

West Chester University

Digital Commons @ West Chester University

---

Health Faculty Publications

Health

---

10-2021

## Concerns of Women Choosing Community Birth During the COVID-19 Pandemic: A Qualitative Study

Sharon Bernecki DeJoy

Deborah Mandel

Niamh McFadden

Lauren Petrecca


Follow this and additional works at: [https://digitalcommons.wcupa.edu/hea\\_facpub](https://digitalcommons.wcupa.edu/hea_facpub)



Part of the [Maternal and Child Health Commons](#)

---

# Concerns of Women Choosing Community Birth During the COVID-19 Pandemic: A Qualitative Study

Sharon Bernecki DeJoy<sup>1</sup>, PhD, MPH, CPH , Deborah Mandel<sup>2</sup>, PhD, RNC-OB, Niamh McFadden<sup>1</sup>, BS, Lauren Petrecca<sup>1</sup>, BS

**Introduction:** During the coronavirus disease 2019 (COVID-19) pandemic, midwives have reported increased demand for community birth services. The purpose of this qualitative study was to understand childbearing persons' decision-making during the pandemic and to illuminate their experiences giving birth in community settings.

**Methods:** The study was framed by the interpretive phenomenological approach. Eligible participants were recruited from midwives providing out-of-hospital birth services. Of the 26 women who agreed to an interview, 17 were able to be reached and interviewed. Interviews followed a semistructured guide. Early paradigm cases were coded by all researchers, and then the first author coded the remaining transcripts. The final thematic structure was developed by the research team through an iterative process and validated through member checking.

**Results:** Four themes were identified: prior desire for a community birth, perceived susceptibility, barriers to choice, and isolation.

**Discussion:** Many participants had a preexisting desire for community birth and used the pandemic to justify their choice. However, birth options were often limited by finances and geography. Attitude toward COVID-19 varied by knowledge and experience. Many participants experienced stress and isolation.

J Midwifery Womens Health 2021;66:624–630 © 2021 by the American College of Nurse-Midwives.

**Keywords:** qualitative research, home birth, public health, COVID-19

## INTRODUCTION

In the United States, pregnant persons may choose to give birth in the hospital, at a freestanding birth center, or in their own home. Births that occur outside the hospital can be considered *community births*,<sup>1</sup> a term that decenters the hospital as the default location for birth. Although the percentage of community births increased between 2004 and 2017, use of community birth remains quite low; approximately 1.6% of birthing persons choose to give birth outside a hospital.<sup>2</sup> Persons who choose community birth are more likely to be non-Hispanic white, married, and older than 25 and to have had previous births than the average American birthing person.<sup>2</sup>

Persons who choose community birth do so for a variety of reasons, including religious or cultural beliefs, desire for greater control over their birthing experience than is possible in an institutional setting, and preference for what they consider a natural or nonpharmaceutical, less interventionist approach to labor and birth, among others.<sup>3</sup> A sense of personal or cultural safety links these disparate motivations. Given perceived safety as a motivation for community birth, it is not surprising that midwives report increasing requests from pregnant clients for out-of-hospital services, particularly

home birth, during the coronavirus disease 19 (COVID-19) pandemic.<sup>4,5</sup>

The purpose of this study was to understand the lived experiences of pregnant people who switched their planned place of birth from hospital to community settings as a result of the COVID-19 pandemic. The main goal of the study was to generate findings that could improve clinical practice for perinatal care during the remainder of the ongoing pandemic. A secondary goal was to explore the needs of birthing people in public health emergencies as a foundation for further research and policy development.

## METHODS

### Theoretical Framework

The researchers framed and conducted this study using interpretive phenomenology, which is both a philosophy and methodology that seeks to understand phenomena from the perspective of individuals' lived experiences.<sup>6,7</sup> Interpretive phenomenology recognizes that individuals make choices within the boundaries of their *lifeworld*, or context, and their experiences occur in dialogue and interpretation with that lifeworld.<sup>6,7</sup> Because the main goal of the study was to identify findings that could be used to improve clinical practice, we selected Benner's interpretive phenomenology method for practitioner-researchers.<sup>8</sup> Benner describes 5 sources of similarity and difference in lived experiences: situation, temporality, embodiment, concerns, and shared linguistic and cultural meanings about phenomena.<sup>8</sup> These constructs provided a valuable framework for exploring the individual experiences of people sharing the embodied state of pregnancy and birth in a specific time, in the United States, during a unique situation.

