

⇒ Research Article



Evaluation of Birth Outcomes of Women Delivering at Home With Midwife Management

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Abstract

Background: Although there are very few studies in the literature, out-of-hospital deliveries are increasing in Turkey. Our aim was to examine trends in out-of-hospital deliveries, the risk profile of these deliveries, differences in women's access to these deliveries, and delivery outcomes.

Methods: This cross-sectional study included 215 women and was conducted retrospectively in a rural setting in Turkey between 2020 and 2021. Data were collected using a questionnaire developed by the authors. The questionnaire included demographic information, obstetric background, and reasons for giving birth at home, as well as data on who encouraged the decision to give birth at home and who helped with home births.

Results: In the study, the delivery time of mothers was found to be 5.99 hours, which is shorter than the average delivery time in the literature. It was observed that 87% of the mothers did not undergo episiotomy, and none of them experienced the need for induction at birth. It was determined that 49.8% of the mothers gave birth in the position they wanted and chose to give birth in bed. It was observed that 99.1% of the mothers did not experience complications at birth.

Conclusion: Overall, midwife-managed births met the mothers' expectations of privacy, a safe environment, social support, and uninterrupted birth. More importantly, there were no complications in midwife-led deliveries, and midwifery care was given in line with evidence-based practices.

Keywords: Birthplace Setting, Home births, Home childbirth, Delivery of health care, Non-clinical distribution

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Received: October 17, 2022, Accepted: November 26, 2022, Published Online: March 13, 2023

Background

Although pregnancy and childbirth are physiological actions, they are essential and unique situations in women's lives. The care given during these processes can physically and mentally affect the mother and her baby in the short and long term (1). The pregnancy and birth process experienced by mothers, both physically and mentally, significantly affects all reproductive efficiency in the future (2). The World Health Organization (WHO) emphasizes that every birth is unique and unique (3). In the medicalization process, apart from the decisions of the mother and family, various factors such as vascular access, many blood tests, continuous electronic fetal monitoring attempts, the issue of asking many questions for anamnesis, excessive vaginal examination, and increased use of pharmacological agents affecting the birth process, especially with early hospitalization create a 'control' effect on the pregnant woman's body. Considering that medical interventions were performed more than necessary, pregnant women increased their tendency to cesarean section (CS) with the thought that CS would be more accessible and the process would be overcome more quickly (4). CS surgery is performed to

avoid medical interventions at birth; therefore, it exceeds the 15% rate given by the WHO for CS. In the United States of America, to avoid these unnecessary attempts, pregnant women turned to home birth, which has been a significant increase in the last ten years (5). In England, the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists published a joint statement on "providing home birth support for women with uncomplicated pregnancies" (6). The National Institute for Health and Care Excellence reported that low-risk multiparous women giving birth at home are safe for the baby. Their interventions will be extremely lower than in a hospital setting (1). The American Society of Gynecology and Obstetrics emphasizes that births are the most reliable environment in hospitals and accredited birth centers and states that mothers have the right to be informed and make decisions (7). In a 4-year study in Canada, home and hospital births (n=2889) were compared with midwife-led births (n=4752) and physician-administered deliveries (n=5631). In the midwife-managed births, in the planned home-birth group, the perinatal mortality rate per 1000 births was 35%, and 57% of women accompanied by a midwife

were in the planned hospital delivery group. This rate was found to be 64% in women accompanied by a physician. It was observed that obstetric interventions, assisted vaginal delivery, perineal tears, and postpartum hemorrhage were significantly lower in pregnant women with planned home birth than in hospital deliveries. However, in-hospital deliveries by a midwife and a doctor were similar in the study. On the other hand, the possibility of resuscitation at birth and receiving oxygen therapy in the first 24 hours was found to be lower in home births with planned meconium aspiration than in hospital births, and the probability of hospitalization of babies born in a planned hospital was reported to be extremely higher (8). In the study examining the home birth experiences of mothers in the Netherlands, mothers who gave birth at home with the support of a midwife expressed that they were more satisfied than mothers who gave birth with a midwife or doctor in the hospital (9).

