strengths and limitations

As this study used social media platforms to promote the online survey, only those with access to the internet and utilising these platforms could participate. However, as there is little known about this hard-to-reach population, these are appropriate recruitment methods. As such, this study does not claim to present generalisable data. Nevertheless, this study has made an important contribution by addressing a gap in knowledge by granting insights into understudied population and topic internationally.

Conclusion

This study suggests that the minority group who have experienced both home and hospital birth have unique perspectives and aspirations for pregnancy and birth. Owing to these divergent perspectives on birth, it is evident that having access to a variety of choices for care, as well as care-givers who are respectful and responsive to divergent perspectives about childbirth, will be essential for those giving birth especially in the prevalent hospital-setting. In light of these findings, it is evident that the maternity care system as a whole could be improved through better implementation of the social model to increase women and people's satisfaction with their birthing experience in the hospital-setting.

Ethical statement

This research was granted approval by the Research Ethics Committee in the School of Social Work and Social Policy, University of Dublin, Trinity College on the 9th June 2021. REC Approval number 961.

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CRediT authorship contribution statement

SG conceived the research design and collected and analysed the data, with supervisory support from LC. Original draft prepared by SG with input and editorial support from LC and DD. All authors provided critical feedback and helped shape the manuscript. All authors have read and agreed to the published version of the manuscript.

Conflict of interest

I confirm that there are no conflicts of interest relating to this publication. I also confirm that there were no outside sources of funding for this research. I confirm that this article is the authors' original work. The article has not received prior publication and is not under consideration for publication elsewhere. All authors have seen and approved the manuscript which is being submitted. The authors agree to abide by the copyright terms and conditions of Elsevier and the Australian College of Midwives.

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