<sup>1</sup>Department of Health, West Chester University, West Chester, Pennsylvania

<sup>2</sup>Department of Nursing, West Chester University, West Chester, Pennsylvania

### Correspondence

Sharon Bernecki DeJoy  
Email: sdejoy@wcupa.edu

### ORCID

Sharon Bernecki DeJoy  <https://orcid.org/0000-0003-4273-4531>



## Quick Points

- ◆ Clients who sought a community birth during the COVID-19 pandemic often had a preexisting desire for this type of birth.
- ◆ Hospital policies that separate laboring persons from their infants or partners may drive some clients out of the hospital setting.
- ◆ The COVID-19 pandemic is a source of stress and isolation for pregnant persons.
- ◆ Ensuring consumers' access to the birth setting and attendant of their choice could improve birth outcomes at all times, but especially during public health emergencies.

Benner's method requires researchers to engage with participant narrative on a clinical and human level, while also regrounding themselves in theoretical concepts, in a continuous cycle of mining participant data and then interpreting that data through their own lifeworld.<sup>8</sup> Because qualitative researchers are emmeshed in their research process and dialogue with participants, they can never be wholly unbiased.<sup>9</sup> Researchers inevitably structure and analyze their inquiry based on their expertise, lived experiences, and understanding of relevant theory and literature.<sup>6,7</sup> To improve credibility and transparency, qualitative researchers must provide information about their background, as well as the specific choices made and actions taken during the entire research process.<sup>9</sup>

### Research Team and Reflexivity

The principal investigator (author 1) is a midwife formerly in community practice (certified professional midwife in inactive status) and holds a faculty and administrative position in a public health academic program. Author 2 is a registered nurse with hospital labor and birth experience who serves as nursing faculty. Authors 3 and 4 were undergraduate student interns in public health with an interest in maternal child health but no experience with midwifery, pregnancy, or birth. All authors identify as white, cisgendered women. Authors 1, 3, and 4 have varying levels of education and training in health behavior theory, and this background knowledge ended up informing some of the codes and themes.

The impetus for this study grew out of anecdotal data from midwife colleagues and popular press reports about an increased demand for community birth services during the pandemic. The research team assumed that participants might have a shared mainstream American cultural understanding of pregnancy and birth (ie, the hospital is the preferred or safest location for birth), and their choice of community birth might reflect a concern about infection with the virus responsible for COVID-19 (severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2]).<sup>8</sup> As practitioner-researchers, the team was concerned that some participants might experience distress or trauma from giving birth in a nonpreferred location, while recognizing others might have a positive experience that would change their beliefs about childbirth. However, the first few interviews yielded paradigm cases that showed these assumptions to be limited. In any case, the interpretive phenomenology approach selected by the researchers required continuous grounding in participant narratives that enabled meaning to emerge from the data.<sup>8</sup>

### Sampling and Data Collection

Selection criteria for the study included being an English-speaking pregnant person who planned a community birth in the spring, summer, or autumn of 2020 after initially planning a hospital birth. The researchers distributed a recruitment flyer and a link to a screening survey to 12 practicing midwife groups on social media and the internet. Ten groups were state midwifery professional, advocacy, and support associations located across the United States, and the remainder had national memberships. Although an effort was made to gain geographic diversity, a mainly convenience sampling technique was used, recognizing that recruiting busy midwives and pregnant and postpartum persons during a global pandemic would be challenging. Although some of the midwives in the social media groups were known to the first author, none of the participants were known to any of the researchers.

Posts and emails asked midwives to forward recruitment materials to new clients who contacted them seeking community birth because of pandemic-related concerns. The recruitment flyer circulated to clients reiterated that the study focused on midwifery clients who had changed their birth site because of the pandemic from hospital to home or free-standing birth center. Participants were asked to register for the study while pregnant or in the first 3 months' postpartum using a screening survey (see Supporting Information: Appendix S1).