Although there are data on home births worldwide, there few studies have focused on planned and water-planned home birth in our country (10,11). Kukulcu and Öncel demonstrated that women gave birth at home due to economic difficulties and received support from midwives at a high rate (11). In addition, Gun Eryilmaz et al observed that women were followed at home until the cervix was fully open, and the rates of CS and episiotomy were low (10). However, women express their demands for a home birth on social media platforms, and it is their most basic right to respect women's opinions on the choice of place of birth (12). In our country, a series of legal regulations and national criteria should be determined to meet women's demands for home birth. With the legal regulation in our country, midwives who fulfill the adequacy requirements of the law can open a health cabin following the provisions of the Ministry of Health No. 1219 on the "Law on the Execution of Medicine and Medical Arts". According to the 11th article of the health cabinet regulation of this law, it is stated that midwives can give birth at home. Some of our midwives, who have a health cabin, perform planned home and water births in our country. After making a risk assessment among pregnant women and giving similar training, such as many birth preparation training sessions, they follow the birth in its natural course and give birth in a healthy, happy, and peaceful environment as much as possible without any intervention. The effects of hospital delivery after home birth have not been adequately studied in our country, and data on these pregnancies are scarce. Accordingly, our study aimed to retrospectively analyze the birth outcomes of women who gave birth at home under midwives' management in our country.

Materials and Methods

The statistical population of this retrospective descriptive study consisted of 280 women who received birth support

from a midwife in the last two years in Konya. No sample selection was made, and it was aimed to reach all women who received midwife support for a home birth from the health cabinet. Two hundred fifteen women who agreed to participate in the study were included in the study. The total statistical population reached 77%. The study data were collected from June 15, 2021, to December 15, 2021. In the study, the data were collected with the data collection form prepared by the researchers and the postpartum attachment scale.

Inclusion Criteria

- To agree to participate in the study
- To have given birth at home under the management of the midwife of the health cabinet determined between 2020-2021.

Exclusion Criteria

- Refusing to participate in the study
- Having given birth in years other than 2020-2021
- Having given birth outside the home
- Having given birth with a midwife other than the midwife attached to the designated health cabinet.

Data Collection Form

It was prepared by the researchers in line with the literature and consisted of 40 questions. The questions included the quantitative characteristics of midwife-led deliveries in the health cabinet.

The Postpartum Bonding Questionnaire

It is a mother-filled scale developed to diagnose attachment problems between the mother and baby early (13). The validity and reliability of this tool were confirmed by Yalçın et al in Turkey (14). It is a six-point Likert-type scale and is scored between 0 and 5 as 'always', 'very often', 'often', 'sometimes', 'rarely', and 'never'. Seventeen items are reversely coded, ranging from 5 to 0. It has 25 questions in total and four sub-dimensions, including 'attachment disorder' (12 items), 'rejection and irritability' (7), 'tension about care' (4), and 'risk of abuse' (2) (14). As the score increased according to the evaluation level of the scale, it was stated that the mothers had attachment problems. Cronbach's alpha values of the sub-dimensions of the scale were 0.93, 0.89, 0.56, and 0.28 for attachment disorder (Factor 1), rejection and irritability (Factor II), anxiety about care (Factor III), and abuse onset (Factor IV), respectively. The total Cronbach's alpha value of the scale has been reported as well. The cut-off points for the four subscales were attachment disorder (subscale 1) ≥ 12 , rejection and irritability (subscale 2) ≥ 17 , infant care anxiety (subscale 3) ≥ 10 , and risk of abuse (subscale 4) ≥ 3 , respectively. The Cronbach's alpha values in our study were 0.78, 0.80, 0.60, and 0.60 for attachment disorder (Factor I), rejection and irritability (Factor II),

caregiving tension (Factor III), and abuse onset (Factor IV), and the total score was 0.83.