Participants were recruited between March and September of 2020, and interviews were conducted between May and October of the same year. Participants' due dates ranged from March 2020 to September 2020; all participants were 2 weeks to 4 months postpartum when the interviews were conducted. The first few interviews in the spring were conducted by the first author, as were the interviews held in the autumn. Most of the interviews conducted over the summer months were led by the student interns, supervised by, and in conjunction with, the faculty researchers.

Twenty-six women completed the screening and registration survey with complete contact information and data about their pregnancy. All completed surveys received follow-up invitations to an interview via phone and email, and 17 women completed an interview. Each participant was interviewed in her own home; all women chose to speak via cell phone or laptop alone in a room, but in some cases the interviewees were interrupted by children, spouses, or caregivers. Interview length ranged from 9 to 22 minutes. Each participant was interviewed only once. After each interview,

the researchers who participated in the interview completed their own field notes.

As reimbursement for their time, each participant received a \$20 online gift certificate to the retailer of their choice. This research study was approved via the institutional review board at the university with which all researchers were affiliated. The researchers obtained written informed consent prior to the interviews and reviewed the informed consent document verbally prior to recording the interview.

### Data Processing, Analysis, and Techniques to Enhance Trustworthiness

Data were collected using a semistructured interview guide that was pretested with 2 individuals who had given birth (see Supporting Information: Appendix S2). Interviews were conducted via Zoom and recorded, with Zoom generating automated transcripts of the interviews. Transcripts were downloaded from Zoom and imported into Microsoft Word, and then each participant was assigned a pseudonym. The researchers worked collaboratively to correct any errors in transcription within 48 hours after each interview.

In addition to each participant being given a pseudonym in the transcript used for coding, participants were assigned a number in an Excel spreadsheet associated with their pseudonym and demographic data. Participant numbers correspond to the order in which they were interviewed; that is, participant 1 was interviewed in the spring and participant 17 was interviewed in the fall.

In Benner's interpretive phenomenological approach,<sup>8</sup> data collection and analysis occur simultaneously, which enables the researcher to explore themes identified in early interviews. Authors 1, 3, and 4 conducted initial coding of the first 4 interviews manually in word processing software using Benner's method of *interpretive dialogue*.<sup>8</sup> The researcher selects an initial *paradigm case* they feel best represents the phenomenon. This case is first analyzed as a whole and then important parts are pulled out for further analysis. Subsequent cases are analyzed in the same way; first, in isolation, and then in relation to the paradigm case. Once this process is complete, the researcher conducts a thematic analysis to identify similarities and differences among the cases.

After coding the results individually, the researchers met virtually to reach consensus on a preliminary codebook that was entered into nVivo software. Once the initial coding was completed for each transcript, field notes were reviewed and discussed by the first author and the lead interviewer (if not the first author) to refine the codes as needed. The remaining interviews were uploaded and coded using the software by the first author. Theoretical saturation was reached after 13 interviews, but all interviews were transcribed and analyzed to ensure that themes and quotations were representative of all participants who took the time and effort to respond. An important part of reporting results from engaged interpretive analysis is to present exemplars extracted from the data that demonstrate the differences and commonalities between lived experiences of the participants.<sup>8</sup> Authors 1 and 2 developed the final thematic structure via consensus. These themes were first emailed to authors 3 and 4 for validation and

**Table 1. Sociodemographic Characteristics of Participants (N = 17)**

| Characteristic                       | Value      |
|--------------------------------------|------------|
| <b>Age, mean (SD), y</b>             | 30.4 (3.6) |
| <b>Race, n (%)</b>                   |            |
| White                                | 13 (76)    |
| Black                                | 2 (12)     |
| Asian                                | 1 (6)      |
| Other (More than one race)           | 1 (6)      |
| <b>Ethnicity, n (%)</b>              |            |
| Latinx                               | 3 (18)     |
| Non-Latinx                           | 14 (82)    |
| <b>Region (state), n (%)</b>         |            |
| Northeast (NJ, MA, and PA)           | 6 (35)     |
| West (CA, CO, and OR)                | 4 (24)     |
| Southeast (WV and FL)                | 3 (18)     |
| Southwest (TX)                       | 3 (18)     |
| Midwest (MI)                         | 1 (6)      |
| <b>Interview month, n (%)</b>        |            |
| May 2020                             | 2 (12)     |
| June 2020                            | 8 (47)     |
| July 2020                            | 3 (18)     |
| August 2020                          | 1 (6)      |
| September 2020                       | 1 (6)      |
| October 2020                         | 2 (12)     |
| <b>Marital status, n (%)</b>         |            |
| Married                              | 13 (76)    |
| Unmarried but partnered              | 4 (24)     |
| <b>Parity, mean, (SD)</b>            | 2.3 (.9)   |
| <b>Planned birth location, n (%)</b> |            |
| Home                                 | 14 (82)    |
| Freestanding birth center            | 3 (18)     |
| <b>Actual birth location, n (%)</b>  |            |
| Home                                 | 9 (53)     |
| Freestanding birth center            | 2 (12)     |
| Hospital                             | 6 (35)     |