Data Analysis

The obtained data were analyzed with the Statistical Package for Social Sciences (SPSS) program for Windows (version 20.0). According to the findings, given that the Skewness and Kurtosis values did not remain within the + 2.0/-2.0 limit range, it was found that the data showed a normal distribution (15). The statistics of continuous variables in the study are represented by means, standard deviations, and minimum and maximum values. The descriptive statistics of categorical variables were analyzed with frequencies and percentages. In this study, paired groups were analyzed with the Mann-Whitney U test, and the significance level was at $P < 0.05$.

Results

In our study, the sub-dimensions of the postpartum attachment scale were attachment disorder (0.65), rejection and irritability (0.71), care-related tension (0.67), and abuse risk (0.90), and the scale total score of the scale was 0.88.

The mean age of mothers participating in the study was 27.97 ± 4.11 years. It was observed that 79.5%, 7%, and 13.5% of the mothers gave birth at home, health cabin, and water, respectively. Further, 54.4%, 28.4%, and 13% of mothers had a university, high school, and primary school education, and 4% of them were postgraduate, respectively. It results further represented that 43% and 21% of mothers worked and were teachers, respectively. Based on the results, 60.9%, 94%, and 60.9% of mothers had an income equal to their expenses, a nuclear family, and social security belonging to the social security institution, respectively (Table 1).

Based on the data related to the obstetric characteristics of the mothers, the number of pregnancies, births, and living children was 2.06 ± 1.13 , 1.84 ± 0.94 , and 1.82 ± 0.95 , respectively. Furthermore, the mean delivery week of women was 39.65 ± 1.28 weeks. The results also demonstrated that 38.61% of the mothers had a previous birth at home. It was revealed that 75.3% of mothers had no problems in their previous pregnancies, and 67.9% of them were followed up during pregnancy. Additionally, 93% and 97.4% of mothers had no problems and used no drugs during this pregnancy, respectively. Likewise, 69.8% and 57.2% of them received preparation for delivery training during their pregnancy and training from midwives, respectively (Table 2).

Moreover, the average delivery time of mothers was 5.99 ± 5.76 hours. The frequency of meeting with the midwife during the pregnancies of mothers was 5.64 ± 3.03 times. According to the results, 87% of mothers did not undergo episiotomy. It was found that 42.8%, 32.6%, 21.4%, and 3.3% of postpartum skin-to-skin contact times

were 30, 10, 60, and 1 minutes, respectively. The results related to the mothers' delayed cord clamping times represented that 38.6%, 32.6%, 25.1%, and 3.7% of them were after 30, 10, 60, and 1 minutes, respectively. Based on the findings, none of the mothers applied induction to support the delivery. In addition, the mothers' cases of perineal injury at birth indicated that 72.6% of them did not experience perineal injury. It was further observed that 49.8%, 26.5%, 10.2%, and 13.5% of mothers gave birth lying down, squatting, knee-elbow, and sitting in the water, respectively. The findings revealed that 99.1%

Table 1. Birth Socio-demographic Characteristics of Mothers

Feature	Mean ± SD	Min-Max (Median)
Age	27.97 ± 4.11	20-39 (27)
Number of people living in the household	3.81 ± 1.13	1-9 (4)
	No.	%
Place of birth		
Home birth	171	79.5
Birth in the health cabinet	5	7.0
Water birth at home/health cabinet	29	13.5
Educational status		
Primary education	28	13.0
High school	61	28.4
University	117	54.4
Postgraduate	9	4.2
Working status		
Yes	43	20.0
No	172	80.0
Job		
Teacher	46	21.4
Housewife	129	60.0
Engineer	8	3.7
Health employee	16	7.4
Other	16	7.5
Income status		
Income less than expenses	24	11.2
Equal to income expense	131	60.9
Income more than expenses	60	27.9
Family type		
Nuclear family	202	94.0
Extended family	13	6.0
Social security status		
SSK	131	60.9
Bagkur	28	13.0
Pension fund	37	17.2
Pension fund	3	1.4
No social security	16	7.4
Total	215	100.0

Note. SSK: Social insurance institution.

Table 2. Obstetric Characteristics of Mothers

Feature	Mean ± SD	Min-Max (Median)
Number of pregnancies	2.06 ± 1.13	1-7 (2)
Number of births	1.84 ± 0.94	1-6 (2)
Number of living children	1.82 ± 0.95	1-6 (2)
Miscarriage/abortion count	0.20 ± 0.52	0-4 (0)
Gestational week at birth	39.65 ± 1.28	43-36 (40)
	No.	%
Where did she give birth before		
At home	83.00	38.61
Public hospital	26.00	12.01
private hospital	59.00	27.44
My first birth	47.00	21.90
Problems in a previous birth		
Yes	53	24.7
No	162	75.3
Check-up status during pregnancy		
Yes	146	67.9
No	69	32.1
Problems in pregnancy		
I had no problems	200	93.0
Hyperthyroid/hypothyroidism	4	1.9
Gestational diabetes (gestational diabetes)	1	0.5
Premature birth threat	8	3.7
Other	2	0.9
Drug use during pregnancy		
I did not use	188	87.4
Progesterone	9	4.2
Progesterone	6	2.8
Vitamin	8	3.7
Blood thinner	4	1.9
Status of receiving childbirth preparation training during pregnancy		
Yes	150	69.8
No	65	30.2
From whom did he receive the training?		
Midwife	123	57.2
Physician	6	2.8
Press. internet	12	5.6
Birth companion	9	4.2
I did not take	65	30.2
Baby's gender		
Girl	115	53.5
Male	100	46.5
Total	215	100.0

of mothers were able to contact their midwives when they had problems (Table 3).

The situations that met the expectations of the mothers

in their birth after home birth were asked. It was seen that almost all of the answers (between 96.7% and 91.2%) were privacy, natural environment with spouse/family, a safe/warm environment, receiving quality care and a healthier environment free from unnecessary interventions. The

Table 3. Characteristics of her Birth

Feature	Mean ± SD	Min-Max (Median)
Birth time	5.99 ± 5.76	1-34 (4)
Frequency of meeting with midwife during pregnancy	5.64 ± 3.03	1-20 (5)
	No.	%
Episiotomy opening status		
Opened	28	13.0
It did not open	187	87.0
Your skin contact application time (min)		
1	7	3.3
10	70	32.6
30	92	42.8
60	46	21.4
Delayed clamping of the cord (min)		
1	8	3.7
10	70	32.6
30	83	38.6
60	54	25.1
Placenta (Baby partner) separation status		
Lotus birth	25	11.6
Half lotus birth	158	73.5
Normal	32	14.9
Condition of application of induction (artificial pain) at birth		
No	215	100.0
Postpartum breastfeeding initiation time		
In the first half hour	147	68.4
Within the first hour	68	31.6
Postpartum complications		
Yes	2	0.9
No	213	99.1
Perineal injury at birth		
Yes	59	27.4
No	156	72.6
Position at birth		
Lying down	107	49.8
Crouching down	57	26.5
In knee-elbow position	22	10.2
Birth in water	29	13.5
Ability to communicate with your midwife when you have problems		
Yes	213	99.1
No	2	0.9
Total	215	100

well-being of postpartum babies was questioned, and it was found that 98.6% of mothers described their babies as “Healthy, with warm pink skin” (Table 4).

The postpartum attachment scale scores of mothers are provided in Table 5. Our results showed that the mothers’ total scores with regard to scales and all sub-dimensions were low. In line with this result, it was revealed that there is no problem with mother-infant bonding (Table 5).