then emailed to participants for member checking and further validation.

## RESULTS

Participants in this study generally reflected the population of women giving birth in community settings,<sup>2</sup> with most participants being white, married, and multiparous (Table 1). All participants identified as ciswomen, and all were currently involved with the father of their child. The hospital transfer rate in this study was higher than reported in the literature<sup>10</sup>; however, because this study was qualitative in nature with a small sample, no inferences can be made about this inconsistency. Experiences of participants who transferred back to

**Table 2. Major Themes and Subthemes**

**Major themes (boldface) and related subthemes**

**Prior desire for community birth**

Prior negative hospital experience

Seeking the “home birth experience”

**Perceived susceptibility**

Personal experience

Natural defenses

Fear of the unknown

**Barriers to choice**

Access to maternity providers

Financial difficulties

**Isolation**

Hospital policies

Telemedicine

Safety bubbles

hospital-based care included the following nonemergency transfer for pregnancy complications: precipitous labor in which the hospital was closer than the midwife, closure of a midwifery practice, desire for pain relief, and lack of insurance reimbursement or self-pay funds for their midwife of choice. The data from women who transferred care were included in the analysis because those stories capture their lived experience of planning a community birth.

The first question in the semistructured interview guide generated the richest narrative from most participants, as they recounted their complex decision-making processes related to birth place and attendant. In relation to the birth experience itself, most participants responded more briefly, reporting a generally satisfying experience. The team identified 4 major themes from the data: prior desire for a community birth, perceived susceptibility, barriers to choice, and isolation. The thematic structure, including major themes and subthemes, is provided in Table 2.

**Prior Desire for Community Birth**

Most participants expressed a desire for community birth, particularly home birth, that existed prior to the COVID-19 pandemic. Raising concerns about hospital birth during the pandemic enabled participants to justify their choice to themselves, their partners, and skeptical family members and friends.

Some participants had experienced a previous traumatic birth and wanted to avoid another hospital birth. Recounting a story of cesarean birth, prolonged recovery, breastfeeding difficulties and postpartum depression, one participant said,

*All of that is ultimately what opened me up to it [home birth], because then I found another midwife that all these women had said would keep you out of the OR [operating room] at this hospital [the only one within driving distance]. (Participant 8)*

Other participants had always wanted to experience a home birth. Although participants provided rich, specific de-

tail about their decision-making processes about birth, many at some point expressed a similar feeling: “It was just something I always wanted.” (Participant 3) One participant captured this sentiment eloquently:

*I was so grateful to this virus because it forced me to be able to make the decision that I wanted to make. Because I wanted the, you know, orgasmic, peaceful experience that I'd read about. I wanted to go through that and feel all of those emotions that I'd read the other women did, about being self-actualized and blah, blah, blah. None of that really happened, by the way. It wasn't orgasmic or peaceful or easy or [hesitation]. It was harrowing, you know? But it was the birth that I wanted. (Participant 2)*

It should be noted that this comment was provided early in the pandemic, before the full extent of mortality and morbidity from the virus was known. Indeed, all interviews were conducted before the large surge in cases and deaths in the fall and winter of 2020/2021. Rather than callousness or indifference, this quote expresses a collective attitude among many participants of gratitude for the opportunity to choose a community birth.