The relationship between mothers’ perineal trauma at birth and their postpartum attachment scale mean scores was analyzed using the Mann-Whitney U test. A significant correlation was found between the mother’s perineal trauma at birth and the sub-dimensions of rejection and irritability, tension about care, and risk of abuse ($P=0.01$, $P=0.00$, and $P=0.00$, respectively). Based on the results, a significant difference was represented in women who experienced perineal trauma or injury at birth (Table 6).

Discussion

In the current study, mothers who gave birth at home were accompanied by a midwife. Communication with the midwife, the rate of opening episiotomy at birth, skin-to-skin contact times, delayed cord clamping times, why they preferred home birth, and the rate of satisfaction with the birth were evaluated during the pregnancy period. In our study, pregnant women had an average of 5 or more visits with their mothers. Overall, 87%, 42.8%, and 38.6% of them did not undergo episiotomy, had skin-to-skin contact for 30 minutes, and had delayed cord clamping after 30 minutes, respectively, and no labor induction was applied to any of them. Based on the findings, 99% of them had no complications, and 99% of them were in good communication with their midwives. According to the analysis, deliveries performed at home accompanied by a midwife were extremely fewer unnecessary interventions than those performed in the hospital, and satisfaction was extremely high among the mother (16). In a meta-analysis of six controlled observational studies, Olsen analyzed 24,092 pregnant women and then compared planned home and hospital deliveries. It was concluded that low APGAR scores and severe lacerations were less considerable in the planned home delivery group. Medical interventions such as induction, episiotomy, and CS were less common than planned hospital deliveries. No maternal death was observed in the pregnant women who participated in this study (17), which is in line with our results.

Bernhard et al qualitatively examined the reasons the US women, who gave birth at home after hospital delivery, chose home birth, and five main themes were revealed in their study, and they formed five focus groups accordingly (n=20). In the first group of these themes, choices, and empowerment, mothers emphasized that with home birth, their belief in themselves is firmer, they

Table 4. Home Birth Expectancy and Newborn Health Status of Mothers

	No.	%
Situations meeting your expectations in your midwife-directed birth*		
Privacy	208	96.7
Natural environment with spouse/family	206	95.8
A safe/warm environment	205	95.3
Getting quality care	196	91.2
A healthier environment free from unnecessary interventions	208	96.7
Other	24	11.2
Your baby’s well-being according to your observations immediately after birth		
Healthy: hot pink-looking skin	212	98.6
Distressed: cold purple-looking skin	3	1.4
Total	215	100

Note. *Multiple options are marked.

Table 5. Postpartum Attachment Scale Mean Scores of Mothers

The Postpartum Bonding Questionnaire	Mean ± SD	Min-Max (Median)
Attachment disorder	20.57 ± 2.18	20 (15-32)
Rejection and irritability	10.63 ± 2.18	10 (10-25)
Tension about care	10.28 ± 1.30	10 (8-20)
Risk of abuse	0.26 ± 0.00	0 (0-10)
Total points	41.49 ± 5.26	40 (35-75)

Table 6. The Relationship Between Mothers’ Perineal Trauma at Birth and Postpartum Attachment Scale Mean Scores

The Postpartum Bonding Questionnaire	Perineal Trauma Survival Status		P*
	Yes	No	
Attachment disorder	20 (17-30)	20 (15-32)	0.15
Rejection and irritability	10 (10-25)	10 (10-22)	0.01
Tension about care	10 (10-20)	10 (8-18)	0.00
Risk of abuse	0 (0-10)	0 (0-8)	0.00
Total points	40 (37-75)	40 (35-72)	0.13

Note. *Mann-Whitney U test [median (min-max)].

feel more robust and believe that they have a natural choice. The second group included intervention and interruptions; mothers emphasized that practices that do not assist delivery in hospital deliveries were performed, and there were interruptions in-hospital deliveries. The third one contained disrespect and expulsion; mothers who opted for home birth were expelled by hospital staff. In the fourth group of birth, mothers stated that they experienced a peaceful and calm birth environment in their own homes, surrounded by people of their choice. In the fifth attachment group, mothers mentioned that the feeling of attachment to birth professionals, their families, newborn babies, and their bodies was more active with home birth (18). In studies conducted by Brocklehurst et al, it was observed that the mother’s home birth increased intrinsic motivation and gave women

confidence in the transition to motherhood and the other areas of their lives (19). In our study, mothers were asked about the situations that met their expectations after birth at home, and almost all mothers (between 96.7% and 91.2%) were asked about privacy, natural environment with spouse/family, a safe/warm environment, and issues such as receiving quality care and avoiding unnecessary interventions. They indicated that they created a healthier environment. In addition, the postpartum attachment scale was applied to mothers, and according to the results of the scale, 94% of mothers felt close to their babies. Further, 97.2% and 99.5% of them declared that their baby was the most beautiful in the world and felt lucky to have a baby, respectively. They were found to have no problem. The results of our study corroborate with previous data regarding why women prefer home birth.

In their study on 3283 Swedish women, Hildingsson et al concluded that home births would increase ten times when Swedish women were given the freedom to choose their place of birth (20). In another study on 500 women in Canada, Janssen et al asked open-ended questions about the positive and negative aspects of births they had with a regular midwife at home. Based on their findings, the women's trust in the knowledge and experience of the midwives, the emotional support and empowerment they obtained through their relationships with the midwife, their perception of relaxation in their own home, their awareness, their involvement in the planning of their care, and their involvement in the midwife's plans made women feel highly positive. Moreover, they believed that the time the midwife spent with her family, the intense preparation, and the partnership with the midwives were also essential to realize in an official setting (21). In our study, based on the relations of women with their regular midwives, the rate of receiving quality care, the rate of a healthier environment free from unnecessary interventions, and communication with midwives was 91.2%, 96.7%, and 99.1%, respectively. These results are in agreement with previous data in the literature.

Davis et al examined New Zealand planned home births and found the rate of planned and home births to be 3.3%. Based on the analysis of data on these deliveries, it was revealed that all intervention rates, including CS and instrumental deliveries, were lower in mothers who gave birth at home (22). In a large prospective cohort study by Johnson and Daviss, 5418 women in North America agreed with their midwives for planned home birth and were supported by their midwives. Further, 655 (12.1%) women who planned to give birth at home were referred to the hospital after labor initiation. Medical intervention rates were determined as an epidural (4.7%), episiotomy opening (2.1%), forceps (1.0%), vacuum extraction (0.6%), and CS (3.7%), and these rates were extremely lower than the US women's delivery in the hospital (23). In our study, however, none of the mentioned medical

interventions were encountered, and no referral to the hospital was necessary. Based on the literature review, a cohort study of 743 070 low-risk planned home and hospital births was prepared in the Netherlands, and it was demonstrated that there was no increase in adverse effects when the results of newborns were extended to 28 days (24). In the study of Janssen et al in Canada, planned home and hospital births were compared, and it was found that neonatal outcomes such as birth trauma, meconium aspiration, and resuscitation were similarly low in both groups, and there was no increase in adverse outcomes for planned home births (21). In our study, mothers were questioned about the well-being of the baby immediately after birth, and 98.6% of them stated that the babies were healthy and had warm skin and a pink appearance, which conforms to the results of other studies.

De Jonge et al concluded that planned home births also showed variability in delayed cord clamping times, skin-to-skin contact times, and breastfeeding compared to deliveries in hospitals (24). In a study conducted in Canada, it was observed that mothers who gave birth at home breastfed their babies at a rate of 95.5%, while mothers who gave birth in a hospital nursed their babies at a rate of 84.5% (25). In our study, regarding the skin-to-skin contact times of mothers with their newborn babies, it was found that 32.6%, 42.8%, and 21.4% of them were contacted for 10, 30, and 60 minutes, respectively. As regards delayed clamping times of the cord, the cord was clamped at 32.6%, 38.6%, and 25.1% after 10, 30, and 60 minutes, respectively. With respect to the postpartum breastfeeding initiation time, 62.3%, 31.6%, and 6% of mothers stated that it happened within the first half-hour, the first hour, and after an hour, respectively. The results of breastfeeding time and delayed cord clamping time in our study were compatible with the literature.