**Perceived Susceptibility**

Participants' attitudes toward COVID-19 and their resulting birth choices were influenced by what can be termed *perceived susceptibility*. Perceived susceptibility is a person's subjective belief in their risk relative to a particular disease or condition<sup>11</sup> and is a term that is top of mind for 3 of the authors based on their background knowledge in health behavior. For participants with personal experience with the virus, the choice to birth in community settings was clear. As one participant explains,

*But then the whole COVID thing hit, and I'm a nurse. I work in the hospital on an infectious disease unit. So of course, we're a dedicated COVID unit. And I just kind of wanted to be as far away from the hospital as it possibly could, just with everything going on. It just felt safer and I was just more at peace with that decision than then going hospital at that time. (Participant 10)*

Others expressed few or no concerns about the virus. Especially for those who desired a community birth as part of natural lifestyle, SARS-CoV-2 was not viewed as a particular threat. Participant 4 stated,

*I would say contracting the virus was honestly at the bottom of our list...At the first signs of any type of flu, you know, we start taking the vitamin C, the zinc, the elderberry and boost our immune system. And that usually that takes care of whatever we have.*

Particularly at the beginning of the pandemic, some participants were unsure what to believe, trying to sift through and evaluate information from the news media and social media. Some participants expressed confusion about how dangerous the virus was, their risks of catching it at the hospital, or which hospital protocols would apply to their birth. One participant explained the effect of changing knowledge on their risk calculations:

*It's just so many unknowns. I think with COVID that really, you know, we're getting new guidelines every single day on how we're handling the whole situation and then, there's just too many unknowns and I just don't want to risk anything if I don't have to. (Participant 9)*

### Barriers to Choice

For some participants, COVID-19 restricted an already small pool of choices. Particularly for those women who lived in rural areas or wanted a vaginal birth after cesarean, a community birth seemed their most reasonable or only acceptable option for a safe birth experience. One participant explains that her search for a home birth midwife began after her small rural hospital closed, "That hospital [where the participant had been seeing a CNM] got closed down. So basically, that happened in February and I was 30 weeks pregnant or something and it was kind of like, okay, now enter COVID." (Participant 10)

For other participants, developing pregnancy complications, lack of midwifery availability in their region, or financial constraints forced them into the hospital setting after planning a community birth. Several participants noted their insurance did not cover their provider of choice, and/or economic constraints due to pandemic-related job losses meant they could not pay out-of-pocket for a home birth.

Others felt that a hospital birth might force them into accepting unwanted interventions, which were particularly dangerous during a time of high health care resource use. Most participants in the study were skeptical of interventions, but some also worried about how providers overworked by the pandemic might coerce them into a cesarean birth or be stretched too thin to care for them appropriately if they did have surgery. One participant explained her fears of having a cesarean birth during a pandemic this way, "We're going to force people into more surgeries that use more resources in a risky environment and have longer hospital stays? Tell me how that's logical." (Participant 12)

### Isolation

Another recurring theme in the interviews was isolation. Several women chose community birth out of fear of losing their social support during labor. Participants explained their choice by citing hospital policies that restricted partners and support people from attending the birth or mandated separation of women and newborns after birth. Some participants also noted that hospital policies would change rapidly, so there was no way of knowing which policies would be in effect when they went into labor. To avoid a potential loss of social support, some women chose community birth, as this participant explains:

*They [hospital] did have the policy that he [partner] could not leave the room. So, we're basically, for the 24 hours that we were in the hospital, we're stuck in the room and could not leave. And our other kids could not be brought up to visit. And that was another concern of ours, because we're very family oriented, and you know, going 24-48 hours without them seeing their sibling was a little distressing. (Participant 16)*

Others noted that receiving prenatal care via telemedicine contributed to their isolation. One participant captured the sentiment of participants who felt that telemedicine, although a necessary safety precaution, added to their feelings of isolation. She had experienced a prior traumatic birth and reported anxiety due to the following:

*That distance, and that whole disconnect from somebody actually being able to see me and pick up on all the external cues. You know, when you sit down with somebody, they can tell there's more going on when there's more going on, even if you're not saying it? So, it was just like that, kind of impersonal. (Participant 8)*

Some participants noted that receiving prenatal, postpartum, and intrapartum care in their home kept them safe in their quarantine bubbles. However, others participants noted that the pandemic contributed to the isolation of the postpartum period. As one participant explained:

*Then of course with COVID, you know, there's not nearly as many visitors as there normally would be. So, you kind of feel isolated, I think. And postpartum can feel isolating anyway, even when we had a lot of visitors, so that was some adjustment, as well (Participant 14)*

### DISCUSSION

To our knowledge, this qualitative study is the first to explore women's concerns and experiences in planning a community birth during the COVID-19 pandemic. Four themes emerged from the data: prior desire for a community birth, perceived susceptibility, barriers to choice, and isolation. These results broadly support the findings of a recent quantitative study that found birthing persons' motivations for planned out-of-hospital birth in the pandemic included a preference for physiologic birth, a need for support people during birth and the postpartum period, and some concern about being infected with SARS-CoV-2.<sup>12</sup>

Benner's interpretive phenomenology method enables practitioner-researchers to highlight distinctions and similarities in the lived experiences of participants. Overall, this study identified some noticeable similarities among participants; namely, many women in this study shared an understanding of birth not as a medical condition but as an inherently healthy and physiologic process that affects the whole person and their family. Their concerns during the COVID-19 pandemic focused not only on the risks of disease but also on the broader implications of the pandemic on their pregnancy, birth, and postpartum experience. Although the pandemic may have intensified participants' concerns, these concerns were not wholly a novel response to the COVID-19 but also reflected the ongoing needs of childbearing persons as identified in the literature; autonomy, support, informed choice, and the judicious use of intervention in birth when indicated.<sup>3</sup>

Although the researchers initially assumed that participants may have felt driven into a community birth, we found the opposite; many participants felt locked into birthing at a specific hospital, whether because of geography, insurance, or prior obstetric history, and the pandemic provided justification to free themselves from those circumstances. Even if

they did not achieve a community birth, most participants in the study reported being satisfied with their birth experience. Some noted that, because of complications that arose in the perinatal period, they ultimately felt that the hospital transfer was prudent or necessary. Others who switched back to hospital-based care for economic reasons decided they had made a sound financial decision for their family, particularly with the economic uncertainty surrounding the pandemic. Most were grateful they had the opportunity to envision and plan for the birth experience they desired.

Overall, the study's results suggest a need for policies and programs that provide greater access to the midwifery model of care and greater integration of midwifery into health care system. Not all states license or provide insurance reimbursement for all nationally certified midwives.<sup>13</sup> In rural areas, access to any type of maternity care may be challenging. And there are still myths and misunderstandings around the safety of midwifery care and community birth that make it difficult for consumers to advocate for these choices. Ensuring all families have access to the birth setting and attendant of their choice could improve birth outcomes at all times, but especially during public health emergencies. Greater flexibility and capacity in the maternity care system could provide not only optimal choice for consumers but also a needed cushion for circumstances when hospitals are overwhelmed or inaccessible. Having experienced providers with expertise in community birth is an important component of public health preparedness.

It should be noted that participants reported a significant amount of mental energy during their pregnancy consumed by weighing risks and making informed choices. During the remainder of the pandemic occurring at the time of this writing, health care providers should be aware of the risk calculations and negotiations being performed by pregnant clients and provide them with support for informed decision-making. Pandemic-related stress may add to the stress of pregnancy, and recent research suggests that women of color, those with prior trauma histories, the economically vulnerable, and those with pregnancy complications and chronic illness are among those most affected by pandemic stress<sup>14</sup> and may require the most support.

Although this study provides a novel contribution to the literature on community birth, it is not without limitations. First, these findings only capture the temporality<sup>8</sup> of a specific moment in time; spring through fall of 2020. They do not capture the implications of the surge of COVID-19 cases in the fall and winter of 2020 and 2021, nor do they address the impact of vaccination rates, pandemic fatigue, or state-by-state lifting of pandemic mitigation measures in 2021.