Jouhki et al examined fathers' perspectives on home birth; fathers mentioned that planned births at home strengthen family ties and strengthen their relationships compared to births in hospitals (26). In addition, studies have shown that the cost of planned home births is extremely lower when compared to that of the hospital. In a cohort study by Schroeder et al examining the cost-effectiveness of alternative planned delivery locations in women with low risk of complications and the costs associated with low-risk vaginal delivery, it was revealed that the home delivery environment reduced the cost by 50% compared to the hospital (27). In our study, no results were related to costs in women's expectation of home birth. Mothers in our study were found to prefer home birth at a high rate (98%) because of their privacy. It was found that mothers' willingness to be in the natural environment with their spouse/family ranked second. These results are in conformity with previous findings.

Controversies surrounding home birth are present in the literature with pros and cons (28). Although the

literature warns against the risks of planned birth at home, it has shown highly positive results (29). Many websites and blogs have represented disagreements in this regard. One group warns against the risks of home birth, while another speaks of its benefits (30,31). Although the USA argues that it is a moral obligation to deter women's desire to give birth at home, some other countries emphasize that women have the right to choose based on autonomy (31). To end these differences of opinion, increasing the reliability of planned home births is one of the most critical factors. It has been argued that uniform guidelines outlining the suitability of the pregnant woman and the fetus and risk factors for home birth are essential building blocks for safe home birth (23,31). According to evidence, applying and adhering to the guidelines will result in planned home births having similar or more favorable outcomes as hospital births (3,30). In our study, it was observed that the rate of episiotomy in home births was extremely low (13%), and no induction was applied to any woman. Moreover, women did not experience postpartum complications. These results confirmed the reliability of home births and showed compatibility with the literature.

This study had some limitations. It had limited results with women who gave birth at home and was conducted only on a population of women who gave birth at home in a certain rural region in Turkey. The, the results should be generalized to other regions and cities with caution. Our findings represented that the traditional approach is common even in a large city in Turkey. However, the findings provided an informative result about home births in a geographic region.

Conclusion

In our study, it was revealed that the mothers' home birth expectations were met and included privacy, social support, and no unnecessary practices. The study results demonstrated that mothers care about safety, want a natural birth experience without medical interventions, and want to feel in control of their birth. The women in our study relied on their body's natural ability to give birth in the setting of their conception without intervention. According to our participants, there is no place like home for a safe, comfortable, peaceful, and relaxing birth. Our findings also emphasized the importance of increasing midwife-managed deliveries in reducing CS rates in our country. Eventually, it is suggested that midwives should manage risk-free births.

Acknowledgements

We would like to thank all the mothers who supported our work.

Authors' Contribution

Conceptualization: Reyhan Aydin Dogan, Vildan Unlü.

Data Curation: Reyhan Aydin Dogan, Vildan Unlü.

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Funding Acquisition: This study received no financial support.

Investigation: Reyhan Aydin Dogan, Vildan Unlü, Aysun Selvi, Şenay Yazici.

Methodology: Reyhan Aydin Dogan, Vildan Unlü.

Project Administration: Not done within the scope of the project.

Resources: Reyhan Aydin Dogan.

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Competing Interests

The authors declared no conflict of interests.

Ethical Approval

The applied procedures were approved by the Ethical Committee of Zonguldak Bülent Ecevit University Human Research Ethics Committee (Date: 31.05.2021, Issue: 190)

Funding

This study received no financial support.

Informed Consent

An informed consent form was obtained from women participating in the study.

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