Second, none of the study participants stated they were forced into community birth; that is, they were not so afraid of coronavirus that they felt hospitals were a completely unacceptable option. Therefore, this study did not meet its objective of identifying insights that could be applied to public health emergencies in which women are unable to access hospital care and are forced to birth in place. Third, the absence of these perspectives from this study raises the question: did the recruitment method miss women for whom community birth felt like their only refuge from a potentially fatal disease, or were concerns about infection underrep-

resented in this population (and overrepresented in media reports)? Because we used a convenience sampling technique, our participants may not be representative of the universe of women seeking community birth during the pandemic. Because participants were recruited via midwives, clients who had a traumatic experience and severed their relationship with their midwives would not be represented, nor would those who considered switching providers but ultimately did not. However, it is also possible that birthing people who had considered community birth in the past would be more likely to have the knowledge and agency to investigate this option during the pandemic. For some birthing people, perhaps fear of the perceived dangers of childbirth outweighed their fear of coronavirus, and they would not voluntarily consider an out-of-hospital birth under any circumstances. Our exploratory qualitative study is unable to answer these questions. Given the unique nature of the COVID-19 pandemic, and interest among researchers in understanding and addressing its challenges, it is likely that other studies on this topic were conducted contemporaneously with ours and will shed light on these issues. Overall, this exploratory study identified intriguing findings that provide a foundation for quantitative studies with larger, more diverse populations in the future.

## CONFLICT OF INTEREST

The authors have no conflicts of interest to disclose.

## SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section at the end of the article.

**Appendix S1.** Screening Survey

**Appendix S2.** Semistructured Interview Guide

## REFERENCES

1. Cheyney M, Bovbjerg ML, Leeman L, Vedam S. Community versus out-of-hospital birth: what's in a name? *J Midwifery Womens Health*. 2019;64(1):9-11. <https://doi.org/10.1111/jmwh.12947>
2. MacDorman MF, Declercq E. Trends and state variations in out-of-hospital births in the United States, 2004-2017. *Birth*. 2019;46(2):279-288. <https://doi.org/10.1111/birt.12411>
3. Boucher D, Bennett C, McFarlin B, Freeze R. Staying home to give birth: why women in the United States choose home birth. *J Midwifery Womens Health*. 2009;54(2):119-126. <https://doi.org/10.1016/j.jmwh.2008.09.006>
4. de Freytas-Tamura K. Women scared of hospitals are increasingly turning to midwives. *New York Times*. April 22, 2020; A14.
5. Henderson G. As coronavirus lingers, home births surge. How midwives are adapting. *Christian Science Monitor*. June 17, 2020.
6. Burns M, Peacock S. Interpretive phenomenological methodologists in nursing: a critical analysis and comparison. *Nurs Inq*. 2019;26(2):e12280. <https://doi.org/10.1111/nin.12280>
7. Neubauer BE, Witkop CT, Varpio L. How phenomenology can help us learn from the experiences of others. *Perspect Med Educ*. 2019;8(2):90-97.
8. Benner P. *Interpretive Phenomenology: Embodiment, Caring, and Ethics in Health and Illness*. SAGE Publications; 2020. <https://doi.org/10.4135/9781452204727>

9. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *Int J Qual Health Care*. 2007;19(6):349-357. <https://doi.org/10.1093/intqhc/mzm042>
10. Cheyney M, Bovbjerg M, Everson C, Gordon W, Hannibal D, Vedam S. Outcomes of care for 16,924 planned home births in the United States: the Midwives Alliance of North America Statistics Project, 2004 to 2009. *J Midwifery Womens Health*. 2014;59(1):17-27. <https://doi.org/10.1111/jmwh.12172>
11. Glanz K, Rimer BK, Viswanath K. *Health Behavior: Theory, Research, and Practice*. 5th edition, Jossey-Bass; 2015.
12. Davis-Floyd R, Gutschow K, Schwartz DA. Pregnancy, Birth and the COVID-19 Pandemic in the United States. *Med Anthropol*. 2020;39(5):413-427.
13. National Academies of Sciences, Engineering, and Medicine. *Birth Settings in America: Outcomes, Quality, Access, and Choice*. The National Academies Press; 2020. <https://doi.org/10.17226/25636>
14. Preis H, Mahaffey B, Heiselman C, Lobel M. Vulnerability and resilience to pandemic-related stress among U.S. women pregnant at the start of the COVID-19 pandemic. *Soc Sci Med*. 2020;266:113348. <https://doi.org/10.1016/j.socscimed.2020.113